Minnesota Women in Psychology

Winter 2012

Networking and support for all women in the mental health professions.

Wine & Chocolate Gathering 2011

by Laura Tripet Dodge, M.S., LP

The sixth annual Wine & Chocolate Fall Gathering took place on a beautiful Thursday evening in late October at Old Arizona. Hosted by the Membership Committee, this is MWP's "welcome back" social, networking, and membership outreach event all rolled into one. This year's gathering was a wonderful success, with over 70 women attending—members and guests, long time professionals and graduate students. All were able to enjoy a complimentary beverage and lovely spread of appetizers (including a few versions of chocolate…) while networking and getting to know more about the organization.

Members of MWP leadership were on hand to greet and facilitate connections through the evening, and information on membership and organizational involvement was available. A table filled with marketing and networking materials brought by attendees provided for information exchange and sharing. Interim Executive Committee Co-chairs Kim Carter and Laura Tripet Dodge provided a brief welcome and introductions, and issued an invitation to all to step into a more active role in MWP through membership or volunteer participation. Linda Richardson-Beaird described the evening as "Great fun!"

Our Old Arizona hosts shared the very interesting history of their organization, and how their for-profit businesses serve to fund their non-profit programs providing support and life skills for girls in their community. The rental fees we paid for the event directly supports their efforts. And at the end of the night, MWP gained ground both in membership numbers and volunteers!

Thanks to: Karrol Butler, Barb O'Brien, Elaine Lyman, Linda Richardson-Beaird, Jenna Frantz, and Laura Tripet Dodge of the Membership Committee; Kim Carter and Karen Wright, greeters for the evening; Lori Wiggenhorn, Cathy Skrip, and Sherry Merriam for their help with hosting and set-up/clean-up.

Newsletter Editor
Asha Mukherjee, Ph.D., LP
Dr.Asha.Mukherjee@gmail.com

Production Coordinator - Susan Johnson
WmPsychlgy@aol.com

Web Site
www.mnwomeninpsychology.org

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Advertising Guidelines: Ads must be of interest to women psychologists, and MWP reserves the right to reject or edit advertising. Publication of any advertising does not constitute endorsement; advertising by psychologists must follow APA guidelines. Cost: Ads will be accepted in increments of business card size (2" x 3 ½"); cost of one business-card-size ad is $20, two—$35, three—$50, four—$60, etc., up to $100 for 8-card-size, equivalent of a full-page ad. All advertising must be prepaid. Procedures: Ads must be camera ready and fit the requirement of increments of business card size. Submit by the newsletter deadline to: WmPsychlgy@aol.com or MWP, 5244 114th Ave, Clear Lake, MN 55319.

Regular Membership in MWP is available to women who hold either a Master's or doctoral degree in one of the fields of psychology or a related field (e.g. counseling & guidance, marriage & family studies, human services, social work, psychiatric nursing, etc) from a regionally accredited institution or have been licensed in Minnesota in one of the fields of psychology. This includes Psychologists, Social Workers, Marriage & Family Therapists, Licensed Professional Counselors, Licensed Professional Clinical Counselors, School Psychologists and Counselors, and Clinical Nurse Specialists.
Student Membership is available to women in graduate programs in one of the fields of mental health. Student members are able to fully participate, but do not have voting privileges. Annual dues are based on a sliding scale according to the annual income of the member, currently ranging from $30 to $80 per year. Membership applications are available by calling the MWP office, 612.296.4060 or email at WmPsychlgy@aol.com or on the website at www.mnwomeninpsychology.org.

More photos from the 2011 Wine & Chocolate Gathering held at Old Arizona in October.

Committee Contributions:
Committee Chairs' Reports

*(**Editor's note:** There being no chair at present, in this issue the newsletter cannot have a "Letter from the Chair". In lieu of that, we have information from the interim committee chairs about the past years' activity highlights. By the time the next newsletter issue comes out in March 2012, we hope to have a chair and the "Letter of the Chair" will resume. The committee reports may continue in the December issue each year).*

Membership Committee Report

Chair: Laura Tripet Dodge, M.S., LP

The Membership Committee has worked hard in 2011 to understand some of the trends in MWP membership, and how to most effectively outreach to new members *and* retain members. Our goals have been growth in both dimensions, and to seek to provide value to our members across the career span. We telephone surveyed members who chose to not renew in order to better understand their decision and solicit their input. We hosted a first time Open House for graduate students to learn more about MWP. Our regular Fall gathering & networking event, "The Wine & Chocolate" netted the highest attendance yet in it's 6-year history! In addition, the Membership Committee welcomes new members to the organization with a personal contact, and responds to concerns raised by members.

Those serving on the Membership Committee this past year include: Karrol Butler, Ruth Markowitz, Barb O'Brien, Linda Richardson-Beaird, Jenna Frantz, Elaine Lyman, Susan Broadwell and Laura Tripet Dodge (chair). Faye Foote has served as Student Liaison and facilitated outreach to Students and graduate programs.

by Laura Tripet Dodge M.S., LP

Professional Development Committee Report

Chair: Kim Carter, M.A.

It has been an exciting and eventful year for the Professional Development Committee. We had a strong committee this year which was devoted to creating new, interesting and relevant programming for our members. Included in this year's new events was our fall retreat, which was a holistic weekend event focused on renewing our minds, bodies and spirits.

Additionally we introduced our Quarterly Growth Series, which gives members both a unique opportunity to share their talents and knowledge, as well as gain continuing education. We also continue to keep mentoring relationships in mind and look forward to finding practical ways to make this an accessible professional development opportunity for our members.

by Kim Carter, M.A.

Social Action Committee Report

Chair: Jane Whiteside, Ph.D., LP

During the past year, the MWP Social Action Committee continued our post-911 focus on immigrant cultures and experiences by reading four very interesting and different books: Three Cups of Tea, by Greg Mortenson (Pakistan, Afghanistan); The Inner World of the Immigrant Child, by Cristina Igoa (many countries); Bravo Your Life, by Mi Soon Burzlaff (Korea); and The Latehomecomer, A Hmong Family Memoir, by Kao Kalia Yang (Hmong)--the last two by young women who spent their early years in the Twin Cities. We have been glad to have a number of new participants bringing new experiences of their own in the last year, and we want to encourage other MWP members who are interested to join us, for one book or for many. We meet upstairs at Black Bear Café every three months on a Saturday (usually the second Saturday of the month) in Como Park, St Paul. The next will be in March 2012.

by Jane Whiteside, Ph.D., LP

Announcements

Insurance Impact

Most insurance companies are soon going to require prior authorization requests for psychological tests and also may authorize less hours than before.

