# Clinical Perspectives

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# *Message from the President*

**Patricia C. Dowds, PhD**

It is an honor and a privilege to serve as this year's President of the Clinical Division. As your new president, I am looking forward to a year that will strengthen our division and provide support to our membership.

To reach these goals, the Executive Board and I have set ourselves several tasks:

First, we are planning two workshops for the support of our members, who are our reason for being. The first will be "The Loneliness of the Private Practitioner: Developing Coping Strategies and Support Systems." As soon as a location contract is signed, you will receive a save-the-date message. The second workshop will be on private practice associations. We are inviting professionals from other states, as well as leaders from our association, to begin an educational discussion of how we might develop more negotiating power in today's changing economy.

Secondly, we are looking to strengthen our division membership, as well as NYSPA's membership.

We have developed a one-year scholarship to kick off this drive. We have reached out to other divisions and, at this point, the Division of Psychoanalysis has voted to join us. This scholarship is for new NYSPA members. It will pay the membership fee for five new members, as well as division dues to Early Career Psychologists and Clinical. Psychoanalysis has voted to match this, with the difference being division dues to ECP and Psychoanalysis.

We are also hosting a division caucus to brainstorm different forms of outreach to increase membership in NYSPA, as well as strengthen our divisions. The concept of this meeting has been well-received. In this newsletter is an excellent article by Dr. Herb Gingold on the importance of strong and diverse divisions.

You, our members, are the heart of our organization. We welcome your input and participation in our activities. Please feel free to email me at patriciadowds@optonline.net with any thoughts or ideas you may wish to share, or if you wish to attend a board meeting.

I hope to meet many of you at our upcoming events.

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# Editor's Corner

***Barbara Trilling, PhD***

Welcome to our new president Dr. Patricia Dowds. Pat brings many creative ideas to the presidency, and the expertise and energy to work with us to make them happen. Thank you to past president Dr. Thomas Mallios for his leadership over the past year. Tom will, of course, continue to be active in the Clinical Division.

I am happy to report that our membership drive was a success, and we have retained both of our seats on the NYSPA Council. Thank you to all who are working to keep NYSPA and the Clinical Division strong and productive. Dr. Dianne Polowczyk has two articles in this newsletter, reporting on recent meetings of the NYSPA Legislative Committee and the APA Council. Dr. Herb Gingold has an article on the importance of divisions in NYSPA.

Congratulations to former Clinical Division President Dr. Patricia Pitta, whose book *Solving Modern Family Dilemmas: As Assimilative Therapy Model* will be published by Routledge this summer. The Clinical Division will sponsor a "Meet the Author" event. The date is to be announced.

As you can see, the newsletter has expanded. We welcome your contributions on anything of interest to Clinical Division members. We particularly encourage contributions to our *Who We Are and What We're Doing* feature, so that the rest of us know what you do for purposes of referrals and resources, and to let students and early career psychologists know about the many aspects and opportunities in clinical psychology. In this issue, we have articles by Dr. Joel Block, Dr. Christina Doherty, and Dr. Charles Silverstein. We also welcome reports on events sponsored or cosponsored by the Clinical Division or by your regional association. Dr. Helga Weiss reports in this issue on a DOWI event cosponsored by Clinical.

Please contact Pat Dowds (patriciadowds@optonline.net), me (barbtrilling@aol.com), your regional representative, or any Executive Committee member about suggestions you have for the division. Or even better, join us at a board meeting! — contact us for details. We are always looking for members who would like to be more active. We have openings for regional representatives for Genesee Valley, Hudson Valley. Brooklyn and the Bronx— but no matter where you live or work in New York State, we welcome your participation.

The NYSPA Annual Convention is May 30—31. As always, it will be informative, thought-provoking, and enjoyable. If you haven't registered yet, now is the time!

# The Importance of Divisions in NYSPA

***Herb Gingold, PhD***

***Division of Psychoanalysis Representative to Council***

NYSPA contains about 15 divisions (not including the renascent Neuropsychology Division and the Student Division, NOFP). Divisions were created to represent interest groups within the organization based on practice issues, treatment techniques and focus, and patient populations. Many divisions focus on practice issues, others on specific workplaces, and some on social issues. Naturally there is some overlap.

Recently, there have been important discussions about the role of divisions in the organization. Several years back, NYSPA Council enacted an informal moratorium on the formation of new divisions which coincided with the petition for the formation of a new division concerned with child and adolescent therapy. The predictable result was that this group, organized after a good deal of effort, disbanded itself with some ill feeling and a number of members resigned from NYSPA. The moratorium has been lifted as a brand new Neuropsychology is currently petitioning for admittance as a division.

