GPPA

THE GPPA *Report*

WINTER 2017

THE OFFICIAL NEWSLETTER OF THE GREATER PITTSBURGH PSYCHOLOGICAL ASSOCIATION

From the Editor...

PAVEL SOMOV, PHD

RIPENING – IN A FRUIT – is a process that results in a fruit becoming more palatable. Ripening – in an editor – is a process with a totally different outcome. I am not saying that after five years of editing the GPPA newsletter, I've become more palatable: I know that I am an acquired taste. But whether we are talking fruits or editors, all ripening eventuates in a dropping off, in a separation. Gravity, as always, wins. I step aside to make room for another exotic editorial beginning. It's spring, after all!

I'd like to introduce GPPA readership to Leswin Laubscher. Dr. Laubscher is the current chairperson of the Department of Psychology at Duquesne University. A graduate of Northwestern University, Evanston, and the University of the Western Cape, South Africa, Dr. Laubscher's academic interests have included issues of race, culture, and identity. He has taught at universities in South Africa and the United States, and his research similarly spans both countries and continents. His current teaching and scholarly interests also involve wrestling with the implications of the work of Jacques Derrida and Emmanuel Levinas for psychology.

Let us "wrestle with the implications" together! And one final editorial note: with this issue of the newsletter, we hit the payload – what a wealth of contributors, what a breadth of scope, what a depth of experience!

I wish you all well, Fellow Minds!

A Letter from the President

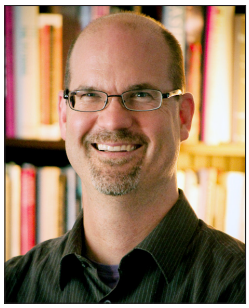
VICTOR BARBETTI, PHD, LICENSED PSYCHOLOGIST

Dear Members of GPPA,

SPRING IS AROUND the corner and I'm happy to report that your Board has been hard at work planning a number of events as well as finishing up a few important projects.

We are very happy to announce a one-day conference, entitled "Creating Safe Spaces: Inclusion and Diversity in Psychological Practice," to be held May 19th at Chatham University's beautiful Eden Hall campus. This conference features a keynote address by Dr. Rachel Levine, PA's first transgendered Physician General, as well as presentations on topics such as inclusion and diversity, supervision, neuropsychology and mindfulness, suicide prevention and more. We're also combining our annual spring social with this training event, so starting right after the conference we'll be joined by Board Member (and Conference Chair) Dr. Teal Fitzpatrick and her wonderful band, Molly Alphabet, for a fun-filled evening of music, food and networking. I was fortunate to see Molly Alphabet open for the Cactus Blossoms last year in South Park and I'm very much looking forward to seeing them perform again. They put on a fantastic show, and one that you don't want to miss!

We also have our monthly happy hour meet-ups scheduled for this spring, so be sure to check your email (or the last page of this newsletter) for information about these networking opportunities. The Networking Fair committee is currently working on a fall networking event, and we'll have more information for you about this event in the near future.



Over the past few months, the APA CE application committee has been researching the feasibility of re-applying to APA for CE granting privileges, and I'm happy to report that at our Board meeting in February, the Committee officially recommended that GPPA re-apply for this status, and the Board unanimously approved this recommendation. This group will now be working on the application process, and we'll keep you posted on its progress.

It was great to see so many of you at the recent Legacy Award dinner honoring Dr. Robert Schwartz, as well as connecting with you at our monthly meet-ups. For those of you who haven't yet made it to a meet-up, you're missing out on free appetizers and rewarding conversations! And if you're interested in participating in GPPA committees or activities, or if you're interested in running for one of the two Board positions opening up for next year, please contact me or our assistant, Angie Phares, and we'll be happy to answer any of your questions.

I look forward to seeing you soon at one of our upcoming events!

Victor Barbetti, PhD

WELCOME NEW MEMBERS:

Members

Annalisa Almendras, PsyD
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Kaylee Curilla, PsyD
Erin Donnelly, PsyD, MEd
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Melissa Taylor, PhD
Marjorie Weinstock, PhD

Affiliates

Janelle Crisp, LPC

Student

Nicole Currivan, MS

FAMILIES IN CONFLICT: Another Tool for Helping Children and Families Succeed

Barbara Baumann, PhD
University of Pittsburgh School of Medicine

IT CAN BE frustrating to provide care for a child and caregivers who struggle with aggression, disrespect, conflict, disobedience, or a history of abuse or harsh physical discipline. This was certainly the case for me when my clinical practice was made up entirely of children diagnosed with ADHD and their parents. When I began working in a clinic with referrals from the juvenile justice system and child welfare, I encountered caregivers who also sometimes exhibited high levels of aggression, conflict, and a trauma history.

That's why I was excited when I was asked by Dr. David Kolko, Professor of Psychiatry, Psychology, and Pediatrics at the University of Pittsburgh to collaborate on a study implementing Alternatives for Families: A Cognitive Behavioral Therapy (AF-CBT). AF-CBT is a trauma-informed, evidence-based treatment designed to improve the relationship between children and caregivers in families involved in arguments, frequent conflict, physical force/discipline, child physical abuse, or child behavior problems.

Now, as a trainer for AF-CBT, I work with clinicians in Western Pennsylvania and all over the country who implement the model with families in clinics, offices, schools, homes, and residential settings. Clients are typically seen on an outpatient basis, usually about once per week, but scheduling is flexible. The average length of treatment may vary, and treatment content is tailored to each family's needs.

Services involve the child or teen, at least one of the child's caregivers, and the family as a unit. We begin services with whoever is available (caregiver or child). Any adult caregiver (biological, foster, adoptive, etc.) with at least one child is eligible for services.