Blue Cross reduces rates following UBH lead - Blue Cross MN has now followed suit with UBH and dropped the reimbursement for PMAP (public info as of Nov 7, 2011)

News Release

To help parents understand the new guidance on ADHD, the AAP (American Academy of pediatrics) has published a detailed and updated consumer resource book entitled "ADHD: What Every Parent Needs to Know." Parent information will also be available at www.healthychildren.org/adhd starting October 16.

The American Academy of Pediatrics is an organization of 60,000 primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists dedicated to the health, safety and well being of infants, children, adolescents and young adults.

Internet Resource: American Academy of Pediatrics
141 Northwest Point Boulevard, Elk Grove Village, IL 60007-1098
Phone: 847.434.4000
Fax: 847.434.8000
http://www.aap.org

Reachable Resources

1. Full citations for 72 recent (published in 2009-2011) journal articles on psychological interventions for people with Alzheimer's or other forms of dementia;
2. Full citations for 39 journal articles on the effects of exercise on Alzheimer's and other dementias;
3. Twelve helpful books;&
4. Links to 18 websites that provide information and support.

Please share this announcement to any lists or individuals who might be interested.

This collection of resources is at: <http://bit.ly/KenPopeAlzheimersResources>

Statement of the American Psychological Association on the DSM-5 Development Process

December 2, 2011

"Diagnostic classification systems of disorders and diseases are an integral part of health care delivery. Any such system, including the upcoming 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) of the American Psychiatric Association and the pending revision of the International Classification of Diseases (ICD-11) of the World Health Organization, must be based on the best available science and serve the public interest".

The American Psychological Association has members with significant expertise in the scientific areas relevant to the DSM, and we have urged them to take part in the DSM revision efforts. We are encouraged that many psychologists are making meaningful contributions to the process as individuals, as members of the DSM-5 Task Force and work groups, and through the divisions of the American Psychological Association. This involvement includes offering comments on draft provisions and participating in field trials.

Announcements *continued*

We applaud the Society for Humanistic Psychology (Division 32 of our association) for its leadership role in generating dialogue and information-sharing within the broader mental health community concerning the revisions process. The Society also has prepared, disseminated, and garnered wide support for an "open letter" to the DSM-5 Task Force and the American Psychiatric Association, which expresses specific concerns related to the DSM-5 development process.

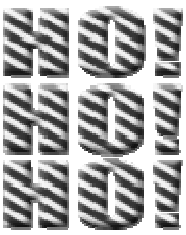
We share their belief that the purpose of any diagnostic classification system should be to improve treatment outcomes. Thus it is essential to consider the impact of any new diagnostic system or category on vulnerable individuals, groups and populations, particularly children, older adults, and ethnic minorities. By appropriately identifying individuals in need of treatment, it is possible to both safeguard the welfare of individuals and to direct treatment resources where they are most needed. Concerns also have been raised that over-identification or misidentification of individuals as being in need of treatment could lead to the use of unnecessary and potentially harmful interventions.

The American Psychological Association recognizes that there is a diversity of opinion concerning the ongoing DSM-5 development process. Our association has not adopted an official position on the proposed revision; rather, we have called upon the DSM-5 Task Force to adhere to an open, transparent process based on the best available science and in the best interest of the public. In this regard, we appreciate the Task Force's expressed commitment to seriously consider the issues and concerns raised by experts in the mental health field in their deliberations.

We call upon our members (either as individuals or groups) to continue to add their perspectives to enhance the validity and clinical utility of the DSM-5. The American Psychological Association will continue to monitor the revision process and be a strong voice for its transparency.

The American Psychological Association, in Washington, D.C., is the largest scientific and professional organization representing psychology in the United States and is the world's largest association of psychologists. APA's membership includes more than 154,000 researchers, educators, clinicians, consultants and students. Through its divisions in 54 subfields of psychology and affiliations with 60 state, territorial and Canadian provincial associations, APA works to advance psychology as a science, as a profession and as a means of promoting health, education and human welfare.

From the APA: Internet Announcement.



Santa Claus

Most people go through three Santa Claus stages.
First, you believe in Santa Claus.
Then you don't believe in Santa Claus.
Finally, you are Santa Claus.

Christmas

Early in December, Holly opened the door to her apartment and found a greeting card taped to the outside, "Merry Christmas form the custodial staff", it read. Nice gesture, she thought.

Then with all she had to do, she forgot all about it. A week later, she came home to find another card taped to her door. This one said, "Merry Christmas from the custodial staff. Second Notice!"

From *Jokes and Anecdotes*
Edited by Joe Claro

MWP's Social Action Group Book Review

"Bravo your Life!"

by Mi Soon Burzlaff

For our fall meeting in September, the Social Action Book Club read "Bravo Your life!" by Mi Soon Burzlaff. Published by the local Koryo Press, this collection of vignettes explores the author's identity and experiences as a Korean-American adoptee. Born to an economically disadvantaged family in Korea in the late 1970s, Ms. Burzlaff was adopted at the age of three-months by a family in Minneapolis.

The vignettes begin as the author, now in her 20s, meets her birth family in Seoul for the first time. Three of her elder sisters greet her with overwhelming emotion, as her parents sit nearby with their heads down, sobbing. The author's guide in this first visit back to Korea is the woman who found her family, a mother of a Korean friend from Minneapolis. The woman translates: "'They are very sorry. They keep saying how sorry they are to you. They worry you are angry at them.'"

"'Don't be sorry. I am not angry. I am okay. I have a nice life in America,'" Ms. Burzlaff asks the woman to translate to her family. "Tears keep pouring out of them," the author narrates, "and for a reason I can't explain, my eyes are dry: I can't even produce one drop."

Thus begins a sometimes lighthearted but always complex narrative of both cultural and

human encounters. Our book club's discussion initially focused on members' differing views of the author's emotional descriptions—or, alternatively, a perceived lack thereof—of her extended sojourn in Seoul. Some readers felt an emotional distance on the part of the author that seemed to detract from her writing, while others perceived a multilayered emotional journey of self-discovery that elicited a range of emotions. One point was clear, as illustrated in the quotes above, that Ms. Burzlaff's emotional experiences in Seoul often contrasted personally and culturally with those around her.

The author highlights other cultural discoveries significant to her, including the closeness of women, including a physical closeness to which she is not accustomed. For example, she describes visiting the public baths—a sort of spa—where women gently washed each other while soaking in the water together, taking turns with the exfoliating cloths in what were for them familiar acts of sisterly care.

