GPPA

# THE GPPA *Report*

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THE OFFICIAL NEWSLETTER OF THE GREATER PITTSBURGH PSYCHOLOGICAL ASSOCIATION

## A Letter from the President

TEAL FITZPATRICK, PHD

*Dear GPPA Members,*

I AM WRITING THIS letter just before the Spring Equinox, and by the time you are reading this newsletter we should be truly starting to feel the transition into a new season. Reflecting on the past six months since our board year began, I am excited about the transitions within our organization: a focus on meeting the needs of our early-career colleagues and psychologists in training, supporting quality continuing education within our community and beyond, and working hard to gather information from you about your needs and hopes moving forward. We are thrilled to be honoring Dr. Rex Gatto as the recipient of this year's Legacy Award for exceptional contributions to the field, and to award Christine Heller, a doctoral candidate at Duquesne University, the Community Partnership Award for her dedication and work to serve the greater community. Please enjoy words by each of them included in this edition of the Newsletter, and we hope you can join us for the award ceremonies on April 25th, 2019 at The Summit in Mount Washington. Please also save the date for our "Big-Three Conference" on September 20th, 2019; this one-day Continuing Education event will offer all credits required by the State Board for licensure, including full credits for Ethics, Mandatory Reporting, and Suicide Prevention. We will be calling on those of you who expressed interest in Continuing Education Committee work to join us as we build this event to best meet member needs.

I would also like to offer a few personal reflections about the role of psychology and mental health professionals in our current cultural and political climate. I opened this letter with glad mentions of spring and new beginnings and projects- and I also reflect deeply on the heaviness of so many world and local events. We approach the six-month mark since the mass-shooting at the Tree of Life Synagogue as news of the horrific massacres in New Zealand at two Mosques is unfolding.

The trial of Michael Rosfeld, the police officer who shot and killed Antwon Rose Jr. is about to begin here in Pittsburgh, magnifying Pittsburgh's still deeply-rooted racial divides. It is difficult to go more than an hour or two without reading about another act of violence or misuse of power. I admit feeling unclear at times about where the personal and professional intersect, and how I can best support my clients, colleagues, and community as I acknowledge the areas where I need support for myself. As I often do, and I suspect many of you will identify with this practice, I go back to the words of others whom I admire and respect, seeking comfort and guidance in the wisdom of those who have made a practice of speaking truth to power, defining ethical behaviors, and showing empathy and love for their fellow human beings.

We each find our homes in different theories or practices; I find writings by intersectional theorists and the Poets help me best make sense of these complicated issues, and no doubt the spaces that each of you would call your own are as diverse and rich as our membership's interests and own personal ethics. My ethics challenge me to spend time reflecting on my own personal work as well as my work in the service to others. I find myself called to learn more about the diverse experiences of others, not only to better understand my clients and colleagues, but to consider my own degree of power and how I use or practice my work within this framework. Furthermore, my ethics call me to consider the entire field of Psychology as not just a helping profession, but as a platform from which we as clinicians, teachers, evaluators, peer-supporters, and researchers have the ability to perform both help and harm, and to be mindful of the ways that we engage with our work to truly serve our communities and ourselves.

I hope to hear from you, our membership, about the ways that you care for yourselves, continue to educate yourselves, and invest in the growth of our community even when working in challenging conditions and while processing personal grief and sadness about local and world events. To borrow words from the great Coretta Scott King, "the greatness of a community is most accurately measured by the compassionate action of its members." I send my best wishes to each of you and look forward to growing together in compassion and community.

Teal Fitzpatrick

Teal Fitzpatrick, Ph.D.

# Veterans' PTSD: Moral Injury, and Nightmares of the Dead

Roger Brooke, Ph.D., ABPP

A FAIRLY RECENT BOOK by state-of-the-art experts in the field of military post-traumatic stress disorder includes a chapter on sleep disorders and nightmares (Brim & Riggs, 2011). Epidemiological statistics regarding nightmares and ptsd are described in detail, and, when it comes to treatment, only medication and a behavioral approach to "sleep hygiene" are discussed. Not a single nightmare is mentioned. Over a hundred years after Freud and Jung, the field has forgotten that dreams have meaning and that discussing the meaning of dreams can be helpful. In my experience this might even be the case when nightmares do not occur during REM sleep and are neurologically more akin to night terrors (see Hartman, 1996).

Veterans returning home carrying the psychological wounds of war are often haunted by memories and nightmares of the dead: dead buddies, civilians, enemy dead, often images of the dead that they had killed. Those of us who work with veterans and bring with us phenomenological or archetypal perspectives find that taking the dreams as calling for attention, as wanting something from the dreamer, can put recurring nightmares to sleep. In some dozen such cases of my own, one- and two-year follow-ups typically find that the nightmares never reoccurred. My experience is consistent with that of more experienced colleagues (Decker, 2014; Tick, 2014)

A brief example. A soldier is haunted in his memories and recurring nightmares by the image of a young enemy soldier that he had killed. He recalled shouting obscenities at the dead teenager in an adrenaline rage. His guilt and shame have left him living as a recluse for years. He feels soiled and monstrous.

The technique I use is a modification of Jung's technique of active imagination (Chodorow, 1997). A conversation about the enemy soldier includes the following: realizing how terrified and courageous he must have been taking on the Americans, realizing that the dead soldier had been with him every day and many nights for years and knew my patient better than his own family ever did, telling him that he would remember him with honor and plant a tree in his memory on Memorial Day, asking him if he needed anything from the veteran in order to move on to the next world, weeping with grief and regret over having killed him and having shouted insults at him, telling the man to tell his living and dead ancestors of his regret, feeling the man's forgiveness, and, now that they were no longer frozen in time and both had accepted that he was dead and that time had moved on, seeing him appear in his imagination with a smile on his face and a thumbs up sign.

At the end of the session, the veteran said the enemy soldier now felt like a guardian spirit. On two year follow-up, the nightmares never returned. He had planted a tree in his memory, and the following year he gave a little gift to his niece "from a brave young soldier I once knew overseas in the war."

Another veteran at the end of a similar encounter wrote a month later to say that he now prayed to the little dead boy he saw to help him be a better father to his own son.

This work presupposes good clinical judgement and therapeutic skills. Excluding factors include severe mental illness, current severe substance abuse, severe personality or impulse control disorders, including a history of impulsively suicidal behavior. It requires a therapist closely attuned to the veteran's experience and affective state, more present to the moment than to the goals of the intervention.

