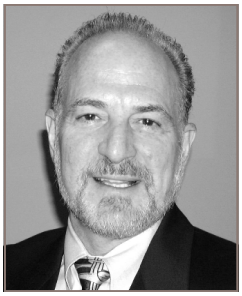
Tarnow CENTER for Self-Management®

The Center Piece

Fall/Winter | *2012*

People who are successful in life are successful at self-management



Got Brains?

"In the coming decades, complementary and alternative medicine (CAM) will evolve from the use of "herbs and vitamins" to a sophisticated research-driven model of integrative medicine based on individualized treatments that incorporate biological, mind-body, informational, and energy therapies... These emerging theories are at the heart of a rapidly evolving paradigm called "integrative mental health care." This will lead to more effective and more compassionate "whole person" mental health care that takes into account the complex biological, psychological, social, cultural, and…spiritual causes and meaning of mental illness." - James Lake, M.D.

Phew! I've been saying the same thing for over 25 years. I even built the Tarnow Center around these same beliefs. It's good to hear from the rest of the mental health community that my team has been doing it the right way all this time. They didn't always think I was right. To their credit, I wasn't. Because back then…

- ✔ We "knew" that Autism was the result of cold, aloof mothers.
- ✔ We "knew" that ADHD was strictly a childhood disorder that resolved in adolescence and did not exist in adulthood.
- ✔ We "knew" that the brain's development was fixed by early adulthood.

I didn't know any of these things. As a matter of fact, I always got in trouble with my professors and colleagues because I kept asking "Yes, but what if…?" What if there's a genetic component to Autism? What if ADHD *does* exist in adults? What if the brain *can* keep developing and changing as we age? They eventually got tired of me questioning everything, and I got tired of them not questioning enough.

Over twenty five years ago, I set out to create something different. I was tired of working in healthcare environments where each professional seemed isolated with their caseload and set in their beliefs about how to approach a problem. I can't work like that! I love learning about new ways to tackle a problem and I can't do that if I'm only bouncing ideas off of the walls of my own brain. I created the Tarnow Center with the goal of surrounding myself with creative thinkers who would challenge me, disagree with me, and in doing so, educate me. Looking back, I can say with absolute confidence that I've been successful. I have brought together amazing clinicians from various backgrounds and expertise, each of whom has added his or her own unique perspective and ability. We meet throughout the week to discuss cases and share perspectives on the newest research from our different disciplines. We discuss, debate, disagree, and eventually come to new understandings.

Inside this issue:

Let's Connect

We've always loved sharing information with our clients through our newsletter and by giving talks in the community. But now we've got brand new ways to get our message out there through social media outlets such as Twitter, Facebook, and our clinicians' blogs. These venues give us the opportunity to share the latest research with our clients, but in small, digestible chunks without all the "psychobabble." You can access all of our social media on our new website, www.tarnowcenter.com. But don't worry, we love talking too much to ever give up our community outreach.

While the Tarnow Center has evolved over time, we've always stuck to our core principles – to deliver the highest quality of care, using the latest research, within an interdisciplinary team. These principles have worked to keep our team always on the cutting edge. To be honest, I'm surprised that we're still the only practice in Houston, even in Texas, who works this way. Despite overwhelming research that proves that the interdisciplinary approach improves outcome and reduces costs of care, many health professionals prefer to stick with

TARNOW CENTER MISSION STATEMENT

To offer a Center of Excellence in the Southwest Region, providing innovative, superior quality therapy, while utilizing an interdisciplinary team approach to assessment and intervention for individuals and families affected by psychiatric, psychological, developmental, learning, and language disorders.

what they know. It's certainly not easy to do it our way. We never allow ourselves to be comfortable or complacent. We constantly challenge each other to evolve and grow as professionals so that we can keep up with the pace of the rapidly changing field of neurodevelopment. So it takes a special breed of clinician to work with us: someone who is energetic, enthusiastic, and armed with the latest knowledge.

Our newest psychiatrist, Dr. Amber Pastusek, is a consummate professional who fits right in with our crew. She brings an extensive knowledge of neuropsychiatric disorders, along with a thirst for knowledge and a passion for teaching. Her article on Autistic Spectrum Disorders in this issue clearly outlines the point that I was making above – that neuropsychiatry is a constantly changing field, and we have to be willing to change with it.

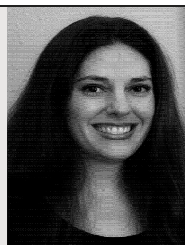
Our newest post-doctoral fellow is Julie Sherman, Ph.D. She brings an added dimension to the Tarnow Center of using Applied Behavioral Analysis (ABA) in a variety of settings including home and school based services. Dr. Sherman's expertise allows us to reach out to underserved populations, such as children with developmental disabilities, aggressive behaviors, and skills deficits.

President George H.W. Bush designated the 1990's as "The Decade of the Brain." But I feel like we're only just now beginning to tap into not only the vast expanse of the brain's potential, but also the brain's crucial role in mental health. That's why those of us at the Tarnow Center are on our third straight "Decade of the Brain." We've been on the cutting edge of neuroplasticity and neurofeedback for over twenty years, and have developed a reputation as the best in the business. I'm pleased to say that the Tourette Syndrome Association of Texas has named me an Honoree of the Year in recognition of the Tarnow Center's years of commitment and dedication to our patients and expanding treatment options for Tourette's and related disorders.