Juxtaposed to such unfamiliar but peaceful experiences of physical closeness is a pervasive tension that reveals itself within the author's Korean family. Ms. Burzlaff comes to learn that her father continuously drinks soju, what the author describes as "cheap, common, and strong Korean alcohol that costs about a dollar at local convenience stores." She recalls her father's ruddy complexion and labile emotions, and she describes her sisters' protectiveness around her when her father becomes uncomfortably physically affectionate. Our book club discussed that possibly the father was so addled by the alcohol that he perceived his youngest daughter as the baby he remembered from more than twenty years ago, trying to kiss and pet her as he would an infant. Others read in the narrative a darker reality in which the alcohol unraveled the father's sexual boundaries to the point of inappropriate advances. Again, at least one clear point emerged, that the author's father's alcoholism was an inescapable factor in the family's poverty and the author's adoption.

Ms. Burzlaff reflects on the personal meaning and emotion regarding her own adoption toward the end of the collection, with a scene from a flight between Korea and the U.S. On the plane with her are a number of women, each with an infant wearing an ID bracelet. The author describes holding one of the infants while his attendant rests: "I hold Cheong Min close to me, kissing his cheeks and forehead, whispering in his ear, putting his name in front of everything I say … because as we fly through each time zone, closer and closer to Kansas, his final destination, I know he may never hear his name like this again."

And even with this perhaps rueful vignette, Ms. Burzlaff sums up in her afterword that "… Seoul became a second home to me. My Korean family graciously accepted that the way I live—and how I interpret the world differently from them—is because of my American upbringing. My Minnesotan family gave me the strong base from which I became the young woman my Korean family is so proud of. I love both my families and feel close to them in similar yet different ways."

For a quick and illuminating read, the richly layered snapshots of culture and human relationship in "Bravo Your Life!" are a good choice. Simultaneously, the accounts are equally as worthwhile for a closer read, to mine each glimpse into the author's psyche and the modern Korean identity for historical, psychological, and cultural insights.

by Leslie Hong, M.Ed., LPCC, LADC

Professional Personalities

Ruth Markowitz, M.A., LP, CST

I was born in Queens, New York, moved to Minnesota in 1973. My most recent university experience was at the University of St. Thomas where I received my Masters degree. I was interested as a younger person in the field of mental health because of mental health issues in my family. I was familiarized with psychiatry when I was about 8 years old and always wondered about it. I worked with college students in a tutoring program in my early 20's and became very interested in family planning and mental health issues, because the college students were encountering these issues with the kids they tutored and as their supervisor they were coming to me to help them attend to these concerns. I wanted to better know how to address these issues. At this point in my life I would say that my most important career goals are to stay creative and vibrant. I believe in a holistic approach to mental health and will spend my time continuing to develop methodologies that utilize an integrative approach. I am interested in pursuing end-of-life care issues, sexuality and aging, and, am exploring doing work with collaborative lawyers. The bottom line is that I want to keep growing , integrating and using my creativity.

What I have always appreciated about the people who have mentored me is their stepping out of the box. I am driven by creativity and value when people challenge systems, create new ideas. I love being around creative thinkers.

I went to the Greek Islands for 30+ years, but actually stopped about ten years ago. I think that period of time has had its closure. I love the Greek Islands, and have been to about 42 of them. I would say that in my life that was my favorite place, another is Madeline Island. But I think I am at a place of finding a new one; who knows what is next! I would like to walk the entire Camino de Santiago, I just walked about half of it. I would like to go to Myanmar, New Zealand, and Portugal. I'm not prepared to share an embarrassing situation, since I play out of the box, there have been any number of them and frankly they are just too embarrassing to be sharing.

by Ruth Markowitz, M.A., LP, CST

Cathy Skrip, M.S., LP

I was born in Berwyn, Illinois, and grew up in nearby North Riverside. I used to walk home from high school through Brookfield Zoo, which is a zoo I would highly recommend to those of you who have never been there.

I received a Master of Science degree from California State University-Los Angeles in 1971 with a specialization in Community College Counseling, which was a one-of-a-kind program in the country at that time. My early interest in a mental health career was shaped by working as a dormitory counselor and resident adviser at Miami University in Oxford, Ohio; but the real truth is that my career was shaped by the offer of graduate school tuition plus a stipend to live in California, where my now-husband of 41 years just happened to be working at the time! I went on to work as a counselor at community colleges in Whittier, California, and Beverly, Massachusetts. Then in Wisconsin I had the opportunity to develop my administrative skills as Assistant Director of the Community Care Organization of LaCrosse County, which was a pilot project funded by HEW and the Kellogg Foundation which offered and then researched the effectiveness of home care versus institutional care for elderly, adult blind, and disabled individuals. After moving to Minnesota in 1982, the early stages of my practice were shaped by volunteer work done at Alexandra House with women experiencing domestic abuse. Prior to starting my private practice in 1990, I was the Executive Director of the Abuse Resource Center, which was a small business dedicated to providing workshops and trainings on domestic violence. I joined MWP in 1988, specifically to figure out how to pass the EPPP after so many years out of school, and MWP has remained a pivotal force in shaping my career in psychology.

My most basic therapeutic career goal is to help each of my clients find the goodness and resilience within themselves so that they can effectively manage their own lives and give something positive back to others around them. I believe in the philosophy of making a difference in the world one person at a time. In a broader sense, my ongoing career goal has been to maintain a healthy balance between running my own business and being fully engaged as a member of my family. I most appreciated my early mentors for helping me redefine my quietness as a strength rather than a deficit because without that redefinition, I would never have had the courage to branch off from my undergraduate degree in English to a career in counseling.

My favorite vacations have been backpacking in the remote areas of Yosemite National Park and canoeing in the Boundary Waters. My future travel hopes are not necessarily place-specific but do involve the desire to travel with my husband as we hopefully will continue to age together. While I continue to do plenty of embarrassing things, I stopped giving as much energy to embarrassment some years ago, when I went through Thought Field Therapy training with Jill Strunk. Placebo or not, it works for me, so thanks, Jill!

'New Book' Review

"A Life Interrupted: The story of my battle with bullying and obsessive compulsive disorder"

by Sumi Mukherjee (published July 2011)

This is a brave experiential account. The author of this short book is a courageous young man, a second generation immigrant from India, who was born in Canada, came to the US at nine months of age, and knew this country as his only country. Sumi Mukherjee, age 34, is remarkably honest and direct in identifying his experience with bullying, anxiety, depression, and Obsessive Compulsive Disorder. He has little self-pity or whining tones and seems remarkably mentally healthy beyond his "casebook" diagnosis of obsessive compulsive disorder (OCD) which was exacerbated with the trauma of persistent long-term bullying.