So, what is the role of divisions in the organization? The following are just a handful of important contributions that divisions make and have made to the parent organization and the public:

- Providing a home for members sharing professional interests
- Bringing new members into the organization
- Organizing programs to educate and entertain members
- Offering opportunities to network
- Sharing important information about the field or some aspect of the field
- Protecting the interests of patients and therapists against misdirected legislation and instigating important legislative initiatives

Within NYSPA, divisions are an important conduit for leadership development. Members of divisions are encouraged to participate in division leadership and thereby develop skills which they can transfer to a larger canvas within NYSPA, itself. Traditionally, division officers are asked to join NYSPA committees and task forces where they can bring both their leadership experience and the particular needs of their division constituents to the greater organization. This allows NYSPA leadership to keep a finger to the pulse of the members, better representing their interests and minimizing the risks of group think. Wise leaders have used this richness to benefit the organization.

Historically, divisions have played an important role in producing and publicizing the annual convention. In the past, with division interests fully represented in programming and on the programming committee, NYSPA conventions were very successful and satisfying events. They also provided an opportunity for all NYSPA members to present their interests and develop their speaking skills.
Divisions continue to be an enormous resource for our organization.

Properly nurtured divisions will continue to enrich NYSPA, build its membership, educate members and the public, and provide experienced leaders.

# Report on NYSPA's Legislative Committee Meeting—January 25, 2014

***Dianne Polowczyk, PhD, Clinical Representative to the NYSPA Legislative Committee***

This well-attended legislative committee meeting with 25 psychologists representing various regional and divisional constituencies and leaders of NYSPA began with opening remarks by Legislative Chair Dr. June Feder, who spoke of advocacy accomplishments of the past year. She discussed the attention that was given to operational issues within the committee to improve the efficiency of its work. This included the establishment of internal subcommittee work groups such as bill review, grassroots advocacy, duty to protect, telepsychology, child policy and SAFE Act. Dr. Feder outlined the urgent goal of effective team functioning between leaders and staff holding advocacy responsibilities that included clarification of roles and responsibilities, a defined operating structure, open communication and availability of consistent and adequate support for all team members. She announced the resignation of Dr. Jeannette Sawyer-Cohen as vice-chair of the legislative committee, who resigned due to personal life demands and responsibilities. Dr. Sawyer-Cohen will remain as chair of the Child Policy subcommittee.

Our lobbyist, Ms. Chrissy Dickinson, was in attendance by speaker phone. In her report she described the current political atmosphere in Albany as one focused on election to office. Governor Andrew Cuomo will be running for re-election in the fall. The major policy issues being addressed by the legislature include medical marijuana, common core curriculum and testing in the schools, and casino sites.

NYSPA major legislative initiatives are as follows:

**PLLC:** The Corporate Practice of Medicine Act would lift the restrictions currently in place which prevent physicians from entering into partnership with psychologists. Passage of the bills A.33481 and S.8010 would allow psychologists to co-own with physicians health care delivery entities such as Accountable Care Organizations (ACOs) and Medical Homes. Senator LaValle hosted a meeting in December to discuss drafting an omnibus bill, since several professions in addition to our own have submitted bills like ours. Concerns were raised by medicine, chiefly regarding malpractice issues, oversight by different credentialing agencies, fee sharing and the like. LaValle's office is considering an omnibus bill at this point, but announced that they would not work to stop individual bills from the respective professions. Ms. Dickinson reinforced the need for grassroots advocacy.

**Mental Health Advisory Board subcommittee:** The legislative committee had previously committed to working for the establishment of a multi-disciplinary mental health/substance abuse advisory board for the New York State legislature upon the recommendation of NYSPA's Health Care Task Force. A model for this can be found in Massachusetts, which has recently established such a board. Ms. Dickinson recommended that we include social work and psychiatry in the initial discussions about the formation of this board. The next step is the development of talking points by the Health Care Task Force.

**Telepsychology subcommittee:** Dr. Larry Baker, chair of this subcommittee responsible for developing a bill focused on insurance reimbursement, will be conferring with lawyers at APA who have worked on similar legislation in other states. Thirteen states presently have such legislation. The bill will require insurance companies to pay for telepsychology sessions. There was a discussion of the issues of working with patients outside the jurisdiction of New York State, which has certain legal perils and issues. The recently passed document by APA council on telepsychology guidelines is a resource for these matters, as is APAPO.