I invite you to join us in celebrating our third Decade of the Brain. Follow us on Facebook, Twitter and Mind News on our website to get the latest research updates, and feel free to share any information you find on your own. But most importantly, never stop asking questions. Never stop wondering "why?" and never stop learning!

Upcoming Changes with Autistic Spectrum Disorders

Amber Pastusek, M.D.



For the past 2 years I have been very involved in the Systems of Care Committee of the American Academy of Child and Adolescent Psychiatry. I have worked closely with my committee and policy makers to continue making advances in the field of child and adolescent psychiatry. A major upcoming change involves the release of the new Diagnostic and Statistical Manual (DSM) for the field of Psychiatry that is scheduled to be released in May 2013.

Early Identification and intervention is essential in treating Autism Spectrum Disorders in order to develop neuropathways that are not developed.

The new classification system for Autism Spectrum Disorders is one of the biggest changes for the field of child psychiatry. There will no longer be a differentiation between Pervasive Developmental Disorder, Asperger's disorder, and Autistic Disorder. Instead the DSM-V will have varying degrees on the Autism spectrum depending on the severity of the disorder. These changes in the diagnostic criteria may broaden the diagnoses of Autism Spectrum Disorders, and the new classification system may include some children that may have been less severe and perhaps overlooked.

A comparison of the DSM-IV to the DSM-V shows that the three previous domains have been reduced to two that consist of social/communication deficits and fixated interests or repetitive behaviors. The DSM-V also merges severe social/communication criteria to streamline and clarify diagnostic requirements. By requiring two symptom manifestations for repetitive behavior and fixated interests improves specificity of the criterion without significant decrements in sensitivity. Unusual sensory behaviors are explicitly included within a subdomain of stereotyped motor and verbal behaviors as well. Reorganization of the subdomains increases the clarity and allows better detection from different age ranges and language levels. Autism spectrum disorder is a neurodevelopmental disorder and must be present from infancy or early childhood but may not be detected until later because of minimal social demands.

There is much speculation as to the cause for Autism. Research shows a significant heritability risk factor; however, no specific genes have been identified for Autism. The genetics of Autism is complex and may involve multi-gene interactions or rare mutations. Two recent studies suggest older fathers may account for some degree of an increase in the rate of Autism due to small mutations occurring during spermatogenesis as men age. In addition, there is new evidence relating auto-immune issues with the occurrence of autism. Researchers are in the process of trying to map the genome for Autism to further learn more about the genetics of Autism.

New Biological Diagnostics

A recent large study evaluates the use of an Electroencephalogram (EEG) to detect Autism. This study reveals changes in an EEG may occur as early as age 2. The Tarnow Center strives to utilize the latest

DSM-IV	DSM-V
Pervasive Developmental Disorder, Asperger's Disorder, Autistic Disorder	**Autism Spectrum Disorders with varying degrees of severity**
A. **Qualitative impairment in social interaction manifested by 2 of the following:** 1. Marked impairment in the use of nonverbal behaviors such as eye to eye gaze, facial expression, body postures, and gestures to regulate social interaction 2. Failure to develop peer relationships 3. Lack of spontaneous seeking to share enjoyment/interests with other people 4. Lack of social/emotional reciprocity	A. Persistent Deficits in social communication and interaction across contacts not accounted for by general developmental delays and manifested by all 3 of the following: 1. Deficits in social-emotional reciprocity (difficulty with conversations, reduced emotions, interests, and lack of initiation of social interaction) 2. Deficits in nonverbal communicative behaviors used for social interaction (eye contact, body language) 3. Deficits in developing and maintaining relationships (difficulties in sharing, imaginative play, lack of interest in others)
B. **Qualitative impairments in communication manifested by at least one of the following:** 1. Delay in or lack of spoken language 2. In individuals with adequate speech, impairment, in the ability to initiate or sustain a conversation with others 3. Stereotyped and repetitive use of language 4. Lack of spontaneous/imaginative play	B. Restricted, repetitive patterns of behavior manifested by 2 of the following: 1. Sterotyped or repetitive speech, motor movements, or use of objects 2. Excessive adherence to routines, ritualized patterns or verbal/nonverbal behavior, or excessive resistance to change 3. Highly restricted fixated interests that are abnormal in intensity or focus 4. Hyper or Hypo-reactivity to sensory input or unusual interests in sensory aspects of the environment (textures, temperatures, smelling/touching objects, fascination with lights or spinning objects
C. **Restricted repetitive/stereotyped patterns of behavior, interests, and activities manifest by one of the following:** 1. Preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal in intensity/focus 2. Inflexible adherence to specific nonfunctional routines or rituals 3. Stereotyped and repetitive motor mannerism 4. Persistent preoccupation with parts of objects	On the DSM-IV, the delays in abnormal functioning must be present prior to age 3 with deficits in all three areas. On the DSM-V, symptoms must be present in early childhood and limit/impair daily functioning. Severity levels will be clearly defined in the DSM-V.

research and technology thus offering QEEG testing to evaluate for Autism Spectrum disorders and other conditions. A QEEG can be used to detect a seizure disorder by specific epileptiform discharges. These epileptiform discharges have been shown to cause irritability and hallucinations. In addition, a QEEG may be performed to evaluate the best medications to use for a patient and responses to the medications on the brain to help guide treatment. An EEG can also provide information for the use of neurotherapy to treat certain disorders and/or behaviors. Neurotherapy is a noninvasive treatment with no known adverse side effects. Transcranial direct current stimulation introduces very small external electrical pulses to the surface of the head to facilitate the development of neuropathways in many disorders including Autism and Attention Deficit Hyperactivity Disorder (ADHD). Changes in EEG patterns suggest improved cerebral blood flow, metabolism, and neurotransmitter function in the brain.