AF-CBT maintains a website to keep practitioners informed and up-to-date on training and networking opportunities (www.afcbt.org). The next training in Pittsburgh is June 5-7, and if you're looking for some warm weather this winter, there are trainings in Laredo, TX and San Jose, CA in March. We can also work with groups of clinicians or community agencies to develop a training to meet the needs of their clinicians.

Here's some basic information we like to share with clinicians who are considering adding AF-CBT to their toolbelts.

Teach families to:

- Manage anger, anxiety, and stress
- Parent using healthy practices
- Solve problems effectively
- Address family conflicts

Families can expect:

- Individual, parent-child, and family sessions
- A focus on skill-building
- Therapists who respect family and cultural values

How families will benefit:

- Improved family relationships
- Enhanced coping and social skills
- Reduced behavior problems in children
- More effective family communication

Counseling Services for the Veterans at Duquesne University Psychology Clinic

The descent to Hell is easy;
Death's gate stands open night and day;
But to retrace our steps, to climb to the air above,
This is our life-work, this our labor.
— Virgil, *Aeneid*

SEVEN YEARS AGO, the Duquesne University Psychology Clinic opened its doors to a Military Services branch of practice. Under the direction and supervision of Dr. Roger Brooke, veterans and their loved ones can seek psychological evaluation and treatment. The Military Psychological Services in the Psychology Clinic offers a wide range of free services sponsored by the University, consistent with its mission. At the Clinic, we seek to treat the invisible wounds of war, such as TBI, PTSD, and MST. For us it is our ethical duty to serve our women and men in arms as they have served us.

We are not programmatic. Rather, we work with individuals in a flexible, collaborative practice. Our general perspective is that what is now called PTSD is the social construction of a human universal as a psychiatric illness—the stigmatizing of a moral and spiritual wound that has been named and ritually addressed as such in all traditional warrior cultures. In our approach we draw from a knowledge base of those cultures, which, for instance, regard the experience of war as an initiation onto the warrior's path of moral and spiritual development throughout the life span. What is now called posttraumatic growth is endorsed and deepened with this personal and communal meaning.

In our perspective, civilians must actively participate in veterans' homecoming. One of the universal conditions of successful homecoming is that veterans share their experiences to a welcoming and loving community, which understands that what veterans have experienced has been done in the name of that community. This insight provides the deeper background of our work; in this way we are aware as clinicians and counselors that we are participating in something older and deeper than simply being psychotherapists "treating" PTSD.

It is our experience that these services provide our veteran community with some of the resources necessary to meaningfully understand and integrate their distressing military experiences. These services aid in the often difficult process of reintegration into civilian life, while offering our veterans those universal needs of gratitude, understanding, joint responsibility, and compassion when re-emerging from the depths of war.

The Impact of Pregnancy and New Parenthood

Jodie Hnatkovich, LPC, CRC
Forward Wellness Counseling and Consulting Services, LLC

TREATMENT FOR MENTAL health around the birth of new parents is multifaceted. Often the most effective model for treatment involves an Integrated Model of Support. The emotional hardships around becoming a new family are known as "Perinatal Mood Disorders." This label encompasses the timeframe of conception to one year postpartum and includes all the events surrounding birth including: infertility issues, adoption, miscarriage, abortion, antepartum depression or anxiety, stillbirth, traumatic birth/ PTSD, postpartum depression or anxiety (including OCD), postpartum psychosis, infant disabilities, and infant death.

Per Postpartum Support International (2015), research tells us that perinatal mood disorders affect 1 in 7 mothers. More than 400,000 infants are born to mothers who are depressed, which makes perinatal depression the most under-diagnosed obstetric complication in America. A mother's mood and anxiety symptoms have a direct impact on her partner as well. Her partner may feel overwhelmed, confused, angry, and afraid she will never be well. This may place a strain on the couple's relationship. About 10% of new dads have depression, mood or anxiety problems, as well (Paulson & Bazemore, JAMA 2010). Adequate screening and early intervention tracking services can protect the well-being and development of the mother, baby and entire family.

Treatment from a Psychotherapist

To work well with new parents, we need to be skilled with multi-dimensional psychological systems. Psychological care includes three unique areas: Greif, Trauma, and Depression/Anxiety. Clinicians need to be knowledgeable with grief care. Families are moving through one of the biggest transitions of their lives (thus far). Parents need to be able to grieve the loss of their old life with the loss of the expectations of what a new baby would be. We need to be effective at sitting with them in their pain or suffering. We need to understand the dynamics of grief and allow our clients to be present in this process.

Clinicians need to be proficient with trauma work. When the idea of death enters the equation, pregnancy, birth and parenting are just one crisis after another. We need to help clients slow down enough to do the work of placing the initial traumatic event. Fathers often have a hard time acknowledging the slow-motion car crash they witnessed with their partner that left them feeling helpless. Psychoeducation, emotional regulation and trauma theory are all imperative to this recovery.

For most new parents, this life transition is the first time they are forced to do the emotional work related to anxiety or depression. It may be first time in their lives that their emotional coping techniques are no longer successful. We see this as their anxiety tendencies, turn into obsessive-compulsive tendencies and now they can't drive a car or walk down steps with the baby. Their difficulty sleeping turns into no sleep because babies don't allow for hour-long bedtime rituals. Their codependency tendencies with their partner become feeling helpless and trapped by not stating their needs. The desire to sleep and make it all better becomes a desire to run away. The desire to run away becomes the desire to make the pain end – anyway possible.

As clinicians, we need to understand that perinatal mental health is not a single dimension issue. There are many dynamics at play to help mothers and fathers feel they are successful and thriving with their new parenting gig. There are emotional needs that require to be nurtured and relationships that strive to be rejoined. We also need to be aware of suffering and when it is necessary to reach out for medical or pharmaceutical interventions.

