San Gabriel Valley Psychological Association

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The Official Newsletter of the San Gabriel Valley Psychological Association

SGVPA.org AN OFFICIAL CHAPTER OF THE CALIFORNIA PSYCHOLOGICAL ASSOCIATION January/February 2021

Continuing Education Presentations

Online

3 CE's Each

SGVPA is proud to continue the

EMBRACING DIVERSITY SERIES

Each Online Presentation is an

Interactive Experience & Discussion

The 2021 DIVERSITY SERIES begins with

Covid-19 and the Asian Community

Glenn Masuda, PhD, and Alex Wong, PsyD
Moderated by Dr. Wayne Kao
Saturday, February 20
9 am - 12 pm

Latinex Mental Health

Dr. Elisa Hernandez and Cinthya Hernandez
Moderated by Dr. Wayne Kao
Saturday, March 20
9 am - 12 pm

Native American and Indigenous Mental Health/Healing

Monique Castro, MFT and Elena Nouri
Moderated by Dr. Wayne Kao
Saturday, May 22
9 am - 12 pm

Presentations will be held virtually via Zoom
For a total of 3.0 LIVE CE Credits Each for Psychologists, LCSWs, and LMFTs.

Price Per Individual CE Event

Licensed SGVPA members	$75	Licensed SGVPA non-members	$100
Unlicensed Post-grad members	$20	Unlicensed Post-grad members	$30
Student members	$10	Student non-members	$20
Affiliate members	$15	Affiliate non-members	$25

Package of Three: Licensed Non-member $275
Licensed member $200

Registration details coming soon by Email from the Listserv*!*
Presentations will be held virtually via Zoom
For a total of 3.0 LIVE CE Credits Each for Psychologists, LCSWs, and LMFTs.

SGVPA supports Black Lives Matter and systemic social justice reform.
We are making efforts to increase diversity representation
in our organization, in our profession, and nationwide.

PRESIDENT'S MESSAGE

Hope is important because it can make the present moment less difficult to bear.
If we believe that tomorrow will be better, we can bear a hardship today.
—Thich Nhat Hanh

Dear Colleagues

As I step into the role of president of SGVPA—the first person of color to take on this position—it comes at a time where more people are suffering than usual. It comes at a time where we have been consistently reminded that, as much as we have made social and cultural progress, we have also continued to leave behind those that are less fortunate, or look different from those who are in charge. It is easy to feel hopeless, to feel that the world is destined to be a representation of our shortcomings as a society, and as a community. It would be easy to give up on the possibility that we can achieve a more perfect union.

What can we achieve if we give up hope? I trust that the answer is evident.

As president of this association, I am guided by the following inspirations: I walk ahead on a path set before me by previous presidents, Dr's. Delker, Plattner, Miller Kwon, Law, and Lake (I hope you can find forgiveness that I am not able to list all past presidents, as I have limited word space). They have provided a strong and valuable foundation of how to lead an organization, treat others with respect and value, and to navigate varying opinions and positions. I will continue to seek guidance and wisdom from previous presidents as I walk forward, honoring and respecting our legacy, while creating new roads for those who will strengthen our organization, our community and fellowship.

I press forward under the inspiration of my mother, who was not able to obtain a college education. Despite this, she taught me more of what it means to be a psychologist than the books I read. As her son, I learned what it means to be empathic towards others, especially when it was not easy. Growing up in poverty, she made sure to provide for those around her that were less fortunate, and more in need of a guiding hand. She was as confrontational as Perls and Ellis, as kind and empathic as Yalom and Rogers. I will continue to return to her guidance and wisdom as I press forward, ensuring that I do not leave behind our colleagues and students that are still finding their voice, their place in this organization and field. I will remind myself of those in our larger community that are less fortunate, ensuring that our organization helps to provide for them as well.

I charge ahead with my colleague and wife, Dr. Amee Velasco, and my psychological assistants and students: Dr. Alex Wong, Dr. Anthony Cecere, Dominique Lloyd, Cinthya Hernandez, Yoojin Cho, and Gabrielle Chan. We intend to learn together, looking to provide for those who have been left behind, forgotten, and perceived as invisible. As we increase our presence in our field and community, we ensure that those we serve are present, are seen. I will not forget my responsibility to my team of early career psychologists, to make sure that their voices are heard, their presence is felt, as they are the future of our field.