Early identification and intervention is essential in treating Autism Spectrum Disorders in order to develop neuropathways that are not developed. By recognizing early symptoms, children are able to begin therapies to facilitate neurodevelopment and improve communication and socialization skills. Applied Behavior Analysis (ABA) therapy is a safe and effective treatment for children with Autism Spectrum Disorders. ABA uses positive reinforcement and behavioral techniques as a foundation for communication, social skills, play, self care, and success in school. At the Tarnow Center, we have excellent results using different evidence based treatments including Interactive Metronome, Fast ForWord, and CogMed for improving brain functioning in Autism Spectrum Disorder. These methods have been used successfully for a variety of disorders. After careful intensive assessment, we develop a treatment protocol specific to that child's needs to improve neurodevelopment.

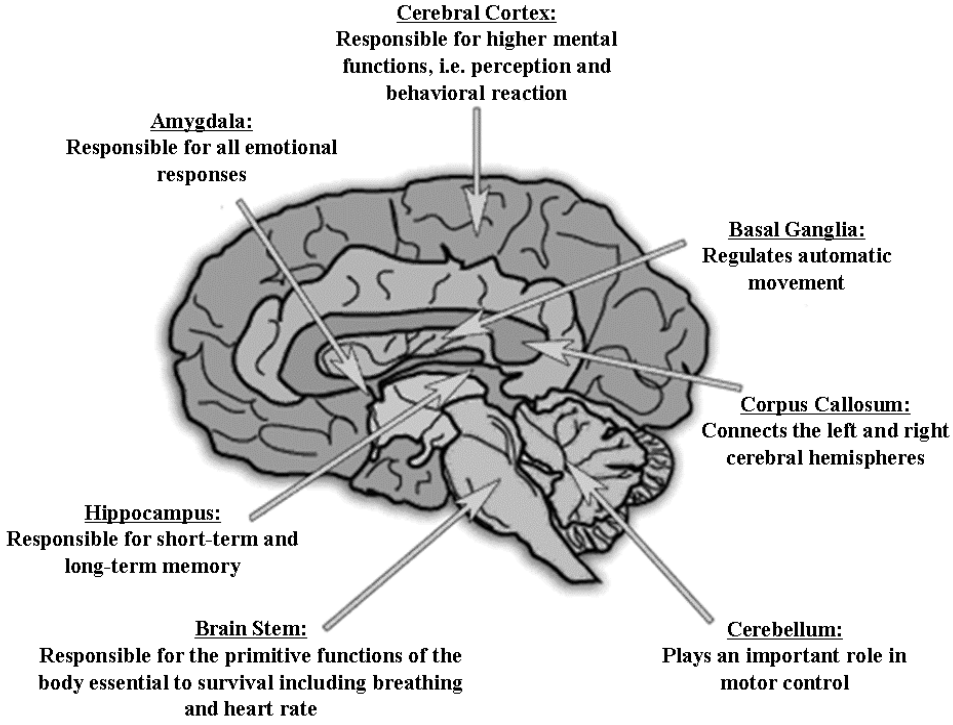
Interactive Metronome
Helps with timing and coordination

No medication has been shown to cure Autistic Spectrum Disorder, but some medications can treat the specific symptoms associated with it. Dr. Tarnow and I are constantly reading the literature to find new and innovative interventions. We have used food supplements and vitamins as a treatment option when indicated. We research these treatment methods to insure that there is a good rational base on our assessment and also to be sure there are no undue risks. Our approach is to leave no stone unturned. We will have open and frank discussions with parents related to any questions they have about treatments not offered at the Tarnow Center. We will research any method and share our findings in an easy to understand language.

The Tarnow Center incorporates the latest technology and utilizes the collabora-

tion of many different clinicians in order to provide a interdisciplinary approach to each individual. This may include corroborating with a pediatrician, neurologist, psychologist, speech and language therapist, occupational therapist, and schools. In addition, my evaluation of each child involves a full neurodevelopmental examination and a family evaluation. I not only treat the child but also treat the family. A diagnosis of an Autism Spectrum Disorder can be overwhelming to families. My job is to provide guidance to families in order to maximize the success of each child. This involves creating an individualized roadmap that may change over time depending on the needs of the child and family. I am optimistic about the upcoming changes in the field of Autism Spectrum Disorder and strive to help each child optimize his/her potential.

Parts of the Brain Affected by Autism



E-diction: *Because You Can Have Too Much of a Good Thing*

W. Walker Peacock, Psy.D.

I love technology. There's so much information out there and it's so easily accessible. With it, I can find information in a minute that used to require an afternoon at the library. I've always had a horrible sense of direction, but I never get lost anymore because my GPS tells me where to go. I can play video games and crack jokes with my buddies in California and Colorado as if they're sitting on the couch next to me. I'm always connected to a network of friends, family, and professionals through email, Facebook, Linkedin, and Twitter.