The fact that the author, as a teenager, was able to keep the secret of his OCD from age 16 until 21 from his involved and loving parents (both well educated and one a Ph.D. psychologist), speaks to the peer isolation, stigma, shame and fear under whose shadows he had to live. Concerned as to why he was treated this way, Sumi sneaked into his mother's psychological books, and thought that he might have schizophrenia. The fear of further isolation through hospitalization/ confinement to 'homes for the crazy' was another factor. Finally at the age of 21, purely out of desperation, he was able to tell his father how he was suffering.

Indeed, the author's experience of being wounded by bullying holds a prominent place in the story. The OCD took hold at age 16 while the trauma of bullying were ongoing. The OCD trafficked on Sumi's images of bullies and he began to believe he had to perform compulsive behaviors to protect those he loved such as family members. His stark details of his thoughts and frenzied attempts to circumvent them are refreshing. Such honesty on this subject has been beyond my experience and mindboggling about the intensity of loss of control and suffering both in bullying and OCD. It makes the story very real and impactful.

This young man's healing journey is, of course, not straight-line progressive. Sumi finally gets some help, but then rebels. As a high school graduate, he wants to experiment with who he is and goes off his medications and experiments with alcohol. This choice is one many of us working with young people and mental illness have witnessed.

The depth of Sumi's learning about OCD itself is huge. The level at which an OCD sufferer has to engage/commit to actually make a difference beyond his own benefit and the 'the prescription drugs-only' choice is a profound learning for Sumi. He has obviously had

excellent help from his family, his therapists, psychiatrists, and a very brief residential treatment, during which he finally (1) got the right medication prescription for him and (2) that OCD was even worse in its control on some others. However, to make needed changes, Sumi still had to learn and institute the cognitive behavioral skills necessary. This process of learning took many years out of his life, depriving him of social life and other opportunities as he was able to perform at a minimal level compared to his potential. This reviewer bases this assumption on the clarity of his writing which indicates a person of exceptional self-awareness, intelligence and strength. After being in control of the OCD, Sumi next had to also deal with the real "rocky road" of the impact of the social-emotional 'lost years'! "A Life Interrupted" is an apt title for this book.

The most poignant part of the book is when the author, Sumi, as an adult, sets up a meeting with the man who bullied him the most intensely during his childhood. That episode was resolved in an understanding and freedom/emancipation which reinforced Sumi's payoff for taking this courageous step of confronting one of his oppressors. The transformation of the bully in a much weaker person in adulthood as compared to the childhood bully, had its impact. Unfortunately, a few years later Sumi accidentally read this man's obituary in the paper and learned that he had had schizophrenia, the very illness of which Sumi had been so afraid!

"A Life Interrupted" is a quick read. It is like a peanut, small but full of meat. It includes tips for OCD sufferers, their parents, significant others and also gives encouragement that even in its severe forms, OCD can be managed sufficiently to render an individual functional. It would be appropriate for anyone afflicted with OCD or bullying or depression/anxiety/PTSD". All physicians should read it. All psychologists in training and in practice should read it. All psychotherapists should read it. All teachers and professors should read it. Its experiential value and flavor grounds the reader in the milieu of a cruel combination of bullying, anxiety OCD, depression.

I felt somewhat cheated after learning so intimately about the author's distress that I didn't know more about Sumi's successes and his whole self, by the time I was finished reading. He is much more than his vulnerability due to OCD and seems worth-knowing. Perhaps his next book will include more of the whole mix of what makes Sumi a person of interest.

by Gail Anderson, M.A., LP (retired)

Reprinted from the Minnesota Psychologist (the newsletter for Minnesota Psychological Association) September-October 2011 issue.

(**Editor's note:** *Sumi Mukherjee also happens to be my son. My pain for his intense suffering is matched by my current pride in his patience, sincere efforts and accomplishments in conquering his OCD and writing this account for others' benefit as well as his willingness to help others through his ongoing speaker-services to many kids about bullying in various elementary, middle & high schools. Sumi Mukherjee was featured on Fox News, Channel 9, as a new author (along with this book) on Saturday 12/10/11 at 5.40 PM, and commended for his self-initiated volunteer work with multi-district school kids (elementary, middle and high) in Minnesota regarding bullying prevention.)*

Spotlight on New Members

Kelly O. Finnerty, M.A., LAMFT

I grew up in the San Fernando Valley, north of Los Angeles, when it was still a place of orchards and horse pastures. Over the years, I made my way up and down the coast, teaching on an Indian reservation at the foot of Mount Palomar near San Diego, counseling adolescents at residential treatment center in Santa Barbara, and working as an artist in the schools in San Francisco.

Along the way, I met and married a fine Minnesota man and we brought our two little daughters back here to learn the rhythms of the seasons, and the life of a large, extended Jewish family. While my children were growing up, I worked in museum education at the Science Museum of Minnesota, the Minnesota Children's Museum and now at the Bakken Museum. As my youngest daughter began college, I returned to St. Mary's University for my second graduate degree in Marriage and Family Therapy to complement my earlier training in Interdisciplinary Creative Arts.

I am deeply interested in the power of creativity and play to build resilience and to heal grief and trauma. I have specialized experience working with children and adults who have experienced physical and sexual abuse. I value the guidance I have received in this area from my supervisor and mentor, Libby Bergman, LICSW, director of the Family Enhancement Center, who consistently exhibits humor, optimism, compassion, determination and insight in her work. These are qualities I value in my role as a therapist.

I have recently opened a private practice in Edina where I work with children and families, as well as individuals. I am currently forming Life Circle groups for women to explore specific themes such as Super Mom guilt. I love providing a supportive community for creative exploration and growth. I am excited to be offering a creative retreat in northern New Mexico at Ghost Ranch Education and Retreat Center this April. More information about these offerings and more is available at my website at www.Kfinnertytherapy.com. My work as a therapist is the culmination of a long held desire to bring many parts of my experience as a daughter, sister, wife, mother, artist, educator and traveler together in a way that helps others to create new meanings from painful or distressing life events and find more joy in life.

by Kelly O. Finnerty, M.A., LAMFT

Spotlight on New Member *cont.*

Lori Ann Wagner, M.A.