**Duty to Protect subcommittee:** This subcommittee is charged with determining the responsibilities of psychologists under the current SAFE Act, given that the state does not have a Tarasoff law. This subcommittee has developed a survey for New York State psychologists to determine how psychologists are dealing with this situation. The results should be forthcoming shortly. Elizabeth Winkelman at APA stated that there are two options: a Tarasoff law and a permissive duty to protect law. Dr. Grodin passed on some links that contain information on these two options.

**RXP - Prescription Privileges for Psychologists subcommittee:** Ms. Dickinson and Dr. Grodin are attempting to secure a sponsor in the legislature for this bill. There is some resistance by medicine to this bill, especially from the New York State Psychiatric Association (see their website, www.nyspsych.org). There was some discussion regarding this issue, in particular how this might effect the passage of our PLLC. Ms. Dickinson advised us that we should not be reluctant to pursue multiple agendas at the same time, and that there may be other physician groups that would be more friendly to this bill. Dr. Grodin will be writing some talking points on this issue and working on the grassroots advocacy piece.

**ABA Licensure:** The Insurance Reform bill of 2011 which NYSPA took an active part in writing protects the ability of psychologists to work in this field without further training or certification if they are practicing within the bounds of their competency and training.

The ABA licensure bill was introduced and NYSPA's advocacy helped shape it. Licensed behavior analysts are not permitted to diagnose, prescribe, or order treatment. A licensed provider— such as a physician or psychologist— must make the Autism Spectrum Disorder (ASD) diagnosis and order or prescribe ABA treatment for a given individual. Any psychologist having difficulties with reimbursement for these services or finding themselves in the situation of not being hired by agencies unless they have the ABA license should contact NYSPA.

The meeting ended with Dr. Feder announcing her resignation as chair of the legislative committee. She also stated that it would be her last meeting as chair. She expressed gratitude for having been given the opportunity to serve in this leadership role and for the many wonderful experiences she has had in working with the committee. She thanked committee members for their support and hard work. She indicated that she would be available for help in the transition. Members were understandably shocked at hearing this. They expressed gratitude for all the work she has done and for her outstanding service to the advocacy efforts of NYSPA.

# Past President's Message

***Thomas Mallios, PhD***

Looking back to my recent and second term as President of Clinical, I realize what a productive year it was, thanks, of course, to all of the very dedicated board members, some of whom have continued to serve for many years. Focus was maintained on building the division by membership drives, and by offering highly relevant programming for members. I was very honored to have been invited by the Independent Practice Division to participate in the PQRS workshop. I look forward to continued active participation this year, and invite all members to become more active with Clinical activities, including board membership. I wish the best of luck to the current executive board members who are already in the process of planning very exciting events this year.

# Report on APA Council Meeting—February 20 and 23, 2014

***Dianne Polowczyk, PhD—NYSPA Representative to APA Council***

The APA Council of Representatives is currently making some of the final decisions, which, if approved by the membership, will change the function and structure of its Council for years to come. After three or more years of work on the Good Governance project, some critical decisions were approved by large margins at its recent meeting. In its effort to streamline Council and to make it more nimble, efficient and inclusive, Council approved several changes.

A Board of Directors will be established on a temporary three year trial basis whose function will be to alleviate Council from spending valuable time on financial and budgetary matters. A Council Leadership Team (CLT) will be established which will function as an executive committee and will be responsible for determining the agenda of Council, managing Council's workflow and prioritizing issues to be considered by Council. A Needs Assessment, Slating and Campaigns Committee (NSCC) will develop slates for those seats on the board elected by and from the membership. They will conduct an annual needs assessment so that the slates include candidates with the particular background or expertise to fulfill those needs. They will do the same for similar seats on Council, should a model be adopted that will include at-large members. Council has not yet decided on a structure for itself other than to approve a change in the structure of Council whereby more than one representative for state, provincial, territory or divisions is no longer possible. It voted in August that each entity will have one and only one representative. This will go into effect on Jan 1, 2015, if approved by membership. New York will lose its second seat then, as will four other states. The hardest hit are the divisions, particularly the practice divisions; for example, Division 42 will lose five seats, and Division 39, six seats.

At the February meeting, Council attempted to come up with a model for the structure of Council, and was offered two models to work from based on our discussions in August. There was no agreement, however, so it was postponed until this August. The models proposed contained the senate type of model as described above (one entity one vote), the officers of APA, and different configurations of the following representatives: ethnic minorities, early career, students, regional association members (research–academic organizations), members at large, members representing the pillars of the organization, such as Science, Education, Public Interest, Practice and Health. It seems whatever model we choose there won't be a substantial decrease in the number of members serving on Council. To be continued.