Finally, to our members, both current and potential, SGVPA will be a place that not only looks like San Gabriel Valley, but represents the needs, and the hopes of a large and beautifully diverse community. In doing so, I welcome you all to join me, to share your voices in how we—how *I*—can continue to grow and improve.

I do not claim to be perfect. In fact, I know I am far from it. However, I have hope that in this time of hardship, if we can learn from our own strengths and shortcomings together, then we can bear this hardship in hopes of a better and more connected tomorrow.

Respectfully,

Wayne Kao, PsyD
President

CALENDAR

UpComing Events

Sunday, 01/24/21— *Virtual Dining, Learning, and Networking Event* — 4:00 pm - 6:00 pm

First SGVPA Virtual January Jubilee!!

New Year Kickoff Address by our new President!
SGVPA Plans and Projects for 2021!
Self-Healing Activities and Meditations!

Communal Dining via Complimentary DoorDash Gift Card!

Register now by RSVP to the Email Invitation sent to you.
[If you have not received your invitation, please contact Dr. Wayne Kao at dr.waynekao@gmail.com]

Saturday, 02/20/21 — *Continuing Education* — 9:00 am - 12:00 pm

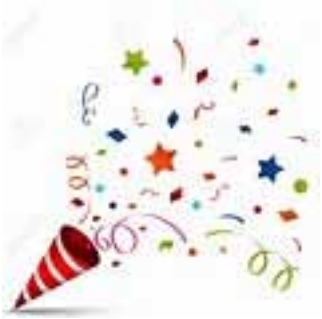
Covid-19 and the Asian Community

Glenn Masuda, PhD, and Dr. Alex Wong, PsyD
Moderated by Dr. Wayne Kao
Saturday, February 20
9 am - 12 pm

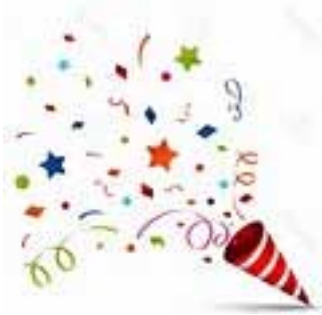
Registration details coming soon by Email!

Virtual

January Jubilee!!



Healing the Healers



Sunday, January 24, 2021

4:00-6:00 PM

New Year Kickoff Address by our new President!

SGVPA Plans and Projects for 2021!

Self-Healing Activities and Meditations!

Dine with us by using your specially delivered Door Dash Gift Card! (BYOB)

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You will receive a Door Dash Gift Code by Return Email!

"See You At the JJ!!"

Harnessing the Power of the Initial Interview in a Time of Telemedecine

By Arthur L. Kovacs, PhD, ABPP

Over the more than 60 years of my career, I have continually read research on what to me is a terrible phenomenon: Studies show a *single session* is the modal number of sessions any member of the public has met with any mental health professional!

If you are in your own practice, at least it is only you who are responsible for welcoming the new potential client. If you are in a group practice or even worse, work in an agency, before being offered anything that passes for possibly meaningful work, the client has had to endure a long wait for a call to be returned, has been scheduled at last to be seen in person many days later, and has had to fill out multiple forms, etc. Who deserves to be treated this way?

A wise colleague, Dr. Moishe Tolman, wrote a book some years back whose title is *Single Session Psychotherapy*. Noting that the most frequent outcome of a request for care is only a single visit, Tolman goes on to celebrate *the enormous power that resides in the first visit.* Both participants are anxious and uncertain—an unknowable adventure is about to begin. The client frets, what is this person seated opposite thinking? The psychologist frets about what is going to be his/her role? To what will the psychologist need to devote attention in order to begin the work? And he or she frets about imagined legal dangers that may lurk if a decision to work with this person is made.

And yet, in this wonderful, timid, yet hopeful testing and searching lies the greatest capacity that the psychologist will ever enjoy to make a positive impact on a new client! Yet most of the time, we don't even make any attempt to do so, treating the opportunity simply as a time for "information gathering." What a waste!

The sad truth is that all human relations become ritualized as they evolve. As a species, we are afraid of freedom and spontaneity. So, instead Tolman exhorts us to treat every session we have with a client as the last one—because indeed it may be. We need to try to turn each 45 minutes into a span of time that is fresh— one in which something novel and important happens.

Now, to the initial visit. How can the power of the first meeting best be harnessed, particularly in the age of COVID-19? Most of us will be meeting new potential clients electronically—and this is a problem. Whether by telephone or video, we are missing huge amounts of gestural and other non-verbal communication that limit us seriously.