Lori Ann Wagner was born in Waukesha, Wisconsin. Her most recent degree is MA, in Professional Clinical Counseling & Marriage and Family Therapy from Adler Graduate School. Her interest in a Mental Health career had was always been there though she had worked as a commercial litigation attorney for 23 years. She was interested in human behavior and psychology and fascinated with psychological assessment and testing. She was the person everyone came to with their problems and questions, so in addition to deciding that she wanted to work more directly in helping individuals, she decided to learn to do professionally the things she had been doing anyway as an amateur, for years.

Her most important mission is to activate people's inner courage to help them overcome fear so they can enjoy healthier, more productive lives and relationships. The features she appreciated most in her mentors/supervisors/teachers are the ability to be encouraging while providing feedback; a sense of humor; an ability to laugh at themselves, which goes along with humility; straightforwardness; a willingness to take time and make our interactions feel like the most important part of their day; genuine connectedness (ignoring their phones and away from their computers).

She is fond of many vacation places and it is difficult for her decide her "best spot" but if pressed, she would choose New Zealand because of its variety, "but it is hard to get there. I've only been to Europe twice (at age 40 and age 50) and definitely not done enough exploration!"
So you just guessed her future travel hopes: to explore the rest of Europe!

Her most embarrassing situation follows in her own words: "As a high school debater I used to get laryngitis anytime I got a cold. To get through a tournament I would bring one of those little plastic lemons filled with lemon juice and squeeze it into my throat allowing me to get out a few paragraphs at time. At one tournament I was not paired with my usual partner and best friend Megan, but rather with Steve, who had the unfortunate habit of declaring his unrequited love for me. We were using Steve and his partner's "evidence box" (a briefcase full of hundreds index cards on which they had either written or pasted facts, figures and quotations to support debate points). An earnest freshman Dan, the brother of Steve's regular partner, was along to watch and keep time for us. I was up in the middle of my initial speech when there was a loud crash and I heard Steve say even more loudly: "Shit!" The evidence box had fallen onto the floor scattering cards across the floor. Steve and Dan were frantically trying to gather cards that were now in hopeless disarray. As a debater you learn to circle breath-like jazz trumpeters-with hardly a pause I squirted in some lemon juice, said: "That's unfortunate, judge my partner apologizes for his language, now if you'll consider the harm that is inherent in the current program that the administration has been funding …"

Children's Challenge: ADHD Diagnosis Issues

American Academy for Pediatrics (AAP) Expands Ages for Diagnosis and Treatment of ADHD in Children

Embargoed for Release: Sunday, October 16, at 12:01 AM ET
Media Contacts: Susan Stevens Martin Debbie Linchesky NCE Press Room
847.434.7131 - 847.434.7084 - Oct. 14—18
ssmartin@aap.org dlinchesky@aap.org
617.954.3964

Boston—Updated guidelines from the American Academy of Pediatrics (AAP) offer new information on diagnosing and treating Attention-Deficit/Hyperactivity Disorder (ADHD) in younger children and in adolescents.

Emerging evidence makes it possible to diagnose and manage ADHD in children from ages 4 to 18 (the previous AAP guidelines, from 2000 and 2001, covered children ages 6 to 12). The new guidelines describe the special considerations involved in diagnosing and treating preschool children and adolescents. They also include interventions to help children with hyperactive and/or impulsive behaviors that do not meet the full diagnostic criteria for ADHD.

"Treating children at a young age is important, because when we can identify them earlier and provide appropriate treatment, we can increase their chances of succeeding in school," said Mark Wolraich, MD, FAAP.

ADHD is the most common neurobehavioral disorder in children, occurring in about 8 percent of children and youth.

The report, "ADHD: Clinical Practice Guidelines for the Diagnosis, Evaluation and Treatment of Children and Adolescents with Attention-Deficit/Hyperactivity Disorder," will be released Sunday, October 16, at the AAP National Conference & Exhibition in Boston, and will be published in the November 2011 issue of Pediatrics (published online Oct. 16).

According to the AAP guidelines, in preschool children (ages 4 and 5) with ADHD, doctors should first try behavioral interventions, such as group or individual parent training in behavior management techniques.

Methylphenidate may be considered for preschool children with moderate to severe symptoms who do not see significant improvement after behavior therapy, starting with a lower dose. For elementary school children and adolescents, the AAP recommends both FDA-approved medications and behavior therapy.

ADHD being "a chronic condition, it requires a team approach, including the patients, their parents, the pediatrician, therapists, and teachers," Dr. Wolraich said.

The AAP is also releasing a newly revised and updated ADHD Toolkit to assist health care providers diagnose and treat ADHD in their patients.

American Academy of Pediatrics

Book Review

"Room"
by Emma Donoghue

'Room' is a beautiful, easy reading, short novel written from a 6 year old child's perspective. It fully illustrates the life and views of an environmentally deprived child who had lived all his 6 years in captivity along with only his mother. She had been abducted at age 19, confined by her captor in a windowless, soundproof, steel-walled 'Room', which was the only domain her 6 year old son knew as his universe. Her first pregnancy had resulted in a stillbirth and the second one, in the 6 year old child, who is narrating this story. Having been born in captivity, he ended up believing that 'Room' was the "real" world and all programs he saw on TV about people were "fantasy". His mother had tried and knew that escape was impossible. She waited for him to become 6 years old to put a plan into work. Would you believe the two were able to escape? Do you wonder how? While Room is a mindboggling account of PTSD for the mother, it is a devastating adjustment to "real" reality for her son, the narrator. The child's language and perspective are enchantingly fresh and typical of children's way, and, make him very endearing to the reader. Despite the sad theme of violence & abduction, Room is a fun reading for the holidays because of the positive attitude and initiative of the characters involved. Enjoy!

By Asha Mukhergee, Ph.D., LP

The Depression Domain

Serious Readings & Questions

Symptoms As Clues to Changes in Emotional Well-Being
Non-specific, somatic symptoms such as headache, dizziness, and fatigue are common reasons for visits to the family physician. How are these linked to emotional distress, anxiety, and depression?
BMC Family Practice, September 2011

Perinatal Depression in Minority, Low-Income Women
How do low-income, minority women perceive the mental health services currently on offer?
Medscape Nurses, September 2011

Adverse Effects of Antidepressants Use During Pregnancy
Are antidepressants safe to use during pregnancy? This review takes a look at the evidence.
Evidence-Based Mental Health, May2011

Pregnancy and Depression Tool Almost Ready for Prime Time
Medscape Medical News, October 31, 2011

Postpartum Depression: Mothers at High Risk in the NICU
Medscape Medical News, October 19, 2011

Depression: Don't Ask, Don't Tell?
In up to 25% of primary care patients with depression, the condition is not diagnosed. Why might this be?
Medscape Psychiatry, November 2011