It helps to be phenomenological in relation to discussions of the dead. You should be able to work with the veteran's relations to the dead without awkwardness. Phenomenology helps because it refrains us from any need to make ontological commitments beyond the veteran's experience. It also helps because we understand the work of imagination not as something reducible to cognitive activity, but as the primary mode in which we engage the world, including the world of the dead. From this perspective the intervention is not psychological trick-cycling but psychological work that reaches in to the sacred and the soul.

An archetypal perspective is helpful because it requires us to learn from traditional warrior societies about their rituals for healing from the psychological and spiritual wounds of war. There were similar themes across all those societies, and they included taking responsibility for the souls of the dead. The Native Americans known as the Plains Indians took responsibility for the souls of the dead enemy before they returned from the battlefield. As the Xhosa would say—as they knew—it is only once one has taken responsibility for the souls of the dead that the ancestors, as carriers of the world as a moral order, would be pleased and allow the warrior's soul to be returned to him from the battlefield. (Within this lesson is a way to understand the common experience of loss of soul among veterans, like the veteran who believed he had been killed down range but did not know it.)

Consistent with such lessons learned from traditional warrior cultures, it is best to do this work in a group format, which includes civilians. I like to have at least the veteran, a buddy of the veteran's choosing, and a civilian (the veteran's therapist works well). The buddy is to help the veteran carry the memory of the work; the civilian is to represent the civilian community in which homecoming ultimately takes place. It is symbolically a good idea to have members of both sexes present. At least for male veterans, the presence of a civilian woman to honor and help hold this work seems extraordinarily meaningful.

***About the author:***

**Roger Brooke** is Professor of Psychology and Director of the Military Psychological Services at Duquesne University. He is author of *Jung and Phenomenology, classic edition.* London and New York: Routledge, (2015). In 2018 he was the recipient of the Pennsylvania Psychological Association's Public Service Award for his work with veterans.

***References:***

Brim, W., & Riggs, D. (2011). *Sleep disorders. In: B. Moore & W. Penk (Eds.), Treating PTSD in Military Personnel: A clinical handbook* (pp. 270–287). New York: Guilford.

Brooke, R. An archetypal approach to testing combat post traumatic stress disorder. In D. Downing and J. Mills (Eds). *Outpatient treatment of psychosis: psychodynamic approaches to evidence based practice*, pp. 171-195. London: Karnac Books.

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# Emotionally Focused Couples Therapy in Pittsburgh

**Harmony Sullivan, Psy.D.**

THE PITTSBURGH COMMUNITY for Emotionally Focused Therapy (EFT) was born 4 years ago from therapist Karin Arnds, LMFT, longing to connect and learn with other therapists in Pittsburgh interested in Emotionally Focused Therapy. While our initial meetings were simply monthly opportunities to connect with each other, seek advice, and talk about the overwhelming challenges in working with couples, we soon started talking about how we needed more EFT training—both for ourselves and the broader Pittsburgh community. So, in 2016 we took what felt like a terrifying leap and organized an official EFT Externship, the 4 day intensive introduction training to EFT and first step in the process of becoming a certified EFT therapist. To do this, we brought in an EFT trainer from The Philadelphia Center for EFT, Dr. Ting Liu, and we hoped and prayed we would get enough participants to cover the costs. We pulled it off and the feedback for Dr. Liu's guidance and teaching was phenomenal! So we kept going, expanding our outreach efforts, organizing more trainings and right now we are about to host another Externship this coming May 1-4 at the Persad Center, once again with Dr. Liu as our trainer. In the months to come, we are excited to be bringing in other internationally known EFT trainers who will be leading our next Core Skills trainings in 2019 and 2020.

So why are we so passionate about Emotionally Focused Couples Therapy? The more skilled we all become at practicing EFT (which most of us insist is still not nearly skilled enough, compared to where we could be!), the more we see the positive impact on our work with couples and the better we feel in our sessions. Couples therapy often makes us feel like we are drowning in the intensity of emotion and the chaotic ocean of information about who said and did what, and who was at fault when. Often we silently wish people would "calm down" so we can help them already! Of course when we actively try to calm people down, it often just makes them either get more upset or turn away from us. EFT provides a map and a language to give direction and meaning to this chaotic mess of emotion and information, and it gives us the tools to help partners do what they are so desperately trying to do: show each other how much they are hurting and enabling them to ask for help and comfort.

The model of EFT is based firmly in Attachment Theory, and posits that when we humans become distressed, we seek an attachment figure to help us feel secure again. If this figure is unavailable, we are left terrified and alone. In adult love relationships, this same dynamic plays out too, only now we have developed complex internal defenses to guard against that horrific feeling of being abandoned in our hour of need. In a distressed couple, partners play out a dance in which they try to reach for each other in a way that feels safest, often with an angry, accusing tone, and their partner plays out the dance step of hiding in terror, and of failing the accusing partner and being abandoned. It's a tragic dance, but when you know the basic unmet attachment needs that guide the steps, you can help couples slow down and see their pattern for the thing that is keeping them apart, instead of feeling as if their partner is trying to hurt or abandon them. Melding the unconditional positive regard of Carl Rogers, the ability to map out the negative cycle using Systems theory, and Experiential strategies for guiding clients to slow down and listen and then share the emotional messages within their bodies, EFT gives us the tools and a map to guide partners towards not just getting along better but experiencing the restructuring of a more secure attachment bond.

There is more than the anecdotal and case study date from our therapy experiences to show that EFT is highly effective, and with long lasting results. A meta analysis of outcome studies done before 1999 show that about 70% of couples who completed EFT reported (as measured by the Dyadic Adjustment Scale) having recovered from relationship distress, and 86% reported significant improvement (Johnson et. al.,1999). Several recent studies indicate that the results of EFT are often long lasting, that the model can be used across cultures and across sexual orientations of partners, and that it has enormous positive impact on symptoms of depression and PTSD in individual partners within the couple (see Brubacher, 2018, for a review of the literature).

Personally, what I love most about EFT is that it is fundamentally validating to both client and therapist. When something seems to be going wrong in my session, EFT teaches me not to beat myself up or to blame the client for "being difficult". The model gently urges me to take a deep breath, remember I am doing the best I can, and that I don't have to know everything; that I can always ask the client to help me understand. It then asks me to be curious, slow down, to remember that the couple is trying frantically to get their need for safety and connection met (even if it looks otherwise on the surface) and to tell them, with authentic feeling, "I hear you, I hear you, you feel so much as you say this and I see how important it is that your partner hear you, can we slow down so I can make sure I understand what you are trying to convey?"

Whether you are already practicing EFT and looking to connect with other EFT therapists, or have never heard of it but are now interested, or are anywhere in between, we welcome you to join us! Check out our schedule for events and trainings, including the May 1-4 Externship, at pgheft.org.