Empowerment

There is a movement in our society right now to break the stigma barriers around motherhood – or better yet – "perfect mothers." New moms and dads feel this pressure to be perfect – while also feeling completely out of control for the first time in their lives. This movement is allowing parents to be authentic and real. It is allowing parents to foster emotional growth – through emotional breakdowns – to become better parents.

My role as a clinician that specializes in Perinatal Mental Health is to empower. I want to empower parents to be authentic, to learn from their mistakes, to know that this is hard – and to know that it can get better with help and treatment. My role as an advocate is to inform other clinicians, medical professionals, and families about the importance of mental health care and support for our new parents.

Contact Jodie at: Jodie@forwardwellnesscounseling.com

GREATER PITTSBURGH PSYCHOLOGICAL ASSOCIATION

THE 2016 - 2017 GPPA OFFICERS:
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Legislative Action: Shannon Edwards, PsyD
Provides updates and participates in local, state and Federal policy issues.

Membership: Cynthia Magistro, PhD
Plans membership drives, processes applications.

Networking & Social: Shannon Edwards, PsyD
Plans networking and social events.

Newsletter, Publications, Website: Victor Barbetti, PhD
Publishes semi-annual GPPA newsletter, maintains & updates website.

Volunteering: Terry O'Hara, PhD
Quietly assist the underserved who need help (not necessarily psychological) and to provide more connection into the community.

How Psychotherapy and Career Counseling Can Complement Each Other

Karen Litzinger, MA, LPC

AS A CAREER counselor, I am often referring my clients to psychologists and other therapists to address deeper issues that may be helpful to explore as they relate to career planning and the job search process. When I read the Fall 2016 article, "The Integration of Career Counseling and Psychotherapy" in the journal, *NCDA Career Developments*, I thought it would be a good topic to explore.

The article cites career theorist, John Krumboltz, as asserting that "career problems are inextricably intertwined with personal problems and must be treated as such by professional counselors." The article was published in the *Ethics in a Nutshell* section of the journal and makes a point that collaboration between career development and mental health professionals is an ethical responsibility to enhance better career choices, employee retention, healthier work environments, and smoother transitions in retirement.

For your consideration, here are some areas of intersection between psychotherapy and career counseling that I have professionally experienced:

Identifying Issues – When I meet with clients who are unhappy in their careers, I often explore the various issues that could be at hand. Is it the career field itself? The specific job or employer? The industry, service, product or topic? Their own issues that follow them around? Pressure or "shoulds" that indicate external motivation? Often it is a combination of these. These can be good questions for therapists to explore as well. If even part of the issue is that the career field itself may not be a good fit, you may do well to consider a referral to a career counselor. Taking constructive action to resolve one's career confusion can reduce anxiety, hopelessness and pessimism.

Career Expertise – Career counseling is a specialty. On more than one occasion I have come across a situation where a client's psychotherapist, while trying to facilitate an organized career exploration, gave a client an assessment to increase awareness of just one facet of self, but did not address the issue more comprehensively in terms of such key four elements as interests, strengths, personality and values. Sometimes brainstorming in therapy leads to a suggestion of shadowing someone professionally to explore an option. From the standpoint of career counseling, however, it might be better to explore the issue first in a broader context. A career counselor can offer a thorough and organized approach to self-awareness and career exploration.

Motivation – Sometimes a person seems to lack motivation for a career change or a job change. This might be rooted in deeper issues, such as external pressures or lack of confidence. Alternatively, moving through the process of career counseling, may help client realize that it is not necessarily a motivational issue and that they, in fact, don't want to make a change after all, or that it might be a timing issue, that they need to deal with some personal issues before taking action.

Decision-making – I typically work on a short-term model for career counseling to give clients all the tools they need to make a decision and then I provide tools to move forward. Clients may later experience decision blocks of anxiety, perfectionism, confidence, catastrophizing, shifting identity, among other things. I often suggest clients consider counseling if emotional blocks emerge.

Action Obstacles – Clients may experience emotional obstacles in taking action in the networking portion of career decision-making or in following through on job search tasks. Besides some of the emotional blocks noted in the decision-making section above, other obstacles could include embarrassment to ask for help during career research networking or fear of rejection during the job search process. In such cases psychotherapists could be a source of insight as well as emotional support.

Problem patterns – Sometimes client career issues follow them around from job to job. This might include work-life balance issues that lead to burnout or, for example, relationship issues around victim mentality. I encourage self-development through counseling or coaching to help clients achieve more success and satisfaction on the job. If a psychotherapist addresses self-development issues in isolation, without considering career-choice or career-fit issues which might related, the holistic approach might suffer. Thus, collaborative work between career counselors and psychotherapist can assure a holistic approach to self-development. Furthermore, the self-knowledge that comes through career counseling may also help shift some unhealthy patterns in psychotherapy progress.

Collaboration between our disciplines can create supportive environments to explore and manage the emotional distress of career issues and address career decisions and the job search in an organized and comprehensive manner.

Karen Litzinger, MA, LPC helps people from high school through retirees with education and career decision-making. For additional information: litzingerkaren@aol.com, www.KarensCareerCoaching.com

Interesting Times: An Invitation From a Member

Laure Swearingen, PhD

I AM INTERESTED in forming or participating in a psychologists' group to discuss our roles in these (politically and culturally) "interesting" times. Here are some of the issues that come to mind.

Over the past several days, lawyers have provided their expertise and direct services to those people who are significantly impacted by the recent executive orders concerning the United States response to certain immigrants and refugees. Is there a way for psychologists to help?

Several of my clients report acute increases in anxiety, fear, and hopelessness in the wake of government actions over the past 10 days; other changes in symptoms of traumatic stress have been disclosed. Would it be helpful to have a professional support group in order to share our own feelings and determine ways to approach these unprecedented political phenomena?