Depression in Dementia
Depression is both a risk factor for and a prodrome of Alzheimer's disease--but the mechanism are complex, and may differ from typical depression. Is there any effective treatment for these patients?
Current Opinion in Psychiatry, November 2011

Depression Common in Primary Hyperparathyroidism
Reuters Health Information, November 1, 2011

Dramatic Increase in Antidepressant Use
Medscape Medical News, October 20, 2011

Major Depressive Disorder Following Terrorist Attacks
Many studies have focused on the psychological after-effects of terrorist attacks, but this systemic review focuses exclusively on major depressive disorder. What is its prevalence and course?
BMC Psychiatry, August 2011

Bright Light Treatment for Non-Seasonal Major Depression
Bright light has shown to be an effective treatment for seasonal depression, but might it also be beneficial in treating non-seasonally associated depression in older adults?
Evidence-Based Mental Health, October 2011

Family Psychoeducation Reduces Relapse in Major Depression
Can educating family members regarding depression and stress reduction help improve outcome and relapse rate in their loved ones with major depression?
Journal Watch, September 2011

Major Depression and Menopause
This long-term, prospective, cohort study demonstrated increased risk for major depression during the menopausal transition.
Journal Watch, May 2011

Postpartum Diagnostic Depression Interview is Problematic
Using a formal DSM-IV-based interview to identify depression in postpartum mothers may have serious flaws that could lead to under-diagnosis
Journal of the American Board of Family Medicine, March 2011

Postpartum Depression: An Essential Overview
Postpartum depression affects many women after childbirth, but more than half the time goes undiagnosed. Primary care physicians and pediatricians are in a unique position to help.
Southern Medical Journal, February 2011

The Truth About Seasonal Affective Disorder
Too much light, or too little light? Many common misconceptions exist about SAD.
Journal of the American Board of Family Medicine, January
Medscape Psychiatry, February 2011

Current Depression Among Adults - United States, 2006 and 2008
How common are depressive disorders among US adults? This report looks at the latest data.
Morbidity & Mortality Weekly Report, Nov. 2010

Humor for Health

Taking Ownership

A Little Story about four people named: Everybody, Somebody, Anybody and Nobody.

There was an important job to be done and Everybody was sure that Somebody would do it. Anybody could have done it, but Nobody did it. Somebody got angry about that, because it was Everybody's job. Everybody thought Anybody could do it, but Nobody realized that Everybody wouldn't do it.

It ended up that Everybody blamed Somebody when Nobody did what Anybody could have done!

by Denise Dworakoski, M.A., LPCC

'Responsibility' in a Dilemma

After learning the dictionary meaning of the word 'responsibility', an elementary school child was asked by his teacher to use it in a sentence. Here is the sentence his creative mind produced: "My shorts have 2 buttons at the waist. One is broken and lost. So, all the responsibility has fallen on the second button!"

Meaning of Pregnancy

Another elementary school student learned the dictionary meaning of the word 'pregnant' as "carrying a child" and she produced the following sentence: "The brave fireman ran up the stairs of the burning building and came back out pregnant".

What is Puberty?

One 7 year old to another: "I am worried about something. I heard my parents talking about it".

His friend: "What is it?"

First kid : "Apparently we all have to go through a place in a few years; it is somewhere between heaven and hell and it is called 'pubertery'!"

Pain, Painkiller-Problems & Power-of-the-Brain

"Rewiring the Brain to Ease Pain; Brain Scans Fuel Efforts to Teach Patients How to Short-Circuit Hurtful Signals"

by Melinda Beck

Clinical Background: Some 116 million American adults, one-third of the population, struggle with chronic pain, and many are inadequately treated, according to a report by the Institute of Medicine in July 2011. Annual deaths due to overdoses of painkillers quadrupled, to 14,800, between 1998 and 2008, according to the Centers for Disease Control and Prevention. Yet abuse of pain medication is rampant. The painkiller Vicodin is now the most prescribed drug in the U.S.

"There is a growing recognition that drugs are only part of the solution and that people who live with chronic pain have to develop a strategy that calls upon some inner resources," says Josephine Briggs, director of NCCAM, which has funded much of the research into alternative approaches to pain relief.

The recent intriguing conclusion neuroscientists are reaching, through scanning technologies to see how the brain processes pain, is that how we think about pain can have a major impact on how it feels. This principle is also behind many old mind-body approaches to chronic pain (relaxation exercises, hypnosis, meditation, yoga, guided imagery, tai chi etc.) that are proving surprisingly effective in clinical trials.

While some of the mind-body therapies have been used successfully for years, we are only now starting to understand the brain basis of how they work, and how they work differently from each other," according to Sean Mackey, chief of the division of pain management at Stanford.

In fact, brain scans show that chronic pain (defined as pain that lasts at least 12 weeks or a long time after the injury has healed) represents a malfunction in the brain's pain processing systems. The pain signals take detours into areas of the brain involved with emotion, attention and perception of danger and can cause gray matter to atrophy. That may explain why some chronic pain sufferers lose some cognitive ability, which is often thought to be a side effect of pain medication. The dysfunction "feeds on itself," says Dr. Mackey. "You get into a vicious circle of more pain, more anxiety, more fear, more depression. We need to interrupt that cycle."

Participants' brain scans before and after showed that while they were meditating, they had less activity in the primary somato-sensory cortex, the part of the brain that registers where pain is coming from, and greater activity in the anterior cingulate cortex, which plays a role in handling unpleasant feelings. Subjects also reported feeling 40% less pain intensity and 57% less unpleasantness while meditating.

The Studies & Techniques: A high tech approach is used in studies at Stanford University's Neuroscience and Pain Lab, wherein subjects can watch their own brains react to pain in real-time and learn to control their response--much like building up a muscle. When subjects focused on something distracting instead of the pain, they had more activity in the higher-thinking parts of their brains. When they "re-evaluated" their pain emotionally--"Yes, my back hurts, but I won't let that stop me"--they had more activity in

the deep brain structures that process emotion. Either way, they were able to ease their own pain significantly, according to a study in the journal Anesthesiology last month.

One technique is attention distraction, simply directing your mind away from the pain. "It's like having a flashlight in the dark--you choose what you want to focus on. We have that same power with our mind," says Ravi Prasad, a pain psychologist at Stanford.

Guided imagery, in which a patient imagines, say, floating on a cloud, also works in part by diverting attention away from pain. So does mindfulness meditation. In a study in the Journal of Neuroscience in April, researchers at Wake Forest taught 15 adults how to meditate for 20 minutes a day for four days and subjected them to painful stimuli (a probe heated to 120 degrees Fahrenheit on the leg).