***References:***


Brubacher, L. L. (2018). *Stepping Into Emotionally Focused Couple Therapy: Key Ingredients of Change*. New York: Routledge.

Johnson, S. M. (2008). *Hold Me Tight: Seven Conversations for a Lifetime of Love*. New York: Little Brown.

Johnson, S. M., Hunsley, J., Greenberg, L., & Schindler, D. (1999). Emotionally focused couples therapy: status and challenges. *Clinical Psychology: Science & Practice*, 6: 67-79.

Chodorow, J. (Ed.). (1997). *Jung on active imagination*. Princeton: Princeton University Press.

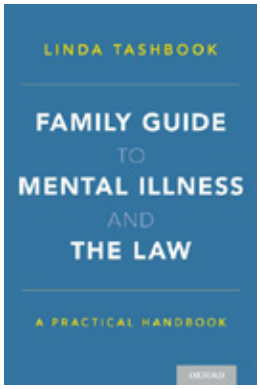
Decker, L. (2014). *The alchemy of combat*. New Lebanon, NY: Omega Publications.

Hartmann, E. (1996). Who develops PTSD nightmares and who doesn't? In D. Barrett (Ed.). *Trauma and dreams*, pp. 100-113. Cambridge: Harvard University Press.

Tick, E. (2014). *Warrior's Return: Restoring the Soul After War*. Boulder, CO: Sounds True.

# Better Conversations About Legal Stress

Linda Tashbook, Esq.




YOU KNOW HOW some people, when a friend admits to feeling depressed or anxious, will just say, "you should see a shrink", often because they don't know what else to say? The same thing happens when people are worried about legal troubles. Listeners, including family members, will hear about hassles at work or a pile of debts or difficulty getting disability benefits, and say, "you should get a lawyer."

I would rather have them say, "You know, I was just reading about this" or "Let me see what I can find out about that." Then, they would not only have a more empathic exchange, they would have an opportunity to convey some useful and potentially calming information. The offer to look for information is also a promise of more time together as well a demonstration of continued interest in whatever is troubling this person.

Maybe the speaker does need, or eventually will need, a lawyer. But perhaps now he or she just wants some context and definitions for the legal issue, or will feel better simply knowing the process for handling it. Having confided about legal worries, the stressed person really does not deserve to be turned away with a dismissive suggestion to get professional help. Again, even though the eventual outcome may be a recommendation for professional help, it is the engaged process to that end that is of importance here as opposed to a summary dismissal of the stressed person's concerns in the rush to "see a professional".

Hoping to facilitate these conversations and to make legal interactions less daunting, I have written a book titled *Family Guide to Mental Illness and the Law: A Practical Handbook* (Oxford University Press, 2019. ISBN 978 019 06 2222 0 $35 https://mentalillnesslawbook.blog). My aim is for this plain-English, well-organized resource to become a household tool. I also think that therapists will have uses for its clear explanations of common legal issues that arise in adult life and what people can do to manage those issues.

The book is organized into five sections: Health Law, Criminal Law, Employment Law, Consumer Law, and Death and the Law. Each section includes multiple chapters, for example, the employment law section has chapters about improper conduct at work, leave time, discrimination, and termination. Throughout the book there are "how to" boxes with guidance about whom to interact with, messages to convey, procedures to follow, and techniques for specific situations. "How to Complain, Generally" and "How to Search for a Missing Person" are two that I think a lot of people will find useful. I also think readers will like the highlighted tax facts in the chapters on financial topics.

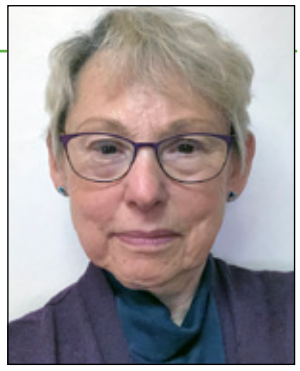
I came up with the concept for Family Guide to Mental Illness and the Law, and the dozens of topics in it, through both private and professional experiences. I have a family member whose very disruptive episodic mental illness has been aggravated by several stressful legal interactions. And as a lawyer, law librarian, and active NAMI member, I have assisted many people whose psychiatric symptoms intersected with legal transactions and assertions of rights. Psychologists will likely see familiar stories among the examples throughout the text. I think that they and others who talk with people experiencing mental illness and legal stress will have much more productive conversations once they read this book.

***About the author:***

**Linda Tashbook, Esq.**, is a law librarian at the University of Pittsburgh School of Law and part-time lawyer in the fields of poverty law, mental health law, and non-profit law. A Fulbright Senior Specialist and winner of the Pennsylvania Bar Association's Pro Bono Award, she also chairs the Mental Wellness Task Force at Pitt.

# Speaking Up for Mental Health

Charelle Samuels



THE PREVALENCE OF MASS shootings in this country has increased public awareness of mental illness. In an attempt to understand the motivation of the shooters, authorities have often considered the possibility of a history of emotional instability. Sometimes the perpetrator has shown signs of distress which were not recognized previously or dismissed. Similarly we need to not neglect attending to the long term impact of these shootings on our youth.

Children trapped in a classroom and targeted by a gunman, or even those simply hearing about such happenings, are learning that places of worship or social gathering as well as schools may not be safe. They struggle to find a way to process these realities. Sometimes children make jokes as they participate in active shooter drills in school. Recognizing the meaning of these exercises is too terrifying for them to digest.

There is a threat to positive mental health when children live in a society where they must participate in lock down drills and learn to hide in closets. As a result, many children will have to cope with post trauma disorders. A child who is afraid of entering certain rooms alone after having been traumatized may not be cured when his or her symptoms subside. Many of us see the impact of childhood trauma on the adults we treat in our offices. They are sometimes the walking wounded in our communities, living marginal lives. Just as active shooter drills are too horrible for children to metabolize, perhaps we adults also insulate ourselves from considering the emotional cost the next generation may pay for living in our violent society.

The first vigil held after the shootings at the Tree of Life synagogue was organized by Taylor Allderdice high school students. Like the Parkland student activists, they are telling us that we need to address their fears. It compromises healthy development when children feel they must take over parental functioning because the grown ups are derelict in their duties. We must not silently watch the development of a mental health crises in our country. As mental health providers we need to face these realities and take steps to inform the public of the potential dangers.