I hate technology. There's too much information out there and it's too easily accessible. A routine Google search for "internet addiction" can easily become a 2-hour rabbit hole that ends up with me looking for vintage *Star Wars* movie posters on eBay. Er… so I've heard…I've become so dependent on my GPS that I've lost whatever navigation skills I used to have. I've lived in Houston for two-thirds of my life, and I still don't trust myself to find my way to the airport. When my friends and I do manage to hook up and play online, we get our butts kicked by hordes of teens who haven't been to class in two weeks and have never been on a date (at least that's what we tell ourselves). The "always on" connectivity of smart phones has robbed me of my ability to *just be*. I check my email and Facebook while I'm in the drive-thru at Starbucks. And forget about patience!

If my phone takes more than ten seconds to live-stream the Rockets game, it's as if the world has ended.

I remember when all we had was rotary phones that were attached to the wall, and leaving a message required pen and paper. It was perfectly acceptable for someone to be "busy" or "not available" and to get back to you later in the week. Now that we have immediate access to everyone, the acceptable response time is counted in minutes, not days. Back in Colorado, I had a client who broke up with his girlfriend (in session, mind you) via text message because she hadn't yet answered a question he had texted her earlier

that afternoon. So what has happened to us?

The truth is - we've always been this way. Our brains are hard-wired to want. In a 1954 experiment, scientists accidentally discovered what they thought was the "pleasure center" of the brain. When a probe was placed in the hypothalamus of a rat's brain, and the rat was allowed to stimulate its own electrodes by pressing on a lever, the rat would press the lever, ignoring food or water, until it collapsed. Similar experiments have been conducted on humans, where human subjects were allowed to press a button to stimulate the same region of their brains. The human subjects chose this "buzz" over everything else, including family, food, sleep, and hygiene.

But it turns out that what these rats and humans were stimulating was the brain's "seeking center" rather than the "pleasure center." The difference is that seeking is tied to searching and wanting, while pleasure is tied to getting. Guess which one is more stimulating to your brain? Have you ever wondered why you experience buyer's remorse after making a significant purchase? The excitement of anticipation far outweighs the satisfaction of obtaining. So, we experience a let-down of sorts, in that we're left wondering, "What do I *want to want* next?" What's interesting is that the same searching circuits are fired when we're searching for meaning or making intellectual connections. That's why it's so easy to get lost in the Google-verse or Facebook for hours on end.

So, back to the question: What has happened to us? The answer, simply, is technology. Technology has gotten really, really good at activating that searching center in your brain. That little buzz or ding on your phone that signals a text, a tweet, or a status update has you unconsciously digging your phone out of your pocket or purse to see what new nuggets of information it contains.

But it's not just Facebook and Twitter that have us glued to our screens. Video games like World of Warcraft, Minecraft, and Starcraft (basically, any game with the word "craft" in it) have all mastered the art of tapping into that searching center. World of Warcraft (W.O.W.) and Starcraft are widely considered to be the most addictive video games on the market because *they have no end*. Read that again. In W.O.W., reaching the "end-game" (point at which a player can no longer level up) only serves to unlock more challenges and better loot. The evil genius of games like W.O.W. is how they feed on the desire for more. The next big thing – the next thing you'll *want to want* – is just around the corner. No matter what sword, shield, or tunic you've just unlocked, there's a better one out there. All you have to do is keep playing.

This brings me to Minecraft. I first heard about this game two years ago from one of my college clients. It sounded innocent enough. It's a seemingly mild and creative game that tasks players with mining for elements and building different structures. There is no foul language, no adult-rated content, and I've seen more violence in an episode of "Scooby Doo." So why does a G-rated video game about looking for materials and building stuff worry me so much?

- The name: *Mine*craft. A game about mining. Mining is digging. Digging is searching. So… yeah.
- The story: Simply put, there is none. You dig, you create, repeat. If you don't have a story, you can't have an end.
- The freedom: Minecraft is an open source game, meaning that it encourages hackers to go in and create their own modifications to the game. These mods allow users to completely redefine the gameplay, like giving someone everything in the game, or creating an entirely different game altogether. For example, there's an available mod that turns Minecraft (nonviolent) into *Doom*, a violent first-person shooter.
- The players: These guys are good. They can create some ridiculous things. How do I know? Because they love to show you. Search for "Minecraft" on Youtube sometime, and you'll see what I mean. There are currently 6,880,000 videos about Minecraft on Youtube (There were 6,400,000 when I started this article two weeks ago, which means that just over 34,000 videos are uploaded each day). To put this in perspective: Minecraft gets more love on Youtube than The Great Wall of China, Katy Perry, Bacon, Nascar, Cats, World War II, President Obama, and Mitt Romney (in an election year) *combined*.