Techniques that help patients "emotionally reappraise" their pain rather than ignore it are particularly helpful when patients are afraid they will suffer further injury and become sedentary, experts say.

Cognitive behavioral therapy, which is offered at many pain-management programs, teaches patients to challenge their negative thoughts about their pain and substitute more positive behaviors.

One of Dr. Mackey's favorite pain-relieving techniques is love. He and colleagues recruited 15 Stanford undergraduates and had them bring in photos of their beloved and another friend. Then he scanned their brains while applying pain stimuli from a hot probe. On average, the subject reported feeling 44% less pain while focusing on their loved one than on their friend. Brain images showed they had strong activity in the nucleus accumbens, an area deep in the brain involved with dopamine and reward circuits.

The Results &Conclusions: People perception of pain is highly individual, involving heredity, stress, anxiety, fear, depression, previous experience and general health. Motivation also plays a huge role--and helps explain why a gravely wounded soldier can ignore his own pain to save his buddies while someone who is depressed may feel incapacitated by a minor sprain.

People typically have “are all walking around carrying the baggage, both good and bad, from past experience and we use that information to make projections about what we expect to happen in the future," says Robert Coghill, a neuroscientist at Wake Forest Baptist Medical Center in Winston-Salem, N.C

People who are anxious are more likely to experience pain after surgery or develop lingering nerve pain after a case of shingles. This can develop a vicious cycle of pain and fear.

"Our subjects really looked at pain differently after meditating. Some said, 'I didn't need to say ouch,' " says Fadel Zeidan, the lead investigator.

Even getting therapy by telephone for six months helped British patients with fibromyalgia, according to a study published online this week in the Archives of Internal Medicine. Nearly 30% of patients receiving the therapy reported less pain, compared with 8% of those getting conventional treatments. The study noted that in the U.K., no drugs are approved for use in fibromyalgia and access to therapy or exercise programs is limited, if available at all.

Anticipating relief also seems to make it happen, as research into the placebo effect has shown. In another NCCAM-funded study, 48 subjects were given either real or simulated acupuncture and then exposed to heat stimuli.

Both groups reported similar levels of pain relief--but brain scans showed that actual acupuncture interrupted pain signals in the spinal cord while the sham version, which didn't penetrate the skin, activated parts of the brain associated with mood and expectation, according to a 2009 study in the journal Neuro -image.

From Wall Street Journal article: The article is online at: <http://on.wsj.com/KenPopeNonMedPainReliefMethods>

"Zen is not a particular state but the normal state: silent, peaceful, un-agitated. In Zen practice neither intention, analysis, specific effort nor imagination take place. It's enough just to be without hypocrisy, dogmatism, arrogance -- embracing all opposites."-- Taisen Deshimaru, Zen Teacher (1914-1982)

Research-Raised Roars

1) Evidence is mounting for the benefits of exercise,
yet psychologist don’t often use exercise as part of their treatment arsenal.
Here’s more research on why they should.

Video: Temple University psychologist Michael Sachs explains how to get reluctant exercisers off the couch.

2) The real secrets to a longer life

Howard S. Friedman says eating vegetables and going to the gym are not as important to our long-term health as having a rich, productive life.

Test: Take Friedman's longevity prediction scale.

3) Deconstructing suicide

MacArthur Fellow Matthew K. Nock studies why people harm themselves.

4) New labels, new attitudes?

Research shows that graphic cigarette warning labels lodge themselves in people’s minds. But do they really help smokers quit?

Slideshow: Cigarette warnings from around the world.

5) Better options for troubled teens

Psychologists are creating and implementing programs that curb problem behaviors among juvenile offenders.

6) Seven words about healthy eating as nature wished us to:

Eat,
Not too much,
And,
Mostly vegetables!

Self-Injury Situation

Below are a few summaries & implications of recent research in self injurious behaviors.

Glenn, C.R. &Klonsky, E.D. (in press). Prospective prediction of non-suicidal self-injury: A 1-year longitudinal study in young adults. Behavior Therapy, available online 12 June 2011. doi: 10.1016/j.beth.2011.04.005

Summary

Eighty one (81) predominantly female, Caucasian, 19-year-old college students completed a series of self-report measures and brief interviews discussing their past experiences with self-injury. The participants were asked to meet for follow-up one year later. Fifty one (51) of the original 81 participants completed a follow-up session allowing for correlates of non-suicidal self-injury (NSSI) to be assessed cross-sectionally and longitudinally over a one-year period. Despite relating to NSSI in cross-sectional analysis, correlates such as depression, anxiety, impulsivity, alcohol abuse, bulimia and associations with and functions of NSSI were all insignificant predictors of future NSSI in longitudinal analysis. The only significant predictors of future NSSI were participant reports of past NSSI, perceived likelihood of future NSSI and borderline personality disorder features. Participants who stopped self-injuring two years prior to the study were less likely to start self-injuring during the study when compared to participants who stopped self-injuring one year before the start of the study.

Practical Implications

Assessing for these predictors may help identify clients presently at risk for engaging in self-injurious behavior. Continued follow up is important with those most recently stopping self-injury (more likely to engage in such behavior in the future as compared to whereas those who have had no instances for two years).

Borges, G., Azrael, D., Almeida, J., Johnson, R.M., Molnar, B.E., Hemenway, D., Miller, M. (2011). Immigration, suicidal ideation and deliberate self-injury in the Boston Youth Survey 2006. Suicide and Life-Threatening Behavior, 41(2), 193-202. doi: 10.1111/j.1943-278X.2010.00016.x

Summary

One thousand and four (1004) surveys from students in 18 Boston public schools were analyzed to gain a better understanding of deliberate self-injury and suicide ideation risk. The Boston Youth Survey (BYS) covered a range of topics from health behaviors and the use of school and community resources to developmental strengths and risk factors. Nativity and time spent in the United States, birth place of the participant's parents and the participant, the main language spoken at home and discrimination based on ancestry/nativity were key independent variables in this study. Researchers also collected information about race, ethnicity, age, gender, academic grade level, number of parents living at home with the student, hours spent working outside of school and single item responses to questions assessing deliberate self-injury and suicide ideation. Students who worked more than 20 hours per week were found to be more likely to participate in deliberate self-injurious behaviors than their peers who did not have jobs. Additionally, students who were born in the United States and were discriminated against because of their nativity were significantly more likely to engage in self-injury and suicide ideation.