How can we present a unified social and political influence in this city and this field? (I am aware that we are not all necessarily in the same political camp.) Perhaps together we might be able to prepare for the likely effects of the specific changes from the new American paradigm in Washington.

A cursory search for similar initiatives in APA and PPA, and in a few other cities across the country, yielded no information. I am willing to bet that there are other groups of psychologists with the same considerations.

Any member with these and related concerns, please email or call me: Lassloss55@gmail.com or 412-841-3720

SPEROPATHIES: The Disorders of Hope

Edward Zuckerman, PhD

HOPE IS USUALLY seen as a fine thing to have. Remember Obama's election poster with just the word "Hope" below his multicolor portrait? We are told after the 2016 election that even if we have lost optimism we can still retain hope. Experts say that hope is essential for life and hopelessness a key element in suicide. *Dum spiro spero* – that is Latin for "while I breathe there's hope."

But, hope can go astray in so many ways. Here is the start of a catalog of how hope can backfire.

Pining away in unrequited love

The lover who sacrifices everything for the unappreciative and unresponsive other is no longer seen as a romantic ideal; they are just stupid and wasteful. Such self-sacrifice shows a lack of self-esteem and self-confidence and the need for assertiveness training.

A further refinement is when the hoped-for other is an impossible mate. In this case the hopeful lover ignores or explains away romantic rejection with such rationalized obstacles as unavailability due to marriage, social class, religious commitment, etc. This scenario has been known as De Clérambault's Syndrome and was first described in 1885 as having a phase of hope followed by a phase of resentment. The French psychiatry, dominant at that time, had many diagnoses for this kind of hopeless-hope scenario: erotomania, erotomanic delusion, paranoia erotica, psychose passionnelle. It is not included in the obsessional disorders of current ICD. A hopelessly-hopeful lover of this kind would nowadays be assigned one or more of the personality disorders such as F60.89 Inadequate, Immature or Self-defeating disorder. Efforts to unite with the beloved would now be seen as stalking. Even more outlandish or resistant delusions might merit F22, Delusional disorder. A good summary of these scenarios can be found at http://patient.info/doctor/de-clerambaults-syndrome. Additional literature and a legal case are also fully discussed at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2552541/

Serial Marriage

When about half of the first marriages and half of the successive marriages end in divorce, surely we have to conclude that we are using bad criteria to choose partners. Oscar Wilde wrote that "marriage is the triumph of imagination over intelligence." Second marriage is the triumph of hope over experience. It is wisely said that women marry expecting that "he will change" and that men marry with the expectation that "she won't change" and that both find that they were wrong.

"We can live on love." "Nothing can stop us if we have each other." "Our love will last forever." These hopeful proclamations inevitably lead to disappointments. Ah, the hopes of romantic love! The evidence is that passion lasts 3-9 months. Marriage strangles love. Almost always. I do recognize that many couples stay in love but it is not the irrational, intense, unrealistic kind of romantic love. Their companionate love is realistic and accepting.

After a divorce, the costs of the loss (the sunk costs of the investment one has made in the marriage) pale beside the pain of the lost hope - the plans for the future together, the children, or the imagined completely wonderful times together.

Omnia vincit amor – "Love conquers all" said the poet Virgil or in contemporary English, "He's not really like that" and "But I love her." From whom do we hear such words? Not those accepting of differences and avoiding the dangerous partners. No, it is from those suffering abuse, violence, or desperation who take these irrational positions. "He'll change. It's my fault," she says after another of his sieges of insults, abandonments, or beatings. She hopes he will change his ways and that his true and delightful self will eventually shine through. Only she can see it now. Others fear for her but lack her trust and vision. Similarly, "but I love her" is never used except to justify some obviously stupid or self-defeating loyalty.

After a disaster those besotted with hope will say, hopefully, "Lightning never strikes twice in the same spot." Of course it does when the spot is high and electrically conductive. But even more often, their analogy is in error. When the disaster they hope to avoid by repeating their choices was created in large part or totally by their own bad decisions, lightning is on its way to strike again and again because they have not changed.

In any case, love is believed to have all the qualities of secularized grace. It is highly changeable and so a ridiculous basis for a long term commitment, cannot be commanded ("You can't hurry love") to appear or resurrected when dead, is the most precious of emotions and desirable of states, etc. We hope for love's magical potency and suffer from its absence.

Cyclic Dieting

Cyclic dieting is another example of how hope backfires. Why are there a thousand diets? If dieting worked, there would be only one diet. As we all know, only a small percent of dieters manage to keep the weight off. See https://www.ncbi.nlm.nih.gov/pubmed/27136388 for the research report on this. New diets (always?) begin at a higher weight than the weight at which the last diet started. Therefore, weight increases are caused by dieting. So why do we diet repeatedly? Alexander Pope said "Hope springs eternal in the human breast" and apparently in the buttocks, belly, etc.

Janet Polivy and C. Peter Herman noted a "cycle of failure and repeated efforts at self change as a 'false hope syndrome' characterized by unrealistic expectations about the likely speed, amount, ease, and consequences of self-change attempts." (Polivy, J. & Herman, C. P. (2002). If at first you don't succeed: False hopes of self-change. *American Psychologist*, 57(9), 677-689.) They detail how people interpret these failures in such a way that they are led to keep trying repeatedly despite apparently overwhelming odds.

I will stop my cataloguing of how hope backfires here. Hopefully, someone else will pick it up from here.

Psychoanalyze, Don't Moralize

Pavel Somov, PhD

EVIL IS NOT a psychological category. Evil is a moral category. I invite you to psychoanalyze, not moralize. Here are a few propositions for you.

"There is no evil – there is just ignorance, greed, fear, obsession and indifference."

Ok, let's unpack this step by step.

Ignorance is not evil.