Council discussed the impact of the Accountable Care Act on psychologists and it came up with lists of opportunities for psychologists and lists of needs to be met if psychologists are to survive. A major need is for us to educate the public about what we do and to describe our unique contributions to the health care market. Other needs include a need for a paradigm shift from mental health to health, more involvement in interprofessional training, and improved education in health psychology and team based treatment. There will be a follow up to this in August and hopefully an action plan will be developed.

Council members participated in diversity training which was devoted to working with transgender clients. The presenters, Drs. Lore Dickey and Annelise Singh, gave an excellent workshop which was informative and sensitive. It resulted in an increase in our knowledge and understanding of transgender people and how best to work with transgender clients.

Good news. We are getting closer to the day when practitioners who support the Practice Organization with their assessments will be able to have a voice in APAPO and have the right to vote for members who serve on CAPP. Council approved the sunsetting of C3 responsibilities of CAPP with 96% in favor.

Other good news is as follows:

- Council adopted as policy a new Resolution on Gun Violence Research and Prevention.
- Council adopted an official definition of early career psychologists as those who are within 10 years of receiving their PhDs.
- Council approved as APA policy the document "Health Service Psychology: Preparing Competent Practitioners."
- Council received the Report of the Task Force on Trafficking of Women and Girls.
- Council learned that APA expects to finish 2013 with a positive operating margin of more than $1.8 million.

The next APA Council meeting will be held on August 6 and 8 in Washington, D.C. prior and during the APA Convention. If you are attending the APA Convention this year, plan to attend the meeting. All APA members are welcome.

# How Do I Get Answers to Legal, Insurance, and Ethical Questions?

***Barbara Trilling, PhD***

NYSPA members often ask how they can get answers to legal, insurance, and ethical questions. I put this query to Dr. Jerry Grodin, Director of Professional Affairs for NYSPA, and former NYSPA President. Jerry replied that such questions should go to the NYSPA Central Office (e-mail nyspa@nyspa.org, or phone 518-437-1040), where they will be sent to him, and he will send them to the person or committee best qualified to answer them.

Jerry also suggested that members ask questions on the list serve, as there are many knowledgeable colleagues who might be able to answer them.

Sometimes members assume that they are on the list serve because they receive official notices from NYSPA and the divisions they belong to. This is not the same as being on "the list serve," where there is a constant lively exchange among members. (Hint: if you don't receive dozens of emails a day with [NYSPA] in the heading, you are not on the list serve!) To join, send an e-mail request to nyspa@nyspa.org. Include your name, the e-mail address where you would like to receive your messages, and that you would like to join the general NYSPA list serve.

I would like to add one more thing to Jerry's advice. Check with your malpractice insurance carrier to see if they offer free consultations about legal and ethical matters. I have insurance through Trust Risk Management Services; I have used their free consultation service several times, and found it very helpful.

# Division of Women's Issues 30th Anniversary Celebration

***Helga Weiss, PhD***
***Clinical Division Liaison to the Division of Women's Issues***

November 10, 2013, was a significant day for NYSPA's Division of Women's Issues, also known as DOWI. On that Sunday, DOWI celebrated the 30th anniversary of the division's founding, hosting a full day conference entitled "Thirty Years of Progress -- Still Facing Resistance and Still Fighting Back." The conference was dedicated to the recognition that although women have come a long way, today they still face violence and discrimination for simply being women, but are finding scientific and humane ways to overcome these obstacles.

Attendees agreed that it was a most meaningful event. In fact, descriptions of ongoing presentations were enthusiastically tweeted to the NYSPA list serv.

The program took place at the Courant Institute for Mathematical Sciences, New York University, and was co-sponsored by the following NYSPA divisions along with DOWI: Clinical, Social Issues, Psychoanalysis, Forensic, Organizational, Consulting and Work Psychology, and by Roy Aranda, Psy.D.

The keynote speaker, Martha E. Banks, Ph.D., a research neuropsychologist at ABackans DCP in Akron, Ohio, whose address was entitled "Battered Brains: A Feminist Response to Domestic Violence," presented research on brain trauma. She vividly explained and demonstrated, via evidentiary data, how severe brain trauma is a major consequence of intimate interpersonal violence, and how frequently it is not recognized, assessed, or addressed.

Barry Duceman, Ph.D, Director of Biological Science at the New York State Police Forensic Investigation Center, and an expert in using DNA to identify rapists, spoke on "The Use of Forensic DNA Tests to Solve Violent Crimes." He presented impressive information on utilizing up to date DNA technology in solving crimes. Such crimes frequently involve occurrences of interpersonal violence. In addition, it is significant that DNA evidence has also enabled the criminal justice system to succeed, many times against tremendous odds, in affirming the innocence of wrongly accused persons.

