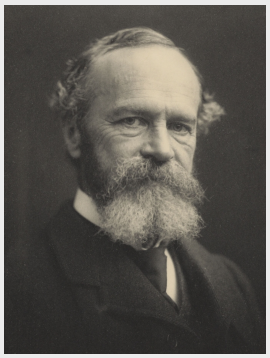

THE CCPA NEWSLETTER

Inaugural Issue

Name that Dead Guy!

Why that's William James, of course! We should all be proud of the progenitor of American Psychology. James was a physician by training who taught anatomy but did not practice medicine. He was arguably the greatest philosopher America has ever produced. With his landmark "Varieties of Religious Experience", he is also considered a progenitor of the field of Religious Studies. James studied mediumship and telepathy, and founded the American Society for Psychical Research. He famously said that it was only upon inhaling nitrous oxide that he could make sense of the German philosopher Hegel. For his contributions to characterizing mystical experience, he is posthumously considered an early transpersonal psychologist. If these aren't reasons to admire him, I don't know what would be. -JH

Welcome

Welcome to the new edition of the newsletter of the Central Coast Psychological Association! It took a bit of arm-twisting by our colleague Dr. Larry Galpert, but I'm glad to take on the task of editor. -JH

News From Members

- Congratulations to Dr. Elexia Estrada who recently obtained a PhD in Clinical Psychology from Saybrook University. Her dissertation was titled 'Affirmative Therapy with Pansexuals: A Case Study'. She specializes in Assessment, hypnosis, and Transgender Health.
- On August 11th, Dr. Michelle Matoff will be interviewed by Kate Berman, AMFT, who co-facilitates a support group for weight-loss surgery patients. Dr. Matoff is a certified bariatric counselor. For more information about this zoom presentation, contact Dr. Matoff at drmichellematoff@gmail.com
- Drs. Cindy Griffin and Silva-Palacios will be presenting cases pertaining to suicide on August 15th at Dr. Griffin's home. Please confirm your intention to attend by email, no later than July 31st. Each attendee may claim 3 CEU's under the Case Consultation category allowed by the BOP.

About the Editor

I've lived in this part of California since 2016 with my wife, Dr. Alison Aylward, who's a clinical psychologist at the Cal Poly CAPS, specializing in eating disorders. My own clinical interests are in long-term, insight-oriented, depth psychotherapy with a philosophical and spiritual inflection. We have two school-aged kids who show us that humans are born with strong and myriad predispositions in temperament, aptitude, seasonal allergies and much more. Therefore, parents should neither take full praise, nor full blame for the unfolding of their children's lives.

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- Jayanta Hegde, Ph.D.