The long and short of it is this: no matter how cool your creation is, somebody out there has done it bigger and better than you. And there's always something more you can build. You just have to keep playing…

Before my teen Minecrafters start sending me death threats, let me clarify that I'm not opposed to Minecraft. In fact, I think that it's a far better game than any of the first person shooters that have players frantically running around and shooting each other in the face. But the key is moderation. In moderation, a lot of things can be good for you. For example:

- Eating a little chocolate every day has shown to reduce cholesterol, reduce blood pressure, reduce risk of heart disease and reduce stress. But a lot of chocolate leads to weight gain, dental problems, and gastrointestinal problems.
- A glass of red wine every day (over

21 only, thank you) can reduce "bad" cholesterol, increase "good" cholesterol, and reduce risk of heart disease. But a lot of red wine every day causes hangovers, high blood pressure, obesity, liver damage, and generally makes you look silly.

- A little Minecraft can serve as a nice break from school, help you unwind and relax, and stimulate the creativity of your brain. But a lot of Minecraft can reduce grades, reduce sleep, and greatly increase conversations about somebody named "Notch."

Moderation is especially important when dealing with online addictive behaviors, because it's not like you can just go cold turkey and stop using the internet. The hard fact is – love it or hate it - we need technology. Many schools are replacing text books with Kindles or iPads, and teachers are posting daily assignments to online portals. Even outside of school, it's not like the impact of social media is going anywhere. In fact, all indications are that more businesses, schools, and colleges are using social media as their primary networking tool. If we simply cut the [modem] cord instead of teaching kids how to use internet and technology responsibly, we're missing an opportunity to teach a valuable lesson.

How do you know it's a problem?

It can often seem like there is a fine line between casual and worrisome internet use. Like I said, there are social and creative benefits to casual use. If your kids are able to log on and off for small periods at a time, and still keep up with academics, extracurriculars, family, and friends, I wouldn't worry about it. But if you notice any of the following, you may be dealing with problematic or addictive internet behavior.

- Irritability and/or aggression when asked to power off
- Preoccupation with a game: constantly talking about or researching the game when not playing
- Noticeable drop-off in grades, athletics, or social events
- Prefers online friends and activities to live activities with live friends
- Dishonesty related to internet use: lying about amount of homework to be done, sneaking extra time in when he/she should be sleeping or studying.

So…what do we do?

If you're noticing problematic internet use, I suggest that you implement these guidelines, in order of 1 – 4. I always recommend starting with the least restrictive plan, seeing how the children do, and adjusting to higher levels if needed. If you don't give them the opportunity to make a mistake, then they're not really learning how to make good decisions.

1. Come up with guidelines for family internet use. How much time does each person get to spend online? How often (weekdays or weekends only)? What must be done to earn that time (homework, chores, etc.)? What can be played or viewed in that time?
2. If set limits aren't followed, or honesty regarding use comes into question, then move all computers to a central, open location of the house. If trust is an issue, then all time spent online needs to be spent in public.
3. Set clear limits for time spent online. Start with a five minute warning when time is almost up. This is a "wind it down, save whatever progress you've made" warning. When those five minutes are up, inform the child. If they are able to get off without an argument, without so much as a "just one second", then they earn extra time the following day. If they resist, they earn less time the following day.
4. If compliance with time limits continues to be a problem, then that's a sign that your children aren't yet able to handle the responsibility on their own. There are several tools you can use to help your kids learn responsible internet use. For example, online parental controls and software programs allow you to regulate and monitor what sites are visited, when, and for how long.

This is a rough draft of a plan to use in helping your children regulate their internet use. But each family and each child requires a different approach in the details. I'm happy to meet with you to discuss your concerns regarding your child's internet use and/or gaming. Together, we can come up with a specific routine to teach your kids how to be independently responsible for their time. Call 713-621-9515 or email me at drpeacock@tarnowcenter.com and we can discuss how to get you started.

How Parents Can Support Development of Self-Management Skills in the Brain

Desireé Gallagher, Psy.D.

What Are Self-Management Skills?

Self-Management skills include planning, organization, time management, working memory, and emotional control. These skills are a significant factor in various social, academic, and home-related problems as well as specific difficulties, such as learning differences, attention deficits, poor impulse control, and emotional reactivity. Self-management skills encompass the well-known executive functioning skills which, at a basic level, can be described as thinking before we act and deciding how to respond.

Deficits in these skills are related to various areas of the brain and are primarily linked to a lack of synaptic activity.

How Do They Develop in the Brain?

These skills begin development at 5 to 12 months of age. Infants and toddlers continue developing executive functioning based upon different experiences in the environment. The brain goes through major developments and extensive learning around ages 5 and 12. Following these periods of intense absorption of information, there are periods of consolidation, which reduces unused or unneeded connections. These changes in the brain can dramatically affect self-management if certain learning experiences are not applied and practiced.

When Will I Notice Problems in Self-Management?

By preschool, specific skills are established, such as following simple directions (e.g., "get your clothes from the bathroom") and inhibiting behaviors (e.g., biting, hitting, pushing). In early elementary, completing simple chores with reminders is an important development. By late elementary, children should be increasingly able to inhibit behaviors, such as temper tantrums and rude behaviors, bring items to and from school, and complete chores without reminders. Problems or delays during these various stages of development complicate the learning process, creating barriers and often relate to self-management problems.

What are other signs?

These problems in specific areas of self-management often lead to a negative cycle of frustration, resentment, and guilt with children and their caregivers. Children with executive functioning problems can be extremely challenging for parents, families, and teachers. The frustration of "why can't my child do what he/she is told?" is an ongoing battle for caregivers. Deficits in these skills can lead to numerous problems and effective intervention is important in building and maintaining self-management skills.