Letty Cottin Pogrebin, award winning journalist, co-founder of Ms. Magazine, and an early strong voice for the rights of women and all people, was presented with DOWI's Public Service Award. She related how her personal health challenges spurred the writing of her book, *How to Be a Friend to a Friend Who's Sick*. She shared her wisdom in a delightful and often moving way. She made us aware of far better responses to the illnesses of friends, family members and others for whom we care, than is commonly an "acceptable" mode, emphasizing, nevertheless, that not all friends are equally able to be supportive in times of crises. Ms. Pogrebin also told us about some of her life history and professional experiences, which served as a fascinating background to how her thinking has evolved.

Judith Antrobus, Ph.D., DOWI founder and its first president, chaired the final session. We learned about her early involvement as a psychologist in sleep research, and the hurdles she faced as a woman. She described her long standing commitment and persistence of vision, together with other NYSPA members, to create a division of women's issues within the organization. These efforts finally culminated in success, and DOWI was welcomed as a new NYSPA division in 1983, a historical first for any state psychological association. It provided a forum for social justice, clinical practice and research from feminist and ethical psychological perspectives.

Many of us who participated in the development of DOWI amplified Dr. Antrobus' descriptions for the audience by sharing our fond memories and reminiscences. This even included a delightful poem by Dr. Irene Deitch!

The conference participants, male and female, truly enjoyed the excellent program and the opportunity to absorb new information, the delicious lunch, the reunions and greeting long time friends, and the networking among all.

Please note: If you are a member of the Clinical Division -- or would like to become one -- and are active in another NYSPA division, with an interest in acting as a liaison to the Clinical Division, please let us know. We would welcome you and would look forward to learning about your division's highlights, with a view to further professional collaboration.

# Family Peer Consultation Via Phone Sponsored by the Clinical Division

For the past five years, the Clinical Division has sponsored a monthly forum via phone to present individual and family cases with feedback from Board Certified Couples and Family Psychologist Dr. Pat Pitta. During the forum, Dr. Pitta comments on cases from an assimilative family therapy perspective that she created and has published in professional journals, books and videos. Her approach includes a theoretical perspective that uses Bowenian family therapy as the home theory integrated with psychodynamic, object relations, behavioral, cognitive behavioral, and communication theories with a deep respect for the context. Dr. Pitta authored a book that will be published by Routledge and will be released this summer. The book is called *Solving Modern Family Dilemmas: An Assimilative Therapy Model*.

Peer consultation is a wonderful opportunity to get input on your cases from Dr. Pitta, as well as from others who join the call. The group meets monthly. The day of the meeting varies, but the time is always from 12:15 until 1:00 pm. Each month, a notice is posted on the list serve two weeks before the consultation with the call-in number (1-877-394-5901) and PIN (6263476#). Join your fellow colleagues and share lunch, thoughts, and get new perspectives about your cases.

# DSM-5 and the Paraphilias

*Charles Silverstein, PhD*

The paraphilias (kinky sex) have had a bumpy ride for the past couple of centuries. Historically, they have included such behaviors as homosexuality (removed in 1973), fetishism, pedophilia, transvestitism, exhibitionism, voyeurism, sadism, masochism, and other even more esoteric sexual behaviors. Its most extreme form is lust murder, as we learned in the case of Jeffrey Dahmer. But DSM-5, published last May by the other APA, made a momentous change in how the paraphilias are to be diagnosed and, by implication, how they are to be therapeutically treated.

While these sexual behaviors are clearly unusual, we need to explain how they were initially identified as medical disorders in the first place. It all goes back to the concept of "Vitalism," which was very popular in the medical literature starting in the 17th century. It decreed that there was just so much "vital energy" in the human body and that when depleted, terrible things would happen, such as disease, and especially mental disease. They believed that there was an interaction between the reproductive and nervous systems. An excess of energy in one would cause damage to the other. Therefore, according to Vitalists, too much sex would drain the nervous system, leading to psychosis. They believed that one ounce of semen was equivalent to many ounces of shed blood. This leaves open the question of exactly what is "too much" sex. Many claimed that married couples should have sex no more than once each month, and never before marriage. To do otherwise would likely drive the abuser to the lunatic asylum.

It is because of the potential damage to the nervous system due to sexual desire that mothers were warned to prevent their children from masturbating. Mothers were told never to let their children slide down a banister, or sleep under a feather bed – not even to allow the child (male or female) to sleep with his/her hands under the covers. There were a number of anti-masturbation devices invented to prevent what was called "self abuse" by children, such as long cardboard cuffs for girls that prevented them from bending their elbows, and contractions for boys with spikes that bit into the penis should the boy have an erection during sleep. Children were told that hair would grow on their hands, or that they would go blind if they gave in to their feelings of lust.