# Prescribing Psychologists: Call for Hobbyist Researchers!

Dan Warner

THIS ARTICLE REPRESENTS AN earnest call for anyone who wants to help complete research on access (and lack thereof) to outpatient psychiatric care in Pennsylvania. More specifically, I would like to compile objective evidence supporting the need for appropriately trained psychologists to gain the right to prescribe psychotropic medications. While there are multiple audiences for this research, the main target group is to help psychologists understand the lack of access to outpatient psychiatric services. A second audience is for local and state officials to understand the lack of access to high quality, medication management for those suffering with mental health concerns.

The research will help practicing psychologists understand the significant problems related to accessing high quality, psychotropic medication management. Because of this lack of access, psychologists are adding clinical psychopharmacology to their practice through ongoing continuing education. However, other psychologists are also working to become prescribers. This pattern is happening in places where access to psychotropic medication is both lacking and essential. All branches of the military, Indian Health Services, and rural states like New Mexico have opted to add appropriately trained psychologists to help with the shortage. Prescribing psychologists currently provide essential services to patients requiring comprehensive mental health care.

While there are psychology "purists" out there, not wanting to change the scope of practice, let me answer some criticisms in advance. Psychology is the science of the human condition. Most psychologists subscribe to a biopsychosocial approach to human suffering. Psychologists pay attention to, among other things, the importance of cognitive styles, brain-behavior connections, meaning, suffering, the power of the unconscious, cultural influences, spiritual concerns, and the importance of relationships. Psychology is not psychiatry. Psychiatry uses the biological and medical approaches to mind and human suffering. When psychologists obtain prescriptive authority, they bring elements of the biopsychosocial approach to prescribing. Psychologists prescribe scientifically, and with a broader conception of the human condition, which is more than just aligning chemicals in the brain. Prescriptions come as a part of the whole psychological package, including appropriate psychological interventions. Therefore, prescribing psychologists are not looking to become junior psychiatrists. Prescribing psychologists are working to provide high quality care with an additional tool in the toolbox.

An important benefit of prescribing psychologists will be to aid the overburdened mental health system, as well as serve rural areas, prisons, community mental health, Federally Qualified Health Centers, and urban areas. First, prescribing psychologists improve access. Obviously, wait times will go down as psychologists are available to help a rural mother suffering with post-partum depression, a homeless person suffering from a psychotic disorder, or a veteran living with post-traumatic stress problems. Second, the patients can receive more than access to medication, including the additional psychological expertise to enhance the work of recovery. Prescribing psychologists can provide psychotherapy, or educate about the value of psychotherapy services for those receiving psychotropic agents. The anecdotal evidence shows prescribing psychologists are working to decrease the number of psychotropic agents and recommending psychological interventions. Full research on these anecdotal reports doesn't exist yet, but I am going to hypothesize that this has to do with the nature of psychological interventions: we take time to work with clients to figure out what they need and what they want. Patients can take greater ownership of their care, and are able to move on and off medications as they need to, and in a way that is biologically and behaviorally sound.

Prescribing psychologists bring the advantages and benefits of neuroscience, as well as what we psychologists know about mind, behavior, and therapeutic relationships. Ultimately, what we know about the human condition is a larger frame of reference for our patients. When psychologists prescribe medications, they can help in ways that the medical profession may not be able to match because prescribing psychologists need to know the psychological interventions before gaining the knowledge and authority to prescribe.

Now that I have laid out my concerns and desire for expanding our scope of practice, the question is: how far are we from doing this in Pennsylvania? To answer this question, I need help. I want to put together a research project where we will find out how difficult it is to access psychiatric care in Pennsylvania right now. What would be the advantage to our patients for prescribing psychologists in Pennsylvania? What would be the advantage to our health care system? Will the data show that we have a significant psychiatric shortage in Pennsylvania and the wait lists/lack of access are unconscionable? This data will not be able to demonstrate the whole impact that our discipline will bring when we have psychopharmacology in our tool box, bit it's a start. It is a start that we can use to educate the second audience, local and state officials. If we truly care about the patients we serve, expanding our scope of practice and educating others are our ethical duties.

So, please, consider giving me a call (Dan Warner: dwarner@communitydataroundtable.org ). The work will involve planning the research, and probably making some phone calls to psychiatrists across the state to see what the current wait time situation is. Maybe you have some other ideas. That's great. Reach out and let me see if we can do it. This work will be totally fun and worth it. Furthermore, it could help make a major difference in our profession, and the health of the citizens of Pennsylvania.

GPPA

***Please join us for our next GPPA Social***
***April 12th from 5-7 pm at Mad Mex in Shadyside.***

# Creating a Better World For and With Our Children

Mary Beth Mannarino, Ph.D., Professor Emerita, Graduate Psychology, Chatham University

*"I don't care if what I'm doing–what we're doing–is hopeful. We need to do it anyway. Even if there's no hope left and everything is hopeless, we must do what we can."*

— Greta Thunberg, 16 year old Swedish climate activist

FAMILIES SEPARATED AT THE border. Forest fires, droughts, food shortages, and hurricanes exacerbated by the climate crisis. Gun violence, hate crimes and pervasive bigotry against marginalized persons. Intense political divisiveness. And this is just in the US. The list of big problems grows and grows.

We have seen an increase in anxiety related to the sociopolitical and cultural tensions of the last few years and immersion in the 24/7 reporting about the big problems (American Psychological Association, 2017; Boukes and Vliegnethart, 2017). As adults, we work hard to maintain our equilibrium and a sense of well-being and agency in the face of such huge problems, but it is often really hard. It is not necessarily that we are in active denial about the problems around us–although that is sometimes the case. It is more that we can feel overwhelmed by the magnitude of the problems, and doubtful that anything we do would make a big difference (Wallace-Wells, 2018). How much harder it must be for children and teens to manage what they are absorbing about the big problems in the world, with their still developing understanding, coping skills, and autonomy. And yes, young people are deeply affected by what is going on (APA, 2018 and n.d.; Rogers et al, 2017).

Fortunately, in recent years, we have seen an increase in community engagement on many fronts where folks put themselves out there to fight for a more just and healthy society–think of the womens' marches, post-card writing parties, DAPL protests, the actions of Parkland students advocating for better gun laws, #MeToo, and #BlackLivesMatter. All of this is evidence of a revived citizenry working from the grassroots level up. As challenging as these times are, what a great opportunity we have, as parents and caregivers, to help our children begin to form their own citizen identities! While we may be tempted at times to shield our children from the ugliness, the ugliness doesn't go away and often has significant impacts on their present and future well-being. It is good that we can serve as guides for our kids, helping them interpret information coming in, express and manage their emotions, and engage in meaningful actions to address problems and to become active members of the community.