Identified problem areas	Objectives
Working Memory	• Make lists for morning and evening routines • Memory games/activities
Sustained Attention	• A short break after 30 minutes of completing homework • Use of games to build attention
Emotional Control	• Make a plan for what to do instead of crying/tantrum • Establish an incentive for every time does not have a tantrum • Games to build frustration tolerance • Play to practice life skills
Impulse Control	• Make specific target goals for decreasing behaviors • Problem-solving games/role-plays
Organization/Planning	• Use of pictures and calendars to practice • Strategic games

Now What?

Through our parent-management sessions, we establish and build connections to increase and practice self-management skills. Specific strengths and weaknesses are identified and treatment goals are developed specific to the child and family structure. Children with self-management difficulties require support from the school and home environments to develop and improve skills. At school, making accommodations specific to the child and setting realistic goals to monitor will be important to academic success. At home, children and their parents benefit from setting specific goals to work towards, making lists and creating visual materials (calendars, pictures, charts), increasing motivation through effective incentives, and prompting for the most effective learning. Additionally, having positive time together through the use of specific skills building games and activities are an important role in the treatment process. The diagram here displays some examples of specific objectives.

At the Tarnow Center, we embrace a collaborative and supportive intervention process. Our focus in therapy is to develop and build skills for the children, as well as the parents. In time, parents develop skills to provide effective intervention at home to practice and maintain self-management skills. Parents are an instrumental aspect of treatment, as they can provide the prompts and reinforcement needed to maintain skills through various phases of development. Parent sessions and parent-focused groups apply a structured approach to building executive functioning in the home and school environments, while also processing various strategies from other parents and obtaining support from people with similar experiences.

Parent-training in family sessions and group sessions are available with Dr. Desireé Gallagher. For more information, please contact the Tarnow Center for an initial consultation.

The following are the days and times scheduled for group this fall. Dr. Gallagher and Dr. Peacock will be scheduling concurrent parents groups running at the same time as the child groups for your convenience. Please contact either of us to schedule an initial intake to determine an appropriate group. Parents groups will also be scheduled at a separate time on Thursdays or Fridays at noon.

Applied Behavioral Analysis

Julie Sherman, Ph.D.

Has your child ever thrown a fit in the store because he didn't get the toy he wanted? Have you ever seen someone throw a chair at the teacher? Why do people act the way they do? The answer: people behave to either get something or get out of doing something. If they didn't get something they wanted as a result of their behavior, they wouldn't keep doing it.

- Johnny interrupts you when you are on the phone again and again. You put your phone conversation on hold to tell Johnny to stop interrupting you because you are busy. You go back to your conversation, but Johnny keeps talking and tapping you on the shoulder. He got your attention once by interrupting, so he is going to try it again.

- Susie has a report to give to the class today, but she is so nervous about it that she tells the teacher she forgot it at home. By telling the teacher she forgot her report, she got out of having to speak in front of the class.

- Daniel is nonverbal. He hits, kicks, and bites his parents when he wants their attention. His parents always put their arms up to block him and yell, "Stop hitting!" or "Don't! That really hurts!"

The goal of Applied Behavior Analysis is to increase good behavior and get rid of problem behaviors. How do we do it? Pair appropriate behavior with something the person wants. Even the most difficult child has appropriate behavior. Appropriate behavior can be anything from sitting still for 2 minutes, getting to school/work on time, saying "Excuse me" before talking, putting up a toy, to looking at you when you talk.

Rewards are different for everyone because everyone likes different things. While you want to get paid money for going to work, your daughter may like to get a bag of chips, praise, or a high five for washing the dishes. I once did a reading intervention with a girl who liked to work for cookie cutters. The problem is how do you know what works? Anything that increases behavior is called reinforcement.

- If John's teacher offers a sticker to her students for turning in work on Friday, and John turns in his assignment on time, stickers are a good reward for John. If John waits 4 days to turn in his work, then it is likely that stickers are not reinforcing enough. Try something else!

- Maibel is really interested in computer games, so interested that she stays home to play on the computer instead of going to school. Maibel's parents tell her she can play on the computer only if she attends school. If Maibel goes to school on time, computer time is a great reward!

What about inappropriate behavior? Give the child what they want for good behavior, and don't give them what they want for bad behavior. Sounds easy enough, but it can be hard.

- If your child is behaving inappropriately to get out of something, keep presenting the task until it is complete. You can break the task into sections to make it less frustrating, but always bring your child back to the task after a break. When your child is done, he can do something fun.

- If your child is behaving inappropriately to get attention, ignore them. Only pay attention after good behavior. For example, you are eating dinner, and your daughter does not like the food. She throws a tantrum because you told her to eat what is on her plate. We have all been there. What do you do? Stick to your guns. Ignore the tantrum. When she calms down, gets hungry, and eats what is on her plate, praise her. It was great that she ate what was cooked for dinner.

ABA is an effective and powerful tool for individuals with the most difficult problems. It can be used with Autism, developmental disabilities, Mental Retardation, Tourette's, Obsessive Compulsive Disorder, ADHD, Oppositional Defiant Disorder, Conduct Disorder, Learning Disorders, compliance, aggression, and many other problems. ABA is also very useful because it can be implemented in a variety of settings: school, work, in a clinic, home, at the store, at the park, anywhere. Everything is an opportunity to learn, and the more settings you teach in, the more successful your child will be.