John Kellogg, famous for his Battle Creek Sanitarium, wrote extensively about how children were to be treated in order to prevent masturbation. He suggested sutures to close the glans of the penis in boys, and applying carbolic acid to the clitoris in girls in order to allay the "abnormal excitement." It was a few years later that he and his brother invented a food that would temper sexual excitement in children. It was called "Corn Flakes," and led to a whole new industry, also centered in Battle Creek, Michigan. (Incidentally, 50 years earlier, Sylvester Graham, one of the founders of the vegetarian movement, invented a food designed to prevent sexual desire in adults – the Graham Cracker!)

It was upon the foundation of the anti-sexual beliefs of Vitalism and religious beliefs that the first DSM was written. The authors of DSM-I virtually copied the list of perversions from Krafft-Ebing whose Psychpathia Sexualis was first published in 1886. DSM-I was published in 1952 and every edition for the next 62 years continued the tradition of identifying all variant sexual behavior as mental disorders. The unfortunate diagnostic category of Not Otherwise Specified (NOS) allowed clinicians to use pejorative labeling toward a patient whose sexuality offended them and/or made them extremely anxious. This is also true today with the disagreement in clinical and research circles about the status of what some colleagues call "Sexual Addiction" and "Porn Addiction." Depending upon your personal point of view, these "addictions" should or should not be included in DSM. Right now they are not.

The 1973 deletion of homosexuality from DSM in 1973 represented an extraordinary revolution in DSM. According to (their) APA, not all homosexuals suffered from a mental disorder, only those homosexuals who were upset by their sexual orientation. Those people were diagnosed as "Sexual Orientation Disturbance." Other homosexuals were not disordered; they were normal. This was the first time in the history of DSM that a sexual behavior itself was not diagnosable. It was how the person felt about it that was the criteria for diagnosis and treatment. Homosexuals (by that time the term "gay" came into common usage) who felt good about their sexual orientation, but not about the discrimination against them, were not to be diagnosed as abnormal and not subject to be treated in order to change them into heterosexuals. In the next edition of DSM, all reference to homosexuality was deleted, including gay people who were still upset about their sexual orientation. Therapeutic energy went into treating their attitudes and feelings, not their sexual orientation.

While many of us thought that making one's feelings about sexual orientation the criteria for diagnosis a positive step, it created a public relations disaster for their APA. Critics, particularly from the religious right, accused them of condoning child molesting since pedophilia was listed as one of the paraphilias. This outrage was echoed in the halls of Congress and condemnations abounded. The attacks were so fierce that even our own APA buckled under attacks against one of our own publications about child/adult sex, and condemned the study and authors of a peer reviewed APA paper. It was a cowardly act by our APA that was itself condemned by other professional organizations. Their APA in DSM-5 of 2013 solved the problem by removing pedophilia from the list of paraphilac disorders and making a separate category that stated that adult sex with children was always a disorder regardless of the feelings of the adult. This was done for the political motivation of shielding the APA from attacks from the political right.

The sexual disorders subcommittee for DSM-5 made a revolutionary change in the diagnosis of the paraphilias that mirrored the 1973 change for the diagnosis of homosexuality. Just as there were homosexuals who were pleased or displeased with their sexual orientation, so there were people with paraphilias who were either pleased or displeased with them. DSM-5 states:

> A paraphilia is a necessary but not a sufficient condition for having a paraphilic disorder, and a paraphilia **by itself** does not necessarily justify or require clinical attention (emphasis added).

Presumably, someone who is, say, a masochist, is either ego syntonic about his/her behavior in which case needs no therapeutic intervention, or ego dystonic and does need to be treated. DSM-5 therefore, is the most liberal statement of the mental status of the paraphilias since a psychiatric nomenclature first began. On the side of the Paraphilia Subcommittee is the fact that sodomy laws were struck down by the Supreme Court in 2003, so that sex between consulting adults, regardless of its atypical nature, is legal throughout the United States.

What are we to make of this diagnostic liberalization of the paraphilias? It appears to be part of a transition from abnormal to normal as a direct parallel to what happened with the diagnostic status of homosexuality in the 1970s. If that is the case, then a future revision of DSM will remove the paraphilias completely as diagnostic categories. "Kinky" is likely to be but one variant from "vanilla" sex.