I believe that certain kinds of responsiveness to our new clients are even more essential these days. In the 80s, an APA Task Force investigated what was the most important attribute in a therapist that psychotherapy seekers looked for. It was "*I want someone who cares*." Yet, our ordinary ways of doing initial interview *convey just the opposite*. They convey, "You are a specimen. I have to examine you carefully," and, "There are many rules and laws that govern our freedom to interact with each other. So there are pages of contracts, warnings and permissions I will need you to sign."

In light of this, I cannot urge you with sufficient intensity to begin to relate instead to new clients as *co-participants* in shaping a journey to greater understanding, greater efficacy in life, and less experienced distress. And even more than that, if we want them to come back, we must provide for them the experience that they are indeed someone about whom you will *care.*

So here are some tips on how to make that happen: return the initial phone call the same day it arrives. If the caller wants to tell you or ask you some things, don't get impatient and try to "get them to come in." If the caller remains interested, offer an appointment within 48 hours of the call. Stress that there will be no charge for the initial consultation. The time will be reserved for exploring and deciding whether or not both want to proceed. If the answer is "yes," there will be time to do the paperwork at some subsequent session.

During the first third of the exploratory session, try to intuit the sources of the client's pain, and please, demonstrate your capacity not only to understand these but to *care*. During the second third of the session, find something to offer the client that might be helpful to mitigate their distress—some homework, or some different way of understanding a dilemma. Please ask yourself, why would anyone want to continue to see you unless you demonstrate something helpful? And finally, towards the end, make a summary of issues you have identified, and what might be your longer term approach for dealing with these.

I promise you that if you let me influence you, you will have more success in having new clients hanging around longer. Listen to Moishe Tolman, and treat every subsequent session as one in which you will strive to help the client move even a small step forward.

Dr. Arthur Kovacs, ABPP, can be reached at arthurkovacsoffice@ aol.com.

The Ups and Downs of Online Therapy

By Enrico Gnaulati, PhD

Almost overnight, given the Covid pandemic, therapists have been compelled to make the switch to teletherapy to preserve continuity of care with their clients. The urgency of the situation dictated that we snap to it and quickly get up to speed on the latest digital platforms and alternative modes of offering therapy. There has been precious little time to reflect on the pros and cons of all this on the quality of therapy we offer. Now that the novelty has worn off, and we are able to step back and analyze the situation, what does the switch to teletherapy portend for our profession?

Let's start with some of the presumed positives. Most therapists I talk to enjoy the convenience of offering therapy from their homes, not having to travel to the office, all the while embracing the ensuing work-life-home-life flexibility. There's even talk that after Covid, many therapists will forego renting office space, and welcome the cost-savings. Some clients reference the benefits of omitting the commute to the therapy office. Scheduling can be executed more easily, with clients being available for daytime appointments, in as much as their own work-from-home arrangement allows. This is notwithstanding how it can be easier for some clients to share personal information during an online session, rather than a face-to-face one—almost like a throwback to when clients lay on the couch with an analyst unobtrusively sitting behind them.

What about the downside? In my estimation, the greatest downside to virtual therapy formats is the potential for privacy to be compromised. I have clients who climb into their cars, parked on busy streets, with pedestrians walking past, ready to start virtual sessions. Several clients have set up an area in their backyard with dogs barking, neighbors walking by, and gardeners milling around. Then there are the bulk of clients who set up in their bedrooms, or living rooms, or other area of their homes. I am surprised by the number of clients who claim they are comfortable with this arrangement, despite family members barging in, Amazon packages arriving, pings from computers and phones, and any number of other everyday distractions.

Most clients seem to dismiss their need for real privacy, even when the signs are obvious that the teletherapy arrangement they are about to embark on is rife with potential risks. One of the pivotal things I have learned from the switch to online therapy is the importance of asserting the need for a *private setting* with minimal outside distractions in which to hold the session. However, even so, it is hard to imagine how some clients can override the subliminal compromises to privacy associated with speaking frankly in the very bedrooms, living rooms and home offices they are used to speaking discreetly in. The invisible ears and eyes that inhabit these spaces perhaps censor clients more than they imagine.

There's the obvious risk of family members, friends, or loved ones overhearing sensitive information with unpleasant consequences. I recently had to interrupt a client, during a Facetime session, who had launched into a verbal diatribe of her wife who was in the next room: "Mary, how thick are the walls in your condominium? Are you 100% sure Debra can't hear you?" Mary began whispering, not having considered whether her wife might overhear. These intermittent reminders of privacy concerns have become a refrain of mine.