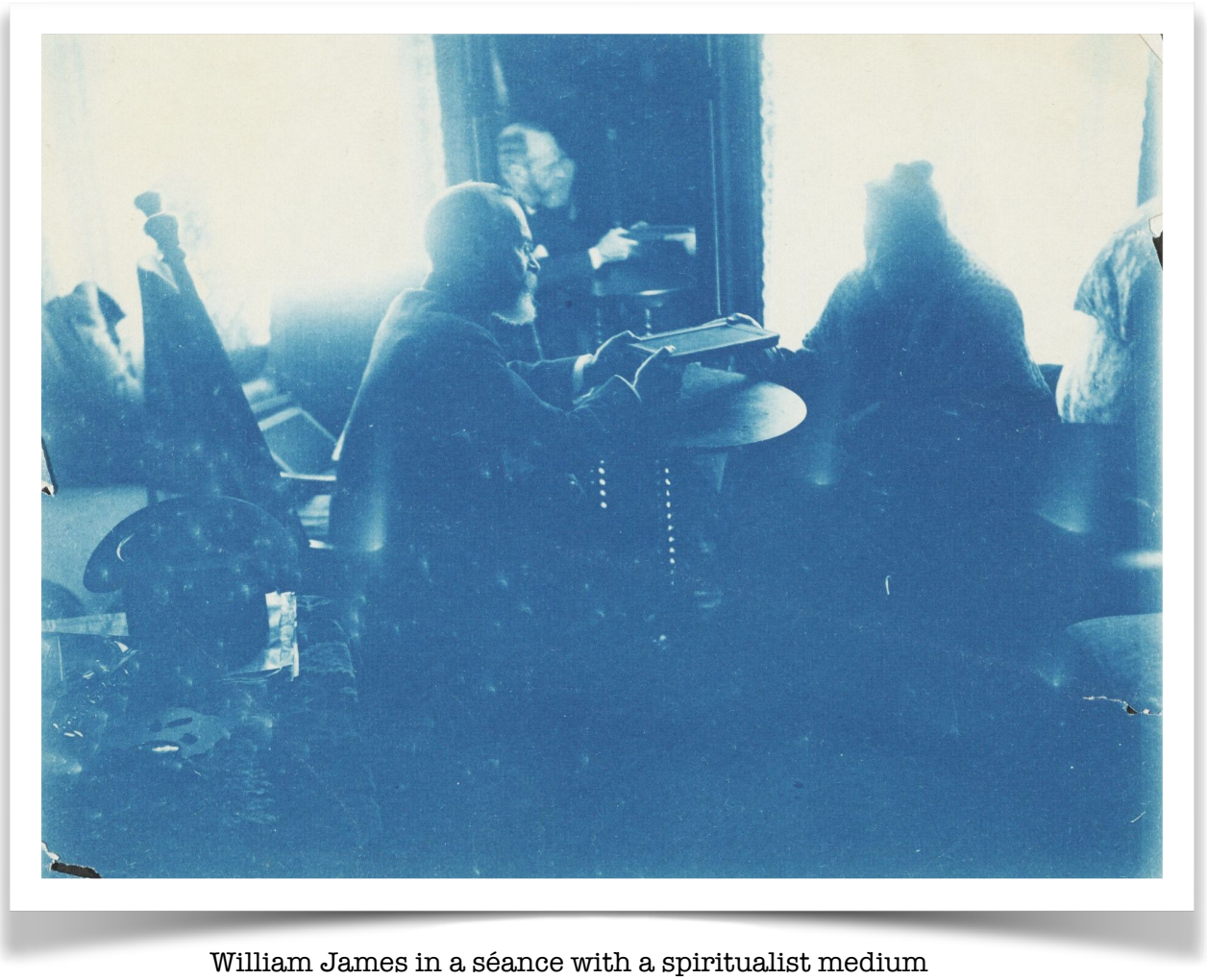
Message from CCPA President, Dr. Victor Silva-Palacios

On behalf of CCPA, I would like to welcome new members and extend a greeting to long-term members in this, our first newsletter post-COVID. CCPA is in a transitional moment, it seems to me. In recent years members of the older generation of psychologists are beginning to slowly move aside from leadership positions. Now, more than ever, there is a need to integrate the younger generation into greater connections with the professional community. We have some strategies to encourage greater involvement, and they include:

- Professional seminars (more on this in another part of the newsletter). Two are scheduled for this year so far: One on August 15, and the other on October 2.
- Peer consultations: We meet monthly on the last Friday of the month at a San Luis Obispo restaurant.
- Social gatherings: Last September we met at a Morro Bay park for a taco truck picnic and enjoyable conversation.
- Community service: Increasingly our community needs mental health services, which can only be offered through traditional psychotherapy, consultation to businesses, and psycho-educational presentations to various organizations. For example, twice in the past year I presented a workshop to several dozen business leaders in the county on the idea "You are not a Therapist: Navigating Mental Health Issues in the Workplace." If any of you are interested in becoming involved in community speaking opportunities, please let me know. Who knows? This could develop into a kind of speakers' bureau, with members reaching various groups with their specialized areas of interest. It often plants seeds for referral sources, as well.
- Plans are in the works to update the CCPA Website. New member Ryan Lubock, Psy.D., is in the data-gathering stage.
- Templeton Hospital Project: We have been working with the county and a land donor to develop an inpatient mental health treatment facility. More on this to come!

- Victor Silva-Palacios, Ph.D., President

Central Coast Psychological Association



William James in a séance with a spiritualist medium

New Members

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‘The Times They are A-Changin’: if Actuarial Prediction > Clinical Prediction, then Human Clinician + AI > Human alone

In 1954, Paul Meehl published what would be one of the most influential books in clinical psychology, “Clinical Versus Statistical Prediction: A Theoretical Analysis and a Review of the Evidence”. Later, in 1989, Meehl expanded on his original thesis, in a paper written with Robyn Dawes and David Faust. Their conclusion, after reviewing decades of research, was that a trained clinician who gathered information by interview, taking a comprehensive history, making clinical observations, and consulting objective testing results was usually less successful at predicting important outcomes such as academic success, treatment response, diagnostic status, and criminal recidivism, as compared to a statistical model that weighed empirical variables according to a fixed formula. Meehl, who was himself psychoanalytically-oriented, did not question whether clinicians could be keen or insightful. Rather, he saw human judgment as vulnerable to vivid but non-predictive details, overconfidence, inconsistent weighting of information, confirmation bias, and a host of other cognitive errors (the Nobel laureate-psychologist Daniel Kahneman would later demonstrate the ubiquity of many of these errors). Meehl didn’t advocate for clinicians to be replaced by machines; he believed that humans were better at generating hypotheses, at apprehending meaning, and individuality, whereas formal models were often better at making predictions.