About Julie Sherman, Ph.D.

Julie Sherman, Ph.D., is a postdoctoral fellow in clinical psychology at the Tarnow Center for Self-Management. She received her doctorate from The University of Southern Mississippi in school psychology, and she completed a clinical psychology internship at Pinecrest Supports and Services Center, a residential facility for individuals with developmental disabilities.

Dr. Sherman is a native Texan. Her training and professional experiences have emphasized a specialization in Applied Behavior Analysis (ABA), which stresses the importance of behavior and environmental consequences in behavior management, academic interventions, and functional skill building. She worked as a behavior consultant in several public schools while in Mississippi, creating and supervising programs to reward students for appropriate behavior and increase teachers' consistency in intervention implementation and discipline. She led anger management, social skills, and coping skills groups and provided intensive individual academic or behavioral interventions. Dr. Sherman also provided assessment and intervention services at an ADHD/Autism clinic designed to improve attention span and decrease disruptive behaviors without the use of medication.

Dr. Sherman's Current Interests

Autistic Disorders
Learning Disorders
ADHD
Developmental Disabilities
Oppositional Defiant Disorder
PICA
Rumination Disorder
Enuresis and Encopresis
Compliance Training
Functional Skill Building
Aggression

Her internship at Pinecrest focused on individuals who were diagnosed with an intellectual disability, and many exhibited severe behavioral challenges (e.g., Pica, Rumination Disorder, Conduct Disorder, Autistic Disorder, self-injurious behavior, running away). In addition, she assisted her clients with daily activities in their homes, Dr. Sherman helped develop an Autism Training Program at Pinecrest, which involved creating training objectives (e.g., compliance training, decreasing self-injurious behavior, toileting, self feeding, Picture Exchange Communication System, decreasing aggression) and implementing programs.

Dr. Sherman provides direct services to children, adolescents, and their families across multiple settings to assist them in reaching their goals and creating positive behavior change. She provides evidenced-based practices that focus on direct observations, functional analysis, and implementation of interventions designed to reduce challenging behaviors and replace them with functional and socially appropriate behaviors. Her current interests include Autistic Disorder, Learning Disorders, ADHD, developmental disabilities, Oppositional Defiant Disorder, Pica, Rumination Disorder, Enuresis, Encopresis, compliance training, functional skill building, and aggression.

G R O U P S

Group therapy seems to be one of our more popular avenues for treatment. The benefit of group therapy is that it allows people the opportunity to learn and practice appropriate skills with their peers. Whether the goal is to improve social skills, practice emotional regulation, learn coping skills, or support each other through life's transitions, group therapy provides a supportive and dynamic environment to produce change.

We offer groups for all ages, from childhood through adulthood. Most of our groups are ongoing, and allow new members to join at any time as long as the group has availability. Below, you can find a description of the types of groups we offer, along with the clinicians who run each group. If you are interested in more information about any of our groups, please contact our intake coordinator at 713-621-9515, ext. 227.

Social Skills Groups: Social skills aren't taught in school, although they should be. Learning how to communicate and interact with others is essential for effective self-management. Our social skills groups are available for elementary school, middle school, and high school. Each group aims to develop age-appropriate skills. For example, our younger groups may work on sharing and turn-taking, while our older groups focus on relationships and empathy. Each of our social skills groups includes Parent Only groups every 6 weeks, for parents and clinicians to share thoughts and feedback.

Launching Groups: Each stage of development requires us to conquer certain challenges before we can move on to our next developmental stage. For

adolescents, there are distinct launching points between 8th grade and 9th grade, and again between high school and young adulthood. Our launching groups are designed to assist our clients with these transitions. First we assess where the teen lands in his/her own readiness for the next stage, and then we help them develop the necessary skills to take on the challenge.

Young Adult: So you've graduated high school. Now what? Whether the next step is college or the workforce, many young adults find that they are unprepared for the challenge ahead. Once the structure of high school is in the past, it can be difficult to manage time and juggle responsibilities in order to be productive and effective. Our Young Adult groups offer support and guidance for young men and women who are looking to find their way towards independence.

Dialectical Behavioral Therapy (DBT) Skills Training: DBT Skills Training teaches adolescent girls how to better manage emotions and life through skills in mindfulness, self-soothing, self-acceptance, distress tolerance, interpersonal effectiveness, and parent-teen conflict resolution. Our DBT group is unique in that both teens and parents participate. Each week, teens work together to learn specific skills, while parents are in a separate group learning and practicing skills to support their child's growth.

Parenting Support: Parenting and family work is central to what we do at the Tarnow Center. Parenting Groups help parents learn the techniques that we use in therapy to promote positive change. These groups combine education and support, and parents will walk away with an individualized plan for their home.

Early Elementary
- Thursdays, *Galleria 4-5 p.m.*
  THERAPIST: Lourdes Valdés, Ph.D. and Desireé Gallagher, Psy.D.

Early Elementary Boys
- Mondays, *Galleria*
  THERAPIST: Lourdes Valdes, Ph.D. and Lynn Ayres, M.Ed.