We have to be mindful, however, that sex in our society is still heir to shame, embarrassment and fear. We do not shed our past so easily as one can write a new manual. Even though homosexuality is

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# Essential Attitudes for Men with Premature Ejaculation

*Joel Block, PhD, ABPP*

It is one of the most common, underestimated sexual problems for men: Ejaculating earlier than desired. More common than erectile dysfunction, this condition can affect men at any point in their lives, and one in four men experience poor control over ejaculation on a frequent basis (Medical News Today, May, 2010).

Research reported at the 99th Annual Meeting of the American Urological Association (AUA) in 2012 by Andrew R. McCullough, M.D. at the NYU Medical Center, suggests men classified with premature ejaculation self-reported low satisfaction with sexual intercourse (23 percent), low satisfaction with sexual relationship (30 percent), low interest in actually having sexual intercourse (28 percent), difficulty in becoming sexually aroused (34 percent), and difficulty relaxing during intercourse (31 percent). These findings highlight the negative impact of premature ejaculation on sexual performance and enjoyment of sex.

In my practice, treating men and women with sexual dysfunction, along with a protocol for prolonging orgasm, I suggest the following for men who are quick ejaculators:

**The Ten Commandments of the Quick Ejaculator**

1. **I Will Be Self-Acceptant.** I will not blame myself or in any way condemn myself for my quick orgasmic response. Instead I will remind myself that my low orgasmic threshold is most likely (especially if it has been that way since I became sexually active), a product of my natural response; it is my biological propensity.

2. **I Will Be a Generous Lover.** I have a responsibility to myself and to my partner to make a positive adaptation to my low orgasmic threshold. To do so, I will learn to be more sensual and focus more on my partner's pleasure throughout our sexual encounter. I will be especially thoughtful to put the focus on my partner in the initial phase of our sexual encounters. In that regard, I will teach myself to be a generous and skilled lover when it comes to being sensual, considerate and competent at non-penile stimulation (like cunnilingus and manual stimulation).

3. **I Will Avoid Sexual Demands.** Despite my best efforts, I may not always do well sexually. In those instances I will not impose conditions on myself. In short, I will not insist that I *absolutely must* perform well sexually. I will remind myself that imposing conditions (usually framed by words like *must*, *have to*, *should* and *need to*) is the best way to needlessly block sexual pleasure and make myself miserable.

4. **I Will Not Be Intimidated.** I will not fall prey to the temptation of sexual avoidance. I realize that the temptation is real and at times strong, since it is easy to believe that I will fail, be criticized for failing, and that the failure or criticism will be devastating. In contrast, I will stay on track, approaching sexual opportunity not as someone who is "handicapped," but as someone who has compensated well and consequently does not have to rely on my penis alone; I have my mouth, tongue and fingers, all schooled in providing sexual pleasure.

5. **I Will Be a Complete Lover.** When I am anxious in anticipation of a sexual encounter I owe it to myself to remind myself that the idea that there is one "proper" and "normal" way of satisfying my partner—with my penis—is false and very limiting. Most women are not satisfied by sexual intercourse alone; and even when they are it is the rare man who can last long enough to bring them to orgasm through intercourse. In short, a main way to a woman's heart, as many researchers have reported, is by opening her sensual, romantic—and not merely her sexual—door.

6. **I Will Not Seek Perfection.** If I want to enjoy sexuality rather than making it a contest at which I fear failure, I had better look at a sexual encounter in the same healthy way I had better view life in general: I will win some and lose some; some experiences will be better and some not as good as I had hoped.

7. **I Will Be Open About My Sexuality.** I will talk openly and frankly with my sexual partner about my sexual desires, her sexual desires and preferences and about my sexual limitations. Together we will discuss ways to limit our limitations and boost our sexual assets. Under no circumstances will I put myself down because of my low orgasmic threshold. I won't do that anymore than I would if I were short, bald or a poor athlete. I will resist making apologies for something I do not have full control over.

8. **I Will Not Rely Solely on My Penis.** I cannot remind myself of this too often: the more I think that I absolutely must give a woman a terrific orgasm with my penis, the more my penis is likely to disappoint me and her. Anxiety about the functioning of my penis stems from the demand that it absolutely must function as well as I believe it should. As a quick ejaculator, demanding that I last as long as I want will only make it worse, both for me and my partner.

9. **I Will Not Let My Emotions Run Me.** I will remind myself as often as needed that emotional reactions are greatly influenced by losing perspective. It is the human bent to do this. If sex doesn't go as I would hope, rather than creating drama, I will stop and do a reality check. I will keep in mind that what is considered over-the-top is often a mole hill that has been fictionalized into a mountain.

10. **I Will Accept That My Sexuality and My Partner's Sexuality Will Likely Evolve Over Time.** I resolve to adapt my lovemaking style to the changes. I will strive to be flexible; rigidity is deadly, especially in the bedroom. I will find the good in the changes, and make the most of each new phase of life.