Ignorance is the result of any number of psychological, sociological and educational factors. Ignorance can be the result of misguided cultural programming (eg racism, chauvinism, nationalism, etc). Ignorance can the result of educational oversight (eg "Earth is flat," etc). Ignorance can be due to a lack of life-experience or a lack of psychological savvy. Ignorance can be an intelligence deficit (a matter of IQ deficit, or a learning disability). Point is: ignorance is not evil.

Greed is not evil.

Greed can be understood as an interplay of love and fear. Greed ("love of the money") can be understood on some level as a fear – a fear of not having enough. Greed can be understood as competitiveness (a desire to have more than others have). Competitiveness-based greed is not evil – it's just a misguided attempt to regulate one's sense of worth, it's a self-esteem project, perhaps, a chronic hunger for narcissistic validation. Narcissism too is not evil, it's just narcissism (a sense of emptiness, a failed sense of self with an attempt to reassure yourself by polishing the social mirror). Greed can also be understood as mis-directed love – a fixation, an obsession, a transfer of libidinal energy onto the material; loving money is safer than loving people, since money doesn't abandon us – that sort of thing … Point is: *greed is not evil*.

Fear is not evil.

This is rather self-explanatory: of course, fear is not evil. Fear is just fear. But in fear, out of fear, we do some horrible stuff to each other. As you've heard, offense is the best defense. There are plenty of moments when we attack, preemptively, out of fear and we attack viciously – out of fear that a measured attack won't suffice. So, we over-react, over-defend, over-kill. None of that is evil. It's just out-of-control fear. Point is: fear is not evil.

Obsession is not evil.

Humans get obsessed. We get imprinted. We get fixated. We get addicted. We develop most unsavory fetishes. None of this is evil. All of this has to do with our reward systems getting highjacked. A "-phile" is not evil, a "-phile" a "lover." "-phile" is Greek for "lover" or "enthusiast." A "-phile" can be an Anglophile (a lover of all things British), a Russophile (a lover of all things Russian) or some unsavory "-phile." "-philes" of any ilk aren't evil. "-philes" are just highjacked brains.

Indifference is not evil. Lack of empathy, antisocial callousness, sadistic insensitivity, psychopathic manipulation and unchecked violence – these are the things we fear, these are the elements of the human jungle that we have to constantly watch out for and protect ourselves from. But we can fear all this and try to protect ourselves from all this without moralizing. Indifference – in all of its disguises and manifestations – is not evil. Indifference can be understood as lack of mirror neuron activity. Mirror neurons underlie our capacity for empathy. Those of us who congenitally lack empathy operate on a different type of neurological hardware than the rest of us. We don't choose our brains. We are thrown into this life as we are. If you lack mirror neuron activity, then your neuro-hardware is not enabled for empathy or your empathy is compromised. Lack of empathy is not all bad – it has situational value. Lack of empathy in a bootcamp sergeant can be quite useful. Same goes for a surgeon and a sniper and anyone in a position of having to make tough, un-empathic decisions on the behalf of others. Lack of empathy is not evil, it's mis-employed. As a civilization, we are still too young to harness and sublimate lack of empathy towards social good. But we'll get there someday. Psychopaths will make wonderful colonizers of Mars. Un-empathic types are great at "going West," at clearing the ground for the rest of us, neurotics. Furthermore, any of us can experience a reduction in empathy – you've heard of "hanger," right? When you are hungry, you get irritable – suddenly, you – who is usually quite nice – become an un-empathic, indifferent, irritable jerk. Our ability to care for others might be wiped with poor sleep, illness, or a neurological event, such as a stroke, which might result in a so-called "personality change." My point is that any and all of this is not evil. Indifference is not evil, it's just a modality of human consciousness.

Why do we moralize, not psychoanalyze?

Moralizing is easy. Moralizing also makes us – moralizers – feel better about ourselves in comparison to those we morally judge. Moralizing is easy because it is nothing more than labeling. Calling something or someone "evil" is simple, isn't it? You slap a moral label and you are done: no more thinking is required. Psychoanalyzing is harder: you have to think, you have to go beyond the simplistic labels, you have to ask yourself a bunch of "why" questions, you have to examine context. Heck, you even have to have the courage to relate! So, not only is psychoanalyzing is harder, from the standpoint of information-processing, it's also humbling. Why? Because as you work to make sense of someone else's behavior you begin to relate to that behavior on some level. Psychoanalyzing humbles us. Unlike moralizing, it doesn't allow us to feel superior. Psychoanalyzing requires of us a courage to relate. And when we do that, we see bits of ourselves in what we try to blot out with judgment. And that creates some cognitive dissonance for us – we don't like that.

Moralizing Isn't Evil Either

So, yes, moralizing is easy. Psychoanalyzing is hard. But I am not going to moralize about moralizing: I get it, doing what's easy is intuitive. Moralizing too isn't evil, moralizing is just self-care. Labeling others with a fleeting judgment is a cheap way to help ourselves feel better. Cheap is good, right? Right. I am not being snarky. I mean it. Of course, cheap is good. When we moralize, we instantly elevate ourselves – we get a little ego bump. It's an information-processing bargain for us, part of our self-regulatory intelligence. Also, when we moralize, when we pronounce something or someone as evil, we are trying to be conservative – we are programming ourselves to be watchful, to be paranoid. All that too is self-care. What is here to moralize? So, yes, we can psychoanalyze moralizing too.

No Evil

We are not fighting demons, we are fighting our evolutionary programming. There is no darkness inside us – just fear, ignorance, indifference, etc. "Evil" is an outdated concept. It's not a psychological concept. It's a medieval theosophical crutch from a time when we thought Earth was flat. Time we upgrade our mindware. Life is not about good and evil. It's all good. Only good. Ordinary perfection, in fact. Just life, you know. So, hear no evil. See no evil. Speak no evil. Psychoanalyze instead!