But more importantly, most conditions in which virtual therapy are conducted counteract the quiet states of inwardness many clients need—to tap, articulate, and elaborate upon dim thoughts and feelings that are a lifeline to reclaiming their muted, or disavowed, emotional self. It is an understatement to say we live in a culture of distraction. The therapy office had become a valued space for clients to tune out the world and tune into their inner lives. What becomes of therapy when it is held in the very world that clients need to tune out? Is there not something unique and sacrosanct about in-person meetings in a therapy office, designed for the very purpose of bracketing everyday responsibilities and distractions, ensuring privacy, and encouraging inwardness? These are questions we will all have to ask, once the Covid pandemic recedes.

Other questions we will have to ask center on how much our preferences for online therapy arrangements meet our own convenience needs versus what clients prefer, and what actually optimizes their therapy. As I see it, teletherapy set ups favor more left-brain, content-heavy, problem-solving, solution-focused, symptom-reduction type therapies, rather than right-brain, explorative, emotionally-evocative, process-oriented, non-verbal-affirmation ones. Research is starting to accumulate equating the benefits of online CBT to an in-person format. Will any greater shift to delivering psychotherapy online once Covid is behind us add to the already lopsided dominance of CBT in our profession?

At present, like so many dimensions of our culture, we are entering uncharted territory. When it comes to teasing apart the pros and cons of in-person versus online therapy, we therapists will have to engage in an honest reckoning, reaching beyond what is simply convenient for us, and keeping client preference and improvement front-and-center of the debate.

Enrico Gnaulati, PhD, can be reached at egnaulati@gmail.com.

Poems to Ponder

Submitted by Daniel Goldin, PsyD

This a beautiful poem, and sort of optimistic.

I dwell in Possibility

By Emily Dickinson
(1830-1886)

I dwell in Possibility –
A fairer House than Prose –
More numerous of Windows –
Superior – for Doors –

Of Chambers as the Cedars –
Impregnable of eye –
And for an everlasting Roof
The Gambrels of the Sky –

Of Visitors – the fairest –
For Occupation – This –
The spreading wide my narrow Hands
To gather Paradise –

A Case of Non-Alzheimer's Dementia

By James S. Graves, PhD, PsyD

When most people—including clinicians—hear the word "dementia," they often think of Alzheimer's disease (AD). While AD is, indeed, the most common type of dementia. it is only one of several forms. Dementia with Lewy Bodies (DLB) is the third most common dementia, after AD and Vascular Dementia, afflicting about 2-percent of Americans over 65 years old. That's a million people just in America alone! Unlike AD, which is more common in women, DLB is 3-4 times more common in men.

DLB is defined by the presence of aggregates of a protein, alpha-synuclein, that are microscopically visualized (i.e., Lewy bodies) in the brain at autopsy. Like most other dementias, DLB has an insidious onset and gradual progression, but the early phase typically shows more executive function impairment (e.g., attention, concentration, orientation) than memory impairment. This type of impairment leads to a characteristic feature of fluctuating attention and concentration that at times may appear to be a disoriented, delirious state of mind. People with DLB may also have Parkinsonian motor disturbances (e.g., tremors in the extremities) that onset after the cognitive impairment has become apparent. This differs from Parkinson's Disease Dementia in which the motor disturbances occur before the onset of cognitive impairment.

In my practice, a client was referred for assessment work in connection with an employment disability lawsuit. The client, a 66 year-old man whom I'll call Al, was an interpreter for American armed forces in the Middle East when an American soldier, who was Al's friend, was killed about 18 months earlier in an assassination by "friendly" forces. Al then feared for his own safety as he was required to be the interpreter in interviews of the witnesses—and possible accomplices—of the killing. In the following three months Al experienced two episodes of either seizures or syncope (i.e., loss of consciousness) with muscle twitching. From the results of extensive interview and testing I was able to clearly diagnose PTSD co-morbid with Major Depressive Disorder.

During this assessment process it became apparent that Al was dealing with significant cognitive impairment. He frequently complained of having difficulties concentrating and paying attention. His memory was impaired. He had stopped driving his car because he would sometimes become very disoriented while driving. It became important to assess for a neurocognitive disorder.