First steps first. Here are some initial thoughts to consider if you are looking for ways to help your child deal more effectively with the big problems around us.

- Know yourself. Tune in to how you are responding, emotionally, physically, cognitively, and spiritually, to the external stresses. How do you stay informed and engaged while also taking care of yourself and your family? Do you sometimes find yourself denying or avoiding what is happening? What helps you balance the competing parental urges to protect and challenge your child? How do you know when you need to step back and take a break? What are your go-to self-care practices? Your self-awareness and self-care prepare you to be more intentional and effective as you help your child.
- Know your child. Consider their age, both chronological and developmental, and their personality and temperament. One child may be more sensitive and easily overwhelmed, another might need time to observe and think before talking about events, and another might be extra curious and eager to find answers. Knowing and honoring who your child is enables you to understand their needs and to discover the best way to talk with them–and to listen–about what is going on.
- Know your family. What values and beliefs guide your involvement with big issues in the larger world? Are there important faith traditions that come into play? Does your family participate in practices that contribute to the larger good? You may do this in small or large ways–all have value. What are your current resources–time, money, energy–that may affect what you or your family can do? What issues are most salient to you and your family–the ones you would prioritize? It is healthy to do what you can do, to do what is most meaningful to you, and to respect your and your family's limits.

These are hard but important questions to consider. Working through them may, however, provide some ideas about how to help your children mature into caring members of the larger community. We want to find actions that can foster resilience and a sense of agency in our children and that reinforce the reality that we live in a big interconnected world that benefits from our participation. There are lots of concrete ways that we can integrate community engagement and citizenship into everyday family life.

***A few examples…***

- Share your own thoughts and emotions about big issues, and keep in mind that it is tremendously important to help your children explore and express their own reactions. Acknowledge your own and their fear, confusion, anger, etc. These are important emotions to own and to use as fuel for action.
- Encourage your child's expression of emotions and thoughts through art, music, writing, dance, theater, and other media.
- Look for ways close to home–in the neighborhood or on the playground or at school or your house of worship–to be a good citizen and helper. Invite your child to participate.
- Involve your children in the electoral process by talking with them about the value of voting and taking them with you to the polls. In language targeted for their age, discuss how you make decisions about who to vote for. Know who your elected officials are, and show your children how you can make calls or write post-cards to communicate your ideas about issues. Invite their participation in this.
- If you engage in public actions or protests, consider taking your child along (so long as it is safe to do so). If your child does not attend, take photos and, if they are interested, talk to them about your experience and what you have learned.

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- Educate yourself and your children about particular issues. Work with the public librarian to find materials for you and your children to investigate together to learn more.
- Explore how religious and spiritual commitments can help us deal with hard times. Consider how prayer, meditation, or mindfulness practices help people of all ages center themselves and prepare themselves for living in compassionate ways.
- Talk about how change is often hard and slow, but possible. Tell stories about big changes that have come only after lots of dedicated work on the part of many people over many years. And always focus on the reality that there are many good people out there who work hard to make things better.

***Some final thoughts.***

Having said all of the above–do let your child be a child, with all of its joys and discoveries, ups and downs, living in the now. Honor and respect your child's uniqueness. Do not force involvement or participation–keep in mind that our children learn so much from just observing us and others. Invite. Listen more than talk. Appreciate your child's different perspective and see what you can learn from them. Share stories about your own engagement–the highlights and the challenges. Prepare yourself for how you might respond to an older child or teenager who wants to be really involved–sometimes this happens in ways that may make you initially uncomfortable, as when your child wants to miss school to be part of a student strike about an important issue. Know that the lessons they learn through such activities can be invaluable for their development as an engaged citizen. And be patient with yourself and with your children as you step out together to make our complicated world a little more just, healthy, and beautiful.

***About the author:***

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***References:***

American Psychological Association (2017). *Many Americans Stressed about Future of Our Nation, New APA Stress in America™ Survey Reveals.* Retrieved from https://www.apa.org/news/press/releases/2017/02/stressed-nation March 5, 2019

American Psychological Association (2018). *Stress in America: Generation Z.* Stress in America™ Survey.

American Psychological Association (n.d.). *In the aftermath of a shooting.* Retrieved from https://www.apa.org/helpcenter/aftermath on March 7, 2019.

American Psychological Association (n.d.). *Tornados, hurricanes, and children.* Retrieved from https://www.apa.org/helpcenter/tornadoes-kids on March 7, 2019.

Boukes, M. and Vliegnethart, R. (2017). News consumption and its pleasant side effects: Studying the effect of hard and soft news exposure on mental well-being over time. *Journal of Media Psychology,* 29(3), 137-147.

Golombek, Sylvia Blitzer (2006) Children as Citizens. *Journal of Community Practice,* 14:1-2, 11-30, DOI: 10.1300/J125v14n01_02.

Gonzalez, K., Ramirez, J., and Galupo, P. (2018). Increase in GLBTQ minority stress following the 2016 US presidential election. *Journal of GLBT Family Studies,* 14(1-2). 130-151. DOI: 10.1080/1550428X.2017.1420849.

Jennings, L., Parra-Medina, D., Hilfinger Messias, D., and McLoughlin, K. (2006). Toward a critical social theory of youth empowerment. *Journal of Community Practice.* 14(1-2). 31-55.

Kashin, D. (2017). *The future is now: The child as citizen. Technology Rich Inquiry Based Research.* Retrieved from https://tecribresearch.wordpress.com/2017/10/28/the-future-is-now-the-child-as-citizen/ on March 10, 2018.

Project Zero: Children are Citizens

Rogers, J., Franke, M. Yun, J.E., Ishimoto, M., Diera, C., Geller, R., Berryman, A., Brenes, T. (2017). *Teaching and Learning in the Age of Trump: Increasing Stress and Hostility in America's High Schools.* Los Angeles, CA: UCLA's Institute for Democracy, Education, and Access.

UNICEF (2011). *The child as citizen: Highlights from Annals of the American Academy of Political and Social Science.* Retrieved from https://www.bostonchildrensmuseum.org/sites/default/files/pdfs/6-The-Cradle-of-Democracy.pdf on March 8, 2019.

Wallace-Wells, D. (2018). You, too, are in denial about climate change. *New York Magazine.* Retrieved from http://nymag.com/intelligencer/2018/12/americans-believe-in-climate-change-but-not-climate-action.html on March 1, 2019.