Those are key attitudes; while there are no approved medical treatments, as there are for erection dysfunction (the vasodilator medications), there are sex therapy interventions that can be the subject of future articles.

*Dr. Block can be contacted at drblock@drblock.com. Visit his website, www.DrBlock.com.*

**DSM-5 and the Paraphilias**

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considered an acceptable life-style, there are gay people who still seek treatment and submit themselves to "reparative" therapy. We can expect people who are ashamed of their paraphilac ideation and behavior to suffer from it for a long time. The Internet and its freedom, together with younger generations who will be less subject to the prohibitions of the past, will be much more generous toward variant forms of sex than we have ever been.

*Dr. Silverstein be contacted at Csilverstein2@nyc.rr.com. Visit his website, www.DrCSilverstein.com.*

# A Personal Reflection on My First Year in Private Practice

***Christina Doherty, PhD***

I am a creature of habit. As a child I would lament the fact that I had to transition from one teacher to another year after year. It would disappoint me to learn that I would have a new Little League coach every season. I never found consistency or repetition to be boring, but rather enjoyable and comforting. Today, I enjoy eating at my favorite restaurant and ordering "my usual." If I find a hiking trail that I like, I am inclined to hike that trail time and time again, before searching for something new. However, with this being said, naturally I have found change to be a wonderful thing. And I am still inspired by how I can change and be changed in incredible ways.

During my first week in the doctoral program at Fordham University, I remember dreaming of opening a private practice. Today I am living my dream; a dream that began to take shape during a casual conversation with my husband over dinner. He looked at me across the table and asked, "When do you think you would like to open your own practice? I think you could do it soon if you wanted." The idea certainly excited me, but I was very secure in my job at a college counseling center. I had been working there for just over six years, and it was difficult to consider leaving a position and an environment that I enjoyed.

On January 16, 2014, I celebrated the first anniversary of the opening of my practice. As I reflect on my first year, I think about what a roller coaster ride it has been. Before I opened my doors, I implemented marketing efforts which included email blasts, business announcements, and general networking. Still, I was only expecting the occasional phone call, a client or two if any, and many quiet days in the office. Surprisingly, I experienced a great deal of early success. My phone was constantly ringing, I was invited to give several presentations and workshops, and before I knew it I had taken on close to ten clients. This early success proved to be both a blessing and curse. It was very exciting to see my practice grow in such a short period of time, but unfortunately I was lulled into a false sense of security. I began scaling back my marketing efforts and focused almost exclusively on what I enjoyed most, the clinical work.

Before I knew it, my phone was hardly ringing and the opportunities to present were few and far between. Additionally, as a clinician who works predominantly with school-aged children, I was seeing fewer clients during the summer months. The anxiety that I had been anticipating finally set in. I worried that perhaps I had made a mistake by striking out on my own. At times, the anxiety was somewhat paralyzing.

Things changed once I was able to channel my anxiety into action. I come from a family of small business owners. When I would begin to feel anxious, I would think to myself, "If my father, uncle, and brother can grow successful businesses, so can I." I garnered added motivation from the fact that while several men in my family had become successful entrepreneurs, I was the first woman in my family to start a small business. Next, I decided to turn to the "experts" in my corner for guidance, encouragement, and fresh marketing ideas. I visited with former professors and supervisors who had always supported me. I reached out to the entrepreneurs in my family. I made cold-calls to psychologists and psychiatrists in the area whose practices were thriving. I read books geared towards mental health professionals trying to build a private practice.

There is no doubt that I am still adjusting to life as a private practitioner, but I find it much easier to navigate the peaks and valleys these days. I understand now that there will be weeks when my phone is ringing constantly and weeks when it barely rings. Today, I strive to maintain my marketing efforts and a positive attitude regardless of how many calls I receive. I have been changed as a clinician and as an individual in positive ways as a result of the experiences of this past year. I find that my confidence and self-efficacy grows with every intake interview and every suicide assessment that I conduct as a solo practitioner. I thoroughly enjoy having control over my work schedule and responsibilities. It is very rewarding to meet with clients and their families in my office in the morning and to conduct an outreach program at a high school on non-violent communication later that day. I am constantly challenged and stimulated, and I continue to learn a great deal about the development of the therapeutic relationship from my clients. Lastly, I believe that as I continue to grow in my ability to embrace and endure both positive and negative changes in my life, I will be more effective in my efforts to assist my clients as they strive to do the same.

*Dr. Doherty can be contacted at cdoherty@gmail.com. Visit her website, www.christinadohertyphd.com.*