Late Elementary
- Mondays, *Galleria 4-5 p.m.*
  THERAPIST: W. Walker Peacock, Psy.D. and Lynn Ayres, M.Ed.

Late Elementary
- Thursdays, *Galleria 4-5 p.m.*
  THERAPIST: W. Walker Peacock, Psy.D. and Lynn Ayres, M.Ed.

Middle School Girls
- Tuesdays, *Sugar Land 5-6 p.m.*
  THERAPIST: Desireé Gallagher, Psy.D.
- Thursdays, *Galleria 5-6 p.m.*
  THERAPIST: Desireé Gallagher, Psy.D.

5th Grade Boys
- Wednesdays, *Galleria 5-6 p.m.*
  THERAPISTS: Lourdes Valdés, Ph.D., W. Walker Peacock, Psy.D. and Lynn Ayres, M.Ed.

Middle School Boys
- Wednesdays, *Galleria 4-5 p.m.*
  THERAPIST: W. Walker Peacock, Psy.D.
- Wednesdays, *Galleria 6-7 p.m.*
  THERAPIST: Lourdes Valdes, Ph.D. and W. Walker Peacock, Psy.D.
- Thursdays, *Galleria 5-6 p.m.*
  THERAPIST: W. Walker Peacock, Psy.D.

High School Boys
- Mondays, *Galleria 6-7 p.m.*
  THERAPIST: W.Walker Peacock, Psy.D.

High School Girls DBT
- Tuesdays, *Galleria 6-7 p.m.*
  THERAPIST: Desireé Gallagher, Psy.D. and Lesley Solomon, LPC

College Readiness Group-High School
- Thursdays, *Galleria 5-6 p.m.*
  THERAPIST: Sophia K. Havasy, Ph.D.

Young Adult Group
- Tuesdays, *Galleria 6-7 p.m.*
  THERAPIST: Sophia K. Havasy, Ph.D.
- Thursdays, *Galleria 3-4 p.m.*
  THERAPIST: Sophia K. Havasy, Ph.D. and W.Walker Peacock, Psy.D.

Social Learning Group for Older Adolescents
- Mondays, *Galleria 5-6 p.m.*
  THERAPIST: Sophia K. Havasy, Ph.D.

Dr. Gallagher's Middle School Girls Group

Pre-teens and teens experience many pressures related to their future, academics, and interpersonal relationships. Between balancing these pressures and building an identity, there can be many conflicts that arise, including problems with parents and friends, a decrease in academic performance, and a poor self-concept. In addition to all of these, bullying has become the latest epidemic with pre-teens and teens. Studies show that most teens are exposed to bullying whether it is as the bystander, bully, or victim. The objectives of Dr. Gallagher's group include discussing the many issues facing teens today, building self-concept, anxiety, depression, and applying assertiveness skills. These skills are an important part of developing a healthy self-identity and self-concept. Groups are available in both the Galleria and Sugar Land Locations.

Reserve Your Space for This Fall

Girls' Group: DBT Skills Training and Self-Development

Group therapy is the best place for your high school aged adolescent to learn skills for managing her emotions and her life. She is socially oriented at this time and is primed to learn from others. Emotion regulation is a core skill that forms the foundation for future successful functioning in all areas.

Skills taught: Self-Soothing, Mindfulness, Self-Acceptance, Distress Tolerance, and Interpersonal Effectiveness.

Facilitated by: Desiree Gallagher, Ph.D. and Lesley Solomon, LPC

Tuesdays, Galleria 6-7 p.m.

College Readiness Group for High School Students

For 11th-12th grade students who plan to go to college but may not have the skills, yet, to be successful there.
*Facilitated by **Sophia K. Havasy, Ph.D.***

Topics to be discussed weekly by students: Self-awareness, Strengths and weaknesses, Motivation, Goals, Skills and accomplishments

Meeting weekly beginning Oct 4, 2012 Thursdays, 5 p.m.

Parents topics: Defining launching goals, In place vs. under construction, Risk factors, and Life skills development

Social Learning Group for Older Adolescents

Topics to be discussed weekly:
Social thinking, Self-awareness, Other awareness, How to engage, Developing Relationships

Facilitated by: Sophia K. Havasy, Ph.D. and Julie Sherman, Ph.D.
Mondays 5 p.m.—6 p.m.

Young Adult Groups

Self-Management and the Young Adult
Continue to develop self-management skills as they relate to daily life, school, employment, and relationships

18 to 30-year-olds

Sophia K. Havasy, Ph.D.

Tuesdays 6 p.m. or Thursdays 3 p.m.

Tarnow CENTER
*for Self-Management*SM

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1111 Highway 6, #210
Sugar Land, TX 77478

Phone: 713-621-9515
Fax: 713-621-7015
Email: jtarnow@tarnowcenter.com

Dr. Tarnow named Honoree of the Year

The Tourette's Syndrome Association of Texas will be honoring Dr. Tarnow at their upcoming January Gala. Dr. Tarnow is being honored for his life-long commitment and support of families dealing with Tourette's Syndrome.

Tourette's Syndrome Association of Texas Gala
"Hope in Bloom"

January 24, 2013
Houston Country Club
7:00 p.m.

If you are interested in receiving an invitation, please call us at 713-621-9515, ext. 241