# Legacy Award Winner, Dr. Rex Gatto

## *What does it mean to create a legacy?*

LEGACY: AN INHERITANCE, GIFT, endowment or provision. A legacy in this case is something left behind or actions that others can observe. Each of us creates our own legacies in many different ways through family, community and at work. Our legacy allows others that we have touched along the way to judge what we have said and done, and what we have not said or done. A legacy can also be seen by how people are influenced by our presence and philosophy, by how we may have influenced others to be inspired to follow what we have done, by how our intents may become their creations. As others adopt our influences, they then construct their own legacies. In some small way, my legacy of family is the one I choose and hope is the legacy of importance.

My legacy begins as a young boy born into a family of Italian immigrants. My paternal grandparents and father came to this country from Southern Italy through Ellis Island. My mother's father came to New York from Sicily in the 1880's, walked off the boat, and went home to the family house in the Bronx. My father went on to school at Duquesne University, studying music and composition. While conducting *La Traviata*, my father met my mother, who sang the lead. A few years later, I was born and at six years old began my schooling at St. Joseph Military Boarding School, where I lived 7 days a week. My parents divorced and I was the only child of that marriage. This was my preparation to understanding life and learning philosophies of different talents and styles. As a child, I was in over 50 operas and was on stage with the greatest known singers of the day. This was all in preparation to continual study and better understanding of how the arts, humanness and philosophy tie together. I received a Music Education degree from Duquesne, played lead trumpet in the Army Band for 2 years in Baltimore/Washington, earned a master degree in education and began to teach. I kept feeling called to do more and went to Pitt and studied education and psychology. I was lucky enough to have professors (Dr. Larry Knowles was one) who pushed me to study neuro-education, which at the time was the novel study of hemispheric function and why we think and do what we do. I furthered my background in psychology with a masters in counseling psychology. I attended post-doctoral classes for a year at the Cleveland Center for Cognitive Therapy, earning board certification in cognitive therapy. After additional study, I was accepted into the Academy of Cognitive Therapy. By chance through my wife (Mickey), I met a gentleman who was doing training at a large corporation in Pittsburgh who asked if I could measure training outcomes. Of course, I responded with a resounding *YES*.

The next 30 years is the story of how psychology, education, coaching, and behavioral training in the workplace merged together for me. I joined the usual associations: APA, ACA, PPA, GPPA. In 1999, I was asked to take a leadership role in the APA sponsored Healthy Workplace Awards for PPA. I was one of 3 psychologists throughout North America that formed the Healthy Workplace Process and Awards in 2000. We established the processes to create measurement which, in turn, could be used to create a healthy workplace. I was on a call with Tom DeWall the Executive Director of PPA and APA Leadership discussing the Healthy Workplace process and tools on September 11, 2001 when the offices of APA were evacuated.

Through academics, experience and great mentors, I have devoted my efforts toward understanding the needs of people in the workplace. I have written skill-based books, assessments, articles and blogs. We have also written a few academic papers on assessment results, based on over two thousand participants/subjects. Dr. Emily Stevic has been a mentor of encouragement to me. She has continually pushed me to take on various roles within PPA and APA. My wife continually pushes and edits all of my writings and our two children (Shawn, an attorney businessman, and Maura, a global compensation analyst) help me stay grounded, as does our 6-year-old granddaughter Brooke. Both of our children are good people who now ask little and provide a great deal to my life. I was asked to run for president of PPA and lost to the Philadelphia group but it was a good experience and I have stayed active on the finance committee. I have continually been on Psychology and Psychotherapy leadership committees for the last twenty-five years. My practice is primarily as a workplace consultant or coach although I do have a very small clinical practice. However, who I am is a humanistic educated psychologist who is enriched by the knowledge of many preceding practitioners who have entered my world through books and lectures.

Do any of us have a legacy? Yes, we all do but, unfortunately, people do not stop to tell us of the impact we have on them. I hope my legacy is a combination of family, students, and people who have permitted me to enter their lives. I think, because I am outspoken and do not hesitate to opine on key issues, I have influenced coming generations by my thoughts in my writing or my approach to questions. I am probably a great clinician because I know I need help everyday learning how to right my own ship from its many listings.

We all ought to ask ourselves, in the words of Jean-Paul Sartre, "Am I really the kind of man who has the right to act in such a way that humanity might guide itself by my actions?" (Jean-Paul Sartre, *Existentialism and Human Emotions.)*

I have so much more to do, and so little time. I do not even know if I have yet left a legacy. But my hope is that those who have read this article may come to understand their own legacy and be guided to achieve those honorable actions that humanity may want to abide by.

**The 2019 Legacy & Community Partnership Awards Dinner Honoring**

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# *Community Partnership Award Winner: Christine Heller*

WORKING ON THE mitigation documentary for a community member's resentencing hearing through the PlaceLab Justice research group, under Dr. Eva Simms's leadership at Duquesne University, has been incredibly meaningful work for me–a real honor. I came into the work with a prison abolition stance, in that I see prisons as being the wrong way to pursue true justice in our society. Working on this project has been an interesting chance for me to simultaneously work within the system, and to stand enough outside of it to remain faithful to my critiques.

Our project will contribute to a resentencing hearing within our current criminal justice system–while simultaneously demonstrating that crime happens in sociopolitical contexts by people with intensely complex bio-psycho-social-spiritual histories, which constitute profound mitigating factors. I have learned so much from the other people participating in this research group: my peers, our filmmaker Christian Nowlin, Dr. Simms, the experts in adolescent neuropsychology, juvenile law, and the family members who we interviewed, and most of all, from the man whose case we are supporting, about what it has been like for him to be in prison for 25 years, his entire adult life. As researchers, we are able to make the product of our research potentially impact the decision of a judge who will decide the fate of this man. We are privileged in our position to not have to tow the line of criminal justice, because we are positioned as expert witnesses, rather than employees of the court. We have been able to introduce community psychology and adolescent neuropsychological development to the legal discourse. My sense is that judges are eager for more input about how to handle the mandatory resentencing hearings of all people who were convicted as juveniles to life without the possibility of parole, since the US Supreme Court deemed it unconstitutional in 2012, and retroactively applied it in 2016. I especially want to acknowledge the ethic Dr. Simms has brought to questioning what our research as psychologists can do out there in the world, especially in the pursuit of justice. I have learned so much through this work about what it means to be an ethically-engaged, heart-centered researcher, and how the fruits of our labor do not have to stay in the ivory tower.

## **Research Briefs** *or a roundup of unabashedly skimpy summaries from recent research studies*

■ Reporting on their research in ***Psychological Science***, it seems people can identify corrupt politicians with better-than-chance accuracy, simply by looking at photos of their faces. One hundred participants were showed black and white photos of 72 US politicians (all white men; all unknown to the participants), half of whom were convicted of corruption related crimes, and half of whom had no history of crimes. Participants correctly identified the convicted politician 70% of the time. The only significant difference between the two sets of photos seem to be a difference in the width-to-height ratio of the faces–those judged as corrupt had wider faces!