Children's Groups: The Power and Fun of CHAATing

Jessie Goicoechea, Ph.D.
Clinic Director and CHAAT Supervisor,
Department of Psychology at Duquesne University

TRANSFORMING PAINT STICKS into shakers with jingle bells, gluing together a story quilt with scraps of fabric, and making masks with plaster of paris – activities not typically associated with training in psychology. But in a house tucked behind the Wesley Center AME Zion Church in the Hill District, it is just this kind of fun that doctoral students in Duquesne University's clinical psychology program are having. In partnership with the Center that CARES, an afterschool program, local African-American artists and community liaisons, Duquesne's Rita M. McGinley Psychology Clinic provides culturally informed, art-based psychoeducational workshops for 4th and 5th grade students.

This program, called CHAAT–Children's Art And Talk groups, helps children explore, give concrete expression to, and better understand their emotional and social experiences. Each Tuesday afternoon, two doctoral students (currently Jennifer Bradley and Brian Coleman), two artists (Amir Rashidd and Donna Reed Williams), and a community liaison (Denise Baskin) meet with about ten children to creatively take up the question, "Who am I?" by way of art activities and discussion. Drawing on African and African-American traditions of mask-, instrument-, and quilt-making, CHAAT facilitates positive relationships and self-expression. In one recent workshop the kids made collages with fabric as they learned about how quilts served as covert maps in the Underground Railroad and looked at pictures of great African-American quilts like those of Harriet Powers and Faith Ringgold. The children's individual collages will be sewn together as one story quilt, the story of this university-community, cross-cultural collaboration.

My niece, Hanna Woodward, who is an artist, and I have been working on a series of cartoons called "In Treetment." In this imaginative endeavor, we try to learn about human nature from trees. We – humans – are but trees-on-legs, are we not?! Please, check Hanna's portfolio at www.hmwworks.com.

Pavel Somov, PhD

CHAAT aims to serve children, enhance after school programming, and train doctoral students in a framework that emphasizes cultural diversity, community engagement and social justice. Many of the children in the Hill District face multiple challenges associated with oppression, racism, and urbanization in low-income settings. Research has found that these challenges, such as inadequate housing, high crime rates, and limited access to resources place children at risk for various problems including elevated rates of delinquency and academic underachievement, post-traumatic stress, depression, substance abuse, and aggression and violence. (1) Prevention efforts are critical to reducing the impact of socio-environmental risk factors and promoting protective factors and systems level change. (2) CHAAT is consistent with such recommendations. A commitment to social justice may indeed require expanding psychology's professional activities and views of cultural competency beyond intervention. As CHAAT does so, it also challenges the doctoral students to examine personal and professional assumptions, another element fundamental to social justice initiatives.

Some African-Americans may be mistrustful of and question the usefulness of traditional mental health care and prevention models. Research has found that African-American and other ethnic minority children may especially benefit from approaches characterized by social/affective emphases, creativity, and non-verbal communication. Furthermore, studies have found that racial pride and cultural affiliation in African-American children are positively related to self-esteem and mediate against depression and other psychosocial difficulties. (3) CHAAT aims to strengthen racial pride by incorporating culturally specific art and connecting the children in positive ways to their community and heritage. Additionally, the children observe white, black, and other ethnic minority adults constructively working together for their well-being, while the adults gain new perspectives on each other's cultures.

Developed out of the Hill District Community Collaborative, with Terri Baltimore's steadfast leadership, and then moved to the Hill House Association's Afterschool Program, both departments of which have dissolved, CHAAT forged a new partnership with the Center that CARES in 2015. Since that time, CHAAT has been supported by a Charles Henry Leach II grant, which includes funding for an art exhibit in the Les Idees Gallery at Duquesne University. For the grand opening, this year on February 14th (open to the public until February 25th), the children are bussed to the gallery to eat cookies and delight in their creations. University-community engagement, often defined as students and faculty going out into the community to develop mutually beneficial partnerships toward the co-construction and application of knowledge, is broadened to include the kids and CARES staff coming onto campus for this event. The kids see their art on the walls of a university campus and may imagine themselves attending college one day. This is the power and fun of CHAATing with our neighbors.

References:

(1) Tucker, C., & Herman, K. (2002). Using culturally sensitive theories and research to meet the academic needs of low-income African American children. *American Psychologist,* 57, 762-773.

(2) Black, M., & Krishnakumar, A. (1998). Children in low-income, urban settings. Interventions to promote mental health and well-being. *American Psychologist,* 53, 635 646.

(3) McMahon, S., & Watts, R. (2002). Ethnic identity in urban African American youth: Exploring links with self-worth, aggression, and other psychosocial variables. *Journal of Community Psychology*, 30, 411-431.

Notes from a False Negative Psychologist

Edward Zuckerman, PhD

I AM A VERY successful psychologist. Here is my evidence: Licensed, PhD and internship, both accredited by APA in clinical. A long career of doing therapy, consulting and teaching. Three very successful books over almost thirty years, originally self-published and now distributed by Guilford, a major quality publisher. Recognized by sight by my peers because of my columns in state and national publications. Presented hundreds of CE programs and decades of teaching psychology as an adjunct at Pitt and CMU.

I tell you these things only to support the false implications of the negative evidence I will present below as predicators of these outcomes. Given the data even I would not have suspected the falsity of the negative import of this history. But I would have been wrong because of the effects of factors not included in the equation and especially of luck.

My Checkered Academic Life

For someone who has taught at all levels all his professional life I was a lousy student.

My mother persuaded someone to admit me to a very prestigious and high-achieving high school where I proceeded to do very poorly but did graduate. I got into a college that admitted anyone who graduated from my high school. I immediately changed my major from one that required lots of math. I had no study skills, was anxious and depressed, and saw no relevance of the classes to my life. I floundered there until they finally threw me out after I failed to attend classes.