It strikes me that his contributions in this area may herald a yet to be realized but ultimately fruitful symbiosis of human therapist and artificial intelligence. While several domains of medicine may be replaced outright by artificial intelligence (i.e. radiology, dermatology, cardiology) in the course of years, I imagine psychotherapy will endure, albeit in a form that is augmented by powerful computational models which counteract some of the limits of human intelligence. After all, we did not evolve to think in statistical terms. Here is a recent paper showingthe sort of computational model that may become helpful in clinical practice:

AI-driven European Retrospective Database Study to predict disease onset in patients with epilepsy and depression

I’m in a bit of disbelief that I’ve come to this conclusion. My sensibilities as a therapist have always been in the existential, the transpersonal, the humanistic, the mythological, the literary, and the unconscious. When Meehl’s 1989 paper was assigned to me as a first year grad student, I thought it was interesting, but I also took it to be part of a scientistic indoctrination that was afoot. But alas, I think now that I was being nearsighted. AI-furnished computational models will play an increasingly prominent role in the day to day practice of Psychology. ‘The times they are a-changin’!

- Jayanta Hegde, PhD

Patients who reject care or attack competence

Responding without defensiveness, maintaining a therapeutic alliance

A contribution from Michael McGee, MD

I recently treated Bob, a man in his 40s who had dropped out of treatment with his prior psychiatrist when the psychiatrist suggested that my patient go to an intensive outpatient program for depression and suicidality. The patient was struggling. He was unemployed, had no friends, and was living week to week on a trust fund disbursement. He complained of chronic pain and had undergone 72 procedures for osteoarthritic difficulties and other medical problems. He came to me on a troubling cocktail of opioids, amphetamines, multiple antidepressants, gabapentin, and benzodiazepines. Not surprisingly, he had had three previous recent hospitalizations for metabolic encephalopathy, all likely due to medication toxicity.

Like most patients with this complex presentation, I soon discovered a history of severe abuse at the hands of a sadistic mother and a harshly critical father. It did not help that he was a sensitive child with ADHD, which brought on an even greater tirade of criticism from his father. His early developmental trauma led to a subsequent cascade of retraumatization throughout his life, including broken relationships, traumatic divorces, job losses, and estrangement from his three children. He had hyperactivity as a child and his impulsivity and dysregulation continued to plague his life. After careful evaluation, he appeared to be suffering from complex PTSD and ADHD.

As is tragically so often the case in patients with severe attachment trauma, he had personality difficulties as well. This included very dramatic and emotional presentations, demanding behavior, extreme emotional sensitivity to criticism, an entrenched victim identity combined with great difficulties experiencing a sense of agency and accountability for his life. Challenging behaviors included many-page emails he continued to send despite several requests not to engage in this form of communication.

Initially treatment went well in terms of our alliance. When I mentioned my concern about over medication and polypharmacy, he agreed to wean off of his multiple psychiatric medications. Unfortunately, he impulsively stopped all his psychiatric medications at once, leading to severe withdrawal decompensation and yet another medical hospitalization.

When I suggested we needed to work collaboratively as a partnership, he reacted with deep hurt, feeling I was harshly judging him when he was just trying to do what I had suggested. In attempting to come to a shared formulation, he took great offense when I suggested that he might have an ADHD component characterized by some impulsivity. When I suggested his multiple somatic difficulties may be exacerbated by stress and his history of severe trauma, he experienced me as invalidating his legitimate medical concerns.

When I suggested very low dose Depakote for his significant emotional dysregulation, he accused me of saying that he was “bipolar and crazy,” and refused the treatment. When I suggested hopefully that he has some challenges related to organization, problem-solving, and impulse control, he again experienced me as being critical like this father.

Dropout rates from treatment can be as high as 58% when dealing with severely traumatized patients with personality disorders. Dropout rates in general medical settings can range from 32% to 60%.