■ Police officers are no better at detecting a suspect with a gun or explosive device than untrained observers. In three experiments, researchers asked police officers and college students to watch a video, and to identity whether someone was holding a gun, whether a device was concealed in a backpack, or which men, walking through a crowd, were concealing a device. In all three experiments, reported in the journal ***Law and Human Behavior***, there was no significant difference in the performance of police officers and college students.

■ Lying is cognitively demanding, so it takes people slightly longer to come up with a lie than tell the truth. According to a study in the ***Journal of Experimental Psychology: General***, this truism does not hold, however, for people speaking in a non-native language. When one responds in a first, native language, there is a time lag between uttering a truth and uttering a lie. However, when one speaks in a second language or non-native language, there is no significant difference, and it takes as long to respond with the truth or with a lie.

■ Is economic class written on your face? Participants in a research study viewed 160 face-only photos, cropped from an online dating site. Half the photos came from people who self-reported income over $150,000 and the other half from people with incomes under $35,000. Participants were able to classify the photos into "rich" and "poor" categories with statistically significant accuracy bigger than chance (68%). However, in an interesting variation (reported in the ***Journal of Personality and Social Psychology***), when all the people in the photos were smiling, participants could not accurately distinguish between "rich" or "poor" groups.

■ Whereas mental health providers tend to lean towards the liberal end of the political spectrum in general, new research in the ***American Journal of Orthopsychiatry*** report significant differences in theoretical approach preferences and political beliefs. Mental health providers who identified as "Republican or conservative" were significantly more likely to prefer cognitive-behavioral therapies (CBT), while those who self-identified as "liberal" were more likely to indicate a preference for psychodynamic approaches.

■ Data suggests proportionally more people die by suicide in rural areas than in urban areas (24 deaths per 100,000 vs. 16 deaths per 100,000). A large scale study published in the ***American Journal of Public Health*** may well explain why that is the case: simply that people in rural areas have greater/easier access to guns, and disproportionally (66% higher) use guns as (the more lethal) means to attempt suicide with.

■ Analyzing data from 191 studies and almost 165, 000 participants, researchers in the ***Psychological Bulletin*** report that self esteem peaks around age 60. People really do seem to "get more comfortable in their own skin as they get older."

■ According to a study in ***JAMA Pediatrics***, teenagers who are worried or stressed about societal discrimination are also more likely to report symptoms of depression and substance use.

■ A study published in the journal ***Animal Cognition*** proposes that chimpanzees use many of the same gestures as human children to communicate the same things. Of 52 gestures human children used to communicate (e.g. waving, stomping, clapping), chimpanzees used 48 of those same gestures.

■ Agreeable people have less money and more debt than people who aren't as nice, says researchers in the ***Journal of Personality and Social Psychology***. After analyzing personality and financial data from more than 3 million participants, agreeableness was significantly associated with lower savings, more debt, and much less of a concern about money.

# Ethical Considerations Involving Psychopharmacology When Working Clinically with Juveniles

Susan G. Goldberg, J.D., Ph.D. & Kathryn Wagner, Ph.D.

THERE ARE UNIQUE ETHICAL considerations when psychologists work clinically with juveniles, especially children or adolescents in the foster care system. In a recent article, (Goldberg & Wagner, 2018) we addressed some of those issues, and applied the American Psychological Association's *Practice Guidelines for Psychopharmacology* ("Practice Guidelines", 2011) to clinical work with juveniles. We are convinced that psychologists would benefit from having greater psychopharmacological knowledge in these circumstances.

The urgency of these considerations emerges from the rapid increase in prescription of psychotropic medications to juveniles in the last two decades (Olfson, Druss, & Marcus, 2015). One study found a six-fold increase in doctors' visits for juvenile antipsychotic prescriptions between 1996 and 2002 (Olfson, Blanco, Liu, Moreno, & Laje, 2006); a few years later another study concluded that the increase had jumped to 75% (Comer, Olfson, & Mojitabai, 2010). Ninan and colleagues (2014) noted that between 1996-2008, prescriptions of multiple psychotropics for children increased from 14.3% to 20.2%. Moreover, recent studies indicate a significant increase in the use of dual or multiple psychotropic medications for juveniles (Comer et al., 2010). For instance, in a large scale meta-analysis, Olfson and colleagues (2010) found that nearly 80% of preschool children on antipsychotic medication were also taking other psychotropic medications.

Of particular concern is that much of the increase in psychotropic medications prescribed to juveniles involves antipsychotic medications, particularly atypical antipsychotics, also called second-generation antipsychotics, which are often preferred over first-generation antipsychotics because of fewer side effects (Sohn, Moga, Blumenschein, & Talbert, 2016; Verdoux, Tournier, & Begaud, 2010). Whereas the long-term effects of psychotropic medications on physically developing children and adolescents are not fully known, there is strong cause for concern, for example around physiological effects, such as weight gain and metabolic changes (Politte & McDougle, 2014). Additionally, concerns remain particularly for foster children and children of low socioeconomic status, who may not receive the same medical follow-up as other children (Crystal et al., 2016; Ramachandran, Banahan, Bentley, West-Strum, & Patel, 2016).

The APA Practice Guidelines provide suggestions for how psychologists should interact with clients taking psychotropic medications, but they do not specifically address work with children. We therefore made suggestions for that context. The Practice Guidelines view psychologists as having three possible levels of involvement in pharmacology decisions, each level with an increasing degree of responsibility in medication management. The Practice Guidelines recognize that some degree of ambiguity exists regarding psychologists' roles, given that psychologists often perform different functions at various points in treatment (p. 836).

APA's first category is prescription prescribers, not relevant in Pennsylvania. APA's second category consists of psychologists who "actively collaborate in medication decision making" (2011, p. 836) ("Collaborators"). Even though Collaborators do not have ultimate decision-making control or responsibility for the medications prescribed, they "play a substantive role in the decision-making process" (p. 836). APA's research found that although "87% of practicing psychologists reported they have been involved in the decision to prescribe medication … it is unclear what role they played in the decision" (p. 836). Indeed, there is no substantive research on the specific roles psychologists play in the psychotropic medication decision-making process. We suspect this lack of clarity in role may have arisen from the ambivalence some psychologists have about psychotropic medication use, which in turn may decrease their confidence in addressing concerns with physicians. We urged psychologists to obtain the necessary education in pharmacology to serve as Collaborators as much as possible, as psychologists often have a wealth of information about clients' experience that may not be available to prescribing physicians.