For the next two years I worked sporadically and restarted college classes at night at a local state teacher's training school (Southern Connecticut State College, which we dropouts called Second Chance State). I moved to their day program in the first class of Bachelor's candidates.

Each semester my QPA was lower. I liked psychology and got good grades and so thought I might become a clinical psychologist although I did not know any except one teacher. I left college without the degree because I failed the second year of Spanish twice.

During the next few years I got into therapy and I worked as a psychiatric aide at a famous giant city psychiatric hospital – Bellevue – because it was the only job in the psych area for those without a college degree. I saw a lot and learned a lot and thought that if I got more education I could help those I only took care of. But I believed I was too neurotic, too unfocussed, too lacking in academic and study skill to get into graduate school. Then, one night between Christmas and New Years of 1967 I had an epiphany: I was the worst judge of myself. In fact, there were hundreds of highly trained professionals across the country who could make the decision about my suitability for a career in psychology much more accurately. All I had to do was send these admission committees some paper and some money.

I immediately quit my job to apply myself full time to applying to graduate schools but could not get them done; procrastination, low persistence, neuroticism. I went back to being an aide but tried again a year later. A famous psychologist at Columbia, Sol Garfield, interviewed me after I applied. He told me I should never even consider becoming a psychologist. So I applied to thirty-three programs. This was more than half the APA-approved programs but being an arrogant New Yorker I deigned to eliminate universities in farm states. I got into one; the perfect one for me. Luck?

Pitt for Me

I believe that if I had applied to fewer I would have not gotten in anywhere because I got into Pitt by error (not even by accident). I believe this although it has been denied by someone on the admission committee twenty years later. Let me offer my evidence.

Each year Pitt had previously admitted eight from about 400 applications to its clinical program. All I had going for me was clinical experience. I had seen every kind of psychopathology. But I had the kind of application that would have gone straight to the trash: flunked out of college then B+ grades and A- in psychology classes. Good GREs but not outstanding. Very high Miller Analogies scores. (Plural because I took it four times over the years with lower scores each time.) Letters of recommendation which were positive but did not address my academics because they were written by a head nurse and a psychiatrist I had worked for. Junk.

Here is my theory: the admissions committee was processing applications in groups of ten. Someone put a pile of ten on the "admit" pile instead of the "reject" pile and the letters went out. As I said, one admission out of 33 applications.

My evidence for this theory is a bit fragmentary at this time but here are some anecdotes. It was 1968 and Pitt had decided to admit a larger group to increase diversity so there were to be 12 instead of 8. I would not have added any diversity. There were indeed four or five African-American faces in the room the first day. Actually there were 22 faces. Among my classmates were those with high achieving records and the rest of us.

Anyone could identify the ten misfits. Allen carried a shotgun under his car seat and told me to mind my own business when I asked about it. He went off to Viet Nam in a few months. Amy cried through each class hiding her face in her hair so I don't recall what she looked like. She disappeared. One immediately switched to the social psychology track. Three received terminal master's degrees from a program that only admitted students aiming for doctorates. One of these appeared to have stepped out of Sicily in 1950 and never spoke to me. Another was very nice and friendly but just didn't get the larger picture and had to work very hard in class. The last had a career in music that was really more important and suited him better. I am the only one of the ten to achieve a PhD.

My luck continued

The year I came to Pitt the language and calculus requirements were dropped. I would have failed both and terminated my career. My evidence: I had passed Latin in high school with D's and failed and dropped German in college. I failed the second semester of Spanish a total of seven times over the next few years until a gentle soul, David Zuniga, out of kindness or maybe exhaustion at my mauling of his native tongue passed me so I could receive my BS. I might have some neurological language defect as I have done poorly or failed Latin and German as well and got nowhere in any computer language. I never even tried calculus knowing that my algebra was fragmentary and my grades low.

I agreed to come to Pitt without any financial aid or any job promise which were then customary. I was given a research assistant position that paid my tuition and some more by the kindliest and most tolerant of all my professors, Joe Golin. He knew I knew nothing of the statistics or the research tools but let me do the data entry and taught me the rest.

I was such a poor graduate student that I failed two of the core classes but was allowed to retake them in summer school. I survived due to the kindness of my professors and the ward keys from Bellevue I hung above my desk that summer.

I tell you these things only to show that there are other paths to success than the usual or the predicted. You can use my story to cheer and reenergize yourself or students or anyone facing defeats and obstacles. You can emphasize persistence and hard work or the randomness of life.

Drs. Nick Flower, Teal Fitzpatrick, Bob Schwartz, Shannon Edwards, and Victor Barbetti

Drs. Dan Warner, Bob Schwartz, and Victor Barbetti

Robert Schwartz, PhD receives 2017 GPPA Legacy Award

ROBERT MARC SCHWARTZ Ph.D. has been in professional psychology since the early 1970s, making contributions to research, clinical work, and professional practice. Jokingly referring to his career as having experienced "the worst of both worlds," Dr. Schwartz has had significant impact in both academic and clinical circles.

Dr. Schwartz's academic research on the "States of Mind" model has gained international attention in clinical and positive psychology circles, and it is regularly discussed in leading psychology and psychiatry journals. Dr. Schwartz also taught in various academic institutions including the University of Pittsburgh School of Medicine, and the University of Pittsburgh School of Dental Medicine.

Clinically, Dr. Schwartz has again found himself "riding multiple horses," through his dedication to an integrative approach that spans across the psychodynamic and cognitive behavioral schools. The very name for the group practice that he co-founded, Cognitive Dynamic Therapy Associates, speaks to his dedication to cultivating a professional clinical psychology that is diverse. He also developed a clinical specialty as a certified sex therapist, which led to his co-founding the Kurtz Center for Love & Intimacy, one of the premier national training centers for sex therapy.