The challenge with patients like Bob is forming a trusting therapeutic relationship, developing a shared understanding of strengths and vulnerabilities, negotiating realistic treatment goals, and then agreeing upon an accountable set of tasks for both the patient and the caregiver to execute. Bob had been floundering in his treatment with his therapist for many years prior. The community see me because of these difficulties. With Bob, my efforts to create a shared formulation were met with deep hurt due to extreme vulnerability and inability to take stock of these vulnerabilities. Sadly, despite multiple attempts to repair the ruptures, Bob dropped out of treatment, but did thank me for helping him to get off his unneeded medications, saying he no longer needed my care.

Bob’s case brings up a good example of what do we do as physicians when patients reject our efforts and attack us.

Several practices come to mind than I used in my work with Bob.

1. The first practice is **therapeutic equanimity**. This means maintaining a relatively even keel emotionally through the stormy seas of the therapeutic relationship.
2. The second practice, which is closely linked to equanimity, is **neutrality**. It is Bob’s life, and he must make decisions as to what is best for him. I worked on honoring his autonomy and holding back against my very strong urges to exam, save him, or making “see the light.” All of those were not possible, and it was my job to let go. when he said he did not want to try any medications , including the Depakote that I prescribed , I honor his wishes, And commended him for wanting to manage his challenges without medications.
3. The third practice is **impersonality**. This means taking everything that our patients do and say very seriously, but not personally. Bob’s reactions to me had to do with his own wounding and not because I was harsh or critical. In retrospect, perhaps I could have been more skillful in raising the concerns that we needed to discuss.

4. This brings me to the fourth practice, which is **reflection**. Truly great clinicians spent time reflecting on their challenging patients and discussing them with colleagues. I have even found AI to be helpful in my reflection work at times. Our reflection work helps us t to get clear and grounded so that we can continue to respond with both wisdom and compassion.

5. The fifth practice is **repair**. I apologized repeatedly for the way my comments landed with Bob, and we were able to do some work clarifying that perhaps his perception of me is harshly critical and had more to do with his experience with his f father than with me (transference interpretation). This turned out to be helpful.

6. The sixth practice is **negotiation**. Bob asked me to write a letter to his trust fund manager requesting permission for him to see a concierge doctor, given the complexity of his multiple medical conditions. In the letter, I mentioned a desire to work with a primary care physician collaboratively on both his medical and psychological concerns. Bob took great offense that I use the word "psychological." He was afraid that this would be used against him by the trust fund. We brainstormed around this, and decided that in the future he would review, edit and approve all communications that I might send into other treatment providers or collaterals.

Patients suffering from personality impairments and trauma are endemic in primary care settings. About 25% of patients in primary care meet criteria for personality disorder these patients can be demanding, argumentative, help rejecting, and even harshly critical of our attempts to care for them. The practices outlined above can help us to provide the best care possible for these challenging patients.

[1] De Salve, F., Rossi, C., Gioacchini, E., Messina, I. and Oasi, O. (2025), Dropout in Psychotherapy for Personality Disorders: A Systematic Review of Predictors. Clin Psychol Psychother, 32: e70080. https://doi.org/10.1002/cpp.70080

[2] Fernández D, Vigo D, Sampson NA, Hwang I, Aguilar-Gaxiola S, Al-Hamzawi AO, Alonso J, Andrade LH, Bromet EJ, de Girolamo G, de Jonge P, Florescu S, Gureje O, Hinkov H, Hu C, Karam EG, Karam G, Kawakami N, Kiejna A, Kovess-Masfety V, Medina-Mora ME, Navarro-Mateu F, Ojagbemi A, O'Neill S, Piazza M, Posada-Villa J, Rapsey C, Williams DR, Xavier M, Ziv Y, Kessler RC, Haro JM. Patterns of care and dropout rates from outpatient mental healthcare in low-, middle- and high-income countries from the World Health Organization's World Mental Health Survey Initiative. Psychol Med. 2021 Sep;51(12):2104-2116. doi: 10.1017/S0033291720000884. Epub 2020 Apr 28. PMID: 32343221; PMCID: PMC8265313.

[3] Tyrer P, Reed GM, Crawford MJ. Classification, assessment, prevalence, and effect of personality disorder. Lancet. 2015 Feb 21;385(9969):717-26. doi: 10.1016/S0140-6736(14)61995-4. Epub 2015 Feb 20. PMID: 25706217.