APA's third–and most common–category consists of those psychologists who "provide information that may be relevant to pharmacotherapy decision makers" ("Information Providers") (2011, p. 836). As Information Providers, psychologists are encouraged by the Practice Guidelines to communicate medical information to physicians. An Information Provider "may offer opinions relevant to the pharmacotherapy but does not play a formal role in the decision-making process," unlike a Collaborator (American Psychological Association, 2011, p. 836). The APA believes that most psychologists, by default, fall into this category. Information Providers give first-hand information to physicians about patient/client information, psychological history, presenting problems, and diagnosis. They may have extensive data to provide, such as symptoms, diagnoses, psychological conditions, psychological background information, feedback from parents and teachers, and findings from psychological assessment.

Whether as Collaborators or Information Providers, psychologists have received extensive theoretical training in understanding the function of, for example, resistance (or non-compliance to treatment, in medical language). For this reason, psychologists' insights are invaluable, and we argued that psychologists should be considered equal and collaborative members of treatment teams, even if serving as "only" Information Providers. Moreover, in sharing their observations with physicians about clients' reactions to medication and levels of use as well as engaging in joint sessions and/or attending treatment meetings, psychologists serve to model open communication among all team members.

When working with juveniles, psychologists have a crucial role to play and one that goes beyond simply reporting client information to physicians. Considering the potentially severe long-term consequences of psychotropic medication use by juveniles, we contended that psychologists should obtain the necessary training

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and education to perform at the level of Collaborator as much as possible. On the other hand, if psychologists have not gained familiarity with psychopharmacology through training and education, it is still ethical to remain in the role of Information Provider. In fact, serving in the role of Collaborator without obtaining the necessary education and training may open psychologists to the charge of practicing outside the scope of competence, an ethical violation.

Yet, a crucial point: the APA notes that the Practice Guidelines are "not intended to apply to those psychologists who choose not to become directly or indirectly involved in [medication] management regardless of their level of competency" (p. 835). We argued that it is ethically problematic for psychologists working–even occasionally - with the juvenile population to be "non-involved"–that is, simply to opt out of involvement in psychopharmacological issues due to beliefs such as theoretical orientation, opposition to psychotropic medication, lack of knowledge, anxiety around being perceived by physicians as overstepping boundaries, or even disinterest. This is especially crucial when working with a vulnerable population, such as juveniles, who may not have the ability to speak up for themselves and do not have the legal right to consent–or not.

Since the Practice Guidelines (2011) indicate that the development of psychologist competence around psychopharmacology occurs on a continuum, we believe all psychologists should be considered Information Providers at a minimum, rather than exempt altogether, and that they should strive to obtain the necessary education to perform at the level of Collaborator whenever possible. Opting out altogether is not illegal by any means; rather, it is our position that it may not always be ethical and does not contribute sufficiently to promoting the psychological and medical well-being of the juvenile population. However, due to the continual rapid changes in psychopharmacology, especially regarding juveniles, we recommended that psychologists, even those working as Information Providers, obtain psychopharmacological training and updates equivalent to specializing in another area (e.g., forensic assessment).

***About the authors:***

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***References:***

American Psychological Association. (2011). Practice guidelines regarding psychologists' involvement in pharmacological issues. *American Psychologist,* 66(9), 835-849.

Comer, J. S., Olfson, M., & Mojitabai, R. (2010). National trends in child and adolescent psychotropic polypharmacy in office-based practice, 1996-2007. *Journal of the American Academy of Child & Adolescent Psychiatry,* 49(10), 1001-1010.

Crystal, S., Mackie, T., Fenton, M. C., Amin, S., Neese-Todd, S., Olfson, M., & Bilder, S. (2016). Rapid growth of antipsychotic prescriptions for children who are publicly insured has ceased, but concerns remain. *Health Affairs,* 35(6), 974-982. doi:10.1377/hlthaff.2016.0064.

Goldberg, S., & Wagner, K. (2018). American Psychological Association practise guidelines for psychopharmacology: Ethical practice considerations for psychologists involving psychotropic use with children and adolescents, *Journal of Clinical Psychology*, 1-20.

Loy, J. H., Merry, S. N., Hetrick, S. E., & Stasiak, K. (2017). Atypical antipsychotics for disruptive behaviour disorders in children and youths. *Cochrane Developmental, Psychosocial and Learning Problems Group*, (8). doi: 10.1002/14651858.CD008559.pub3.

Nevels, R. M., Dehon, E. E., Alexander, K., & Gontkovsky, S. T. (2010). Psychopharmacology of aggression in children and adolescents with primary neuropsychiatric disorders: A review of current and potentially promising treatment options. *Experimental and Clinical Psychopharmacology,* 18(2), 184-201. doi:10.1037/a0018059.

Ninan, A., Kriter, G., Steele, M., Baker, L., Boniferro, J., Crotogino, J., Stewart, S., & Dourova, N. (2014). Developing a clinical framework for children/youth residential treatment. *Residential Treatment for Children & Youth*, 31(4), 284-300. doi:10.1080/0886571X.2014.958346.

Olfson, M., Blanco, C., Liu, L., Moreno, C., & Laje, G. (2006). National trends in the outpatient treatment of children and adolescents with antipsychotic drugs. *Archives of General Psychiatry*, 63, 679-685.

Olfson, M., Crystal, S., Huang, C., & Gerhard, T. (2010). Trends in antipsychotic drug use by very young, privately insured children. *Journal of the American Academy of Child & Adolescent Psychiatry*, 49, 13-23.

Olfson, M., Druss, B. G., & Marcus, S. C. (2015). Trends in mental health care among children and adolescents. *The New England Journal of Medicine*, 372(21), 2029-2038.

Politte, L., & McDougle, C. (2014). Atypical antipsychotics in the treatment of children and adolescents with pervasive developmental disorders. *Psychopharmacology*, 231(6), 1023-1036.

Ramachandran, S., Banahan, B. F., Bentley, J. P., West-Strum, D. S., & Patel, A. S. (2016). Factors influencing the use of second-generation antipsychotics in children with psychosis. *Journal of Managed Care and Specialty Pharmacy*, 22(8), 948-957. doi:10.18553/jmcp.2016.22.8.948

Sohn, M., Moga, D. C., Blumenschein, K., & Talbert, J. (2016). National trends in off-label use of atypical antipsychotics in children and adolescents in the United States. *Medicine* (United States), 95(23). doi:10.1097/MD.0000000000003784.

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