Dr. Schwartz is equally devoted to his family and his faith. He is the father of four young men of whom he is very proud, and the husband of Amy, the love of his life. He currently splits his time between Jerusalem and Pittsburgh and he continues to write professional papers.

The award was presented on Thursday, January 26 at Bar Marco in the Strip District.

GPPA CONFERENCE: MAY 19, 2017

CREATING SAFE SPACES: Inclusion & Diversity in Psychological Practice

Keynote address by Dr. Rachel Levine, Physician General of Pennsylvania and Advocate for Transgendered Youth

ALSO PRESENTING:

Audra Lee, LMFT & Ashley North Cook, LMFT
Supervision Practices and Multicultural Competency

Dr. David Brent, MD
Saving Holden Caufield: Long and Short-term Strategies for Preventing Youth Suicide

Dr. Timothy Barksdale, PsyD
The Culture of Disability

Dr. Richard King
A Mindfulness Exercise Workshop for Resilience, Awareness, Habit Change, and Neuroplasticity

CHATHAM UNIVERSITY'S EDEN HALL CAMPUS
6035 Ridge Road, Richland Township, PA 15044

WE ARE EXCITED to offer a variety of educational programming events (with up to 7 CE credits available) as well as activities and events that promote well-being at Chatham University's beautiful Eden Hall Campus. Our focus on safety, both physical and psychological, is the uniting theme that links our presentations on inclusion and diversity, supervision, neuropsychology and mindfulness, community psychology, ethics, and suicide prevention. Practitioners seeking mandatory credits for coursework in supervision, ethics, and suicide prevention will be able to fulfill these requirements. The conference will be followed by the annual Spring GPPA Social with live music at the amphitheater from Molly Alphabet band, cash bar and Hors d'oeuvres.

To register or for more information, visit:
www.GPPAonline.org

REGISTER ONLINE NOW!

Feasting, Fasting and Eating Disorders

IN THE JEWISH COMMUNITY

MAY 3, 2017
8:00 AM - 1:15 PM
PITTSBURGH, PA

5 CE CREDITS

The Renfrew Center Foundation
FOR EATING DISORDERS

TO REGISTER, VISIT:
WWW.RENFREWCENTER.COM
QUESTIONS? CALL: 1-877-367-3383

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EFT Training Externship

(Emotionally Focused Couple's Therapy)

EFT had been developed alongside the science on adult attachment and bonding to expand our understanding about what is happening in couple relationships

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Wyndham Hotel
Oakland, PA

Early Bird Registration: $775
(before 1/31/17)
Standard Registration: $850
28 CEUs available for an additional fee

More information can be found at:
eftpittsburgh.wixsite.com/home

Pittsburgh EFT Collaborative
Tanya Bass: 412-407-2545
Karin Arnds: 412-473-7814
Tawna Loutsenhizer: 412-901-7573

CONTINUING EDUCATION CALENDAR

Francine Fettman, Ph. D.

MARCH

Friday **3/10/17** **7:30 – 4:00**
Mindfulness Techniques to Integrate Into Your Clinical Practice
Debra Burdick LCSW, BCN
CE Credits: 6.25
Fee: $219.99
Information: 800-844-8260 or www.pesi.com
Crowne Plaza Pittsburgh South
164 Fort Couch Road, 15241, 412-833-5300

Wednesday **3/15/17** **7:30 – 4:00**
Early Intervention for Autism: Birth to Five
Susan Hamre, MA, CCC-SLP
CE Credits: 6.25
Fee: $199.9 if postmarked 3 weeks before seminar date, $219.99 after
Information: 800.844.8260 or www.pesi.com
Crowne Plaza Pittsburgh South
164 Fort Couch Road, 15241, 412-833-5300

Saturday **3/25/17** **8:00 – 1:30**
Transitioning an Adolescent with Autism
The Children's Institute of Pittsburgh
1405 Shady Avenue, Pittsburgh PA 15217
CE Credits: TBD
Fee: $85. Space limited to 125 attendees.
Information: Barbara Thomas at 412.420.2438 or bth@the-institute.org

Thurs/Fri **3/30/31** **7:30 – 4:00**
Acceptance & Commitment Therapy: 2 Day Intensive ACT Training
Avigail Lev, PsyD
CE Credits: 12.5
Fee: $389.99 postmarked by 3/9/17, $429.99 after
Information: 800.844.8260 or www.pesi.com
Crowne Plaza Pittsburgh South
164 Fort Couch Road, 15241, 412-833-5300

APRIL

Thursday **4/6/17** **7:30 – 4:00**
Psychopharmacology
Tom Smith, P.D., LMHC
CE Credits: 6.25.
Fee: $199.9 if postmarked 3 weeks before seminar date, $219.99 after
Information: 800-844-8260 or www.pesi.com
Crowne Plaza Pittsburgh South
164 Fort Couch Road, 15241, 412-833-5300

Notices & Announcements

GPPA Social Calendar

Check out our new social media:
'Like' us on Facebook:
https://www.facebook.com/GPPACommunity/
Add us on Twitter: @GPPACommunity

Wednesday, March 30
5 – 7pm
Grand Concourse 100 W Station Square Drive
Pittsburgh, PA 15219

Friday, April 21
6 – 8pm
The Summit on Mt. Washington
200 Shiloh Street Pittsburgh, PA, 15211

Please join the GPPA Community for an evening of networking and socializing in a relaxed atmosphere. GPPA especially encourages Students and ECPs to attend. Significant others, partners, and friends are also welcome.

We hope to continue growing our @GPPACommunity and see you there!

Interested in contributing to The GPPA Report? Email editor Pavel Somov at psclinical@hotmail.com

Interested in Advertising in the Newsletter? Contact Angie at GPPAPittsburgh@gmail.com

Visit our website for updates and more information:
www.GPPAonline.org