An initial step in assessing for a neurocognitive disorder was to administer the Montreal Cognitive Assessment (MoCA) in an online Zoom format as a standardized screening assessment for cognitive impairment. Al's score on this assessment was 14 out of a possible 30. The mean score for people with Mild Cognitive Impairment (MCI) is 22 and for those with Alzheimer's Dementia is 16 (MoCA Normative Data Manual). His responses showed significant errors in virtually every subtest of the assessment tool. In the delayed recall subtest, his ability to encode (i.e., more frontal lobe involvement) the five words was equally impaired as the ability to recall them (i.e., more hippocampal involvement). His score and breadth of impairment in various subtests on the MoCA would be consistent with major impairment. However, a diagnosis of Major Neurocognitive Disorder requires that, "[t]he cognitive deficits interfere with independence with everyday activities . . . . ." (DSM-5). Except for having stopped driving his car, there was insufficient evidence of this level of impairment.

Al described several unusual life experiences that helped make a specific diagnosis related to cognitive impairment. He experienced two of the "core diagnostic features" outlined in the DSM-5 related to DLB: 1) Fluctuating cognition with pronounced variations in attention and alertness; 2) Recurrent visual hallucinations that are well formed and detailed. The two episodes of hallucinations involved seeing "unreal" men talking to him. In addition, he described having frequent nightmares that involved screaming loudly before being awakened by his wife. Such nightmares meet the criteria for rapid eye movement (REM) behavior sleep disorder, which is a "suggestive diagnostic feature" of DLB. People with DLB are also known to often have unexplained falls and syncope, such as the "seizures" that occurred in the months after his friend's murder. Further, the incidence of seizures or myoclonus (i.e., muscular twitching) is about 10-fold higher in people with DLB. Based on these characteristics and criteria, Al qualifies for a diagnosis of Probable Mild Neurocognitive Disorder with Lewy Bodies.

Because Al's cognitive issues were noticeable to him only after the traumatic incident, an intriguing question arises: Can PTSD promote the onset of neurocognitive disorder symptoms? There is a significant literature related to this question which indicates that PTSD is at least a risk factor for dementias (e.g., 2-fold higher risk) and possibly increases the rate of cognitive decline. Thus, Al's PTSD may have played a role in the manifestation of symptoms and awareness of his cognitive impairment.

Dr. Jim Graves can reached at jgraves1@charter.net.

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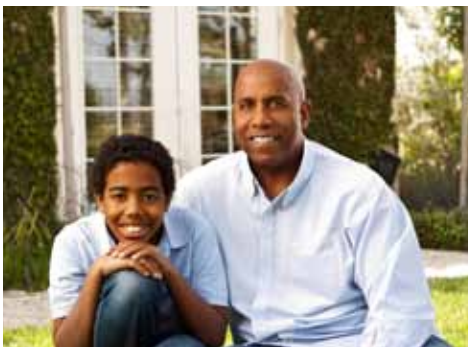

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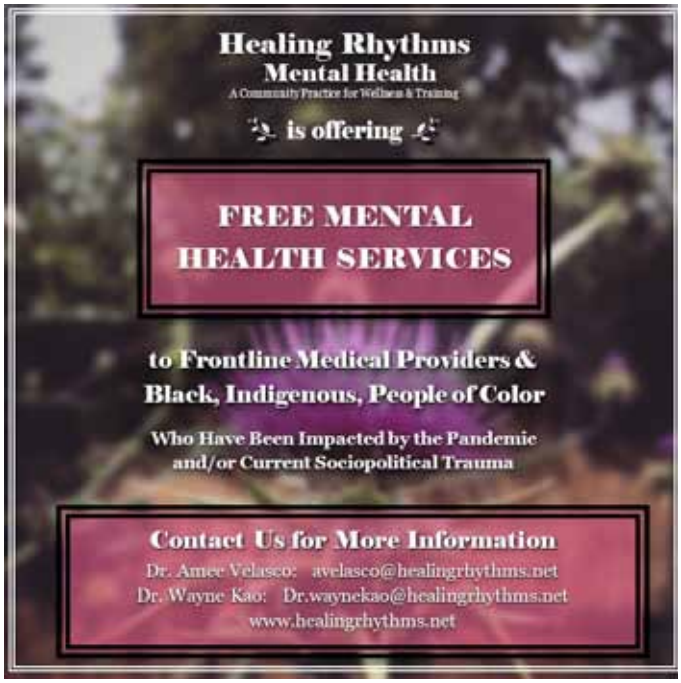

San Gabriel Valley Psychological Association

c/o Suzanne Lake, PsyD, Editor
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