Practical Implications

It may be that immigrants have some protection from self-injurious behavior and suicide risk, whether because of closer connection to the immigrant culture or some other protective factor. Native-born students not of the dominant culture may experience more discrimination and lack adequate, healthy coping responses. Helping teens find alternative means to address challenging situations and strong emotions is essential to reducing the incidence of self-injurious behavior.

Adrian, M., Zeman, J., Erdley, C., Lisa, L., &Sim, L. (2011). Emotional dysregulation and interpersonal difficulties as risk factors for non-suicidal self-injury in adolescent girls. Journal of Abnormal Child Psychology, 39, 389-400. doi: 10.1007/s10802-010-9465-3

Summary

Non-suicidal self-injury (NSSI) and risk factors for NSSI were assessed from a sample of 99 predominantly Caucasian, middle-class adolescent girls admitted to a psychiatric hospital. Youth completed self-report measures of emotion processing, interpersonal relationships, social experiences and nonsuicidal self-injury. The authors found multiple connections between emotion regulation and family and peer interpersonal conflict. Emotional dys-regulation and NSSI were facilitated through "unsupportive social contexts" such as family and peer discord. Family relational problems directly affected emotional dys-regulation. Ultimately, adolescents who did not have the opportunity to learn how to identify and express negative emotions in a supportive environment often developed unhealthy coping skills, such as NSSI.

Practical Implications

A thorough assessment of a client's social and interpersonal environment may reveal risk factors and developmental gaps that make the client more vulnerable to self-injurious behavior. Early identification of such risks may shape treatment and allow the psychologist to target development of needed emotion regulation skills more quickly. Family interventions might also be warranted.

Messina, E.S. &Iwasaki, Y. (2011). Internet use and self-injurious behaviors among adolescents and young adults: An interdisciplinary literature review and implications for health professionals. Cyberpsychology, Behavior, and Social Networking, 14(3), 161-168. doi:10.1089/cyber.2010.0025.

Summary

The authors categorized themes into "pros" and "cons" of internet usage and its connection to self-injurious behavior in an interdisciplinary literature review. It was found that, at their best, self-harm message boards often served as sources of self-worth validation, support and safe places for venting. The notion of the message board as a safe place was reiterated by many users, who reported feeling more comfortable using these platforms to discuss and explore their behaviors and feelings than talking with a friend, family member or therapist. Most participants reported a decrease in self-injury

in part due to involvement with these message boards. On the other hand, many professionals are concerned that message boards and interactions therein normalize self-injurious behaviors. Unfiltered or poorly moderated message boards can often serve as a trigger for increased self-injury and provide encouraging materials such as new techniques and ways to reduce the scarring that might result from self-injury.

Practical Implications

It is important to inquire about internet usage by clients in general. It is important to ask clients who self-injure whether they visit websites about self-injury and if so, how often and what level of involvement they have with such websites. Clinicians are encouraged to visit websites identified by clients to gain first-hand information about what the client is exposed to and how these sites are used. A clinician who understands the client's triggers for self-injury and where they come from will be more able to detect these potential triggers on regularly visited sites.

Kleespies, P.M., AhnAllen, C.G., Knight, J.A., Presskreischer, B., Barrs, K.L., Boyd, B.L., & Dennis, J.P. (2011). A study of self-injurious and suicidal behavior in a veteran population. Psychological Services, 8(3), 236-250.

Summary

United States military veterans who were medical or psychiatric patients enrolled at a Northeastern VA health care system were each given a "post self-injury" interview. The interview was based on three well-established measures: the Suicide Intent Scale, Risk-Rescue Rating Scale and Self-Harm Behavior Questionnaire. The interview and nature of the study were designed to learn about the frequency and type of self-injurious behaviors as well as how these behaviors relate to intent to die. Patients tended to rate their risk of suicide significantly higher than those assessing them. Most who reported self-harm behaviors in the past rated their behaviors as moderate to high lethality regardless of the objective immediate lethality of those methods. Women and younger veterans were less likely to self-injure with suicidal intent, and women and those who were experiencing a divorce or separation were more likely to be repeat self-injurers. More than 80 percent of participants viewed their self-injuries as impulsive acts, which is of concern since impulsivity is a personality trait often seen in those who commit suicide. Planned self-injury was associated with greater reports of intent to die. Those participants who committed suicide over the course of the study were most likely to have been in combat.

Practical Implications

Clinicians and clients may not share the same belief regarding the intent and lethality of the self-injurious behavior. Objectively, some behavior may not be lethal but the intent might be suicide. Understanding the client's belief is critical in determining whether such actions are truly self-injurious but non suicidal, or whether suicide is a desired outcome. The finding that those who committed suicide over the course of the study were most likely to have seen combat emphasizes the substantial risk combat soldiers are exposed to and the necessity of making needed services accessible and convenient for those returning from combat.

Self Care

Remembering Your Oxygen Mask: Thoughts on Therapist Self-Care

Two to ten minute fixes for increasing your energy:

1. Keep a bag of nuts in your office drawer and snack on some when you are feeling low energy. The protein increases your energy and the healthy fats help keep it lasting. Walnuts and almonds are a great choice!
2. Drink water. Sometimes you can feel lethargic when you are dehydrated. Keep a bottle of fresh, purified water on hand at all times.
3. Take a brisk walk. Even just ten minutes can increase the oxygen to your brain and stimulate your energy.
4. Do a measured breathing exercise. You can choose any that are comfortable to you, but I like square breathing, which is simply breathing in to a count of four, holding your breath for a count of four, exhaling for a count of four and holding again for a count of four before resuming the cycle.
5. Practice gratitude. If you are feeling low energy, take five minutes between sessions to make a short list of things you are grateful for and feel your energy increase.
6. Reach out to an optimist. Make a quick five minute phone call in the middle of your day to someone you know who has great energy. Just touching base with a positively focused person will increase your energy.
7. Add your own favorite way here: _____

I am sure many of you already know these handy tricks (and a lot more I haven't included here), but it can be easy to forget the basics when we feel overwhelmed. Add one of your tried and tested favorites to this list and post it near your computer or carry it in your planner for a quick reminder of just a few of the ways to maintain your energy and take good care of yourself.

by Kim Carter, M.A.

Indulge Your Senses During the Holiday as a Way of Self-Care

Scent
Smell a candy cane—studies show that the menthol smells alone will pep you up to enjoy festivities. It also can help calm and upset stomach.

Peel an orange—the scent has been shown by researchers to boost joy by the citrus scent.

Hearing
Try listening to something new: Tejas bells, Manheim Steamroller, Handel's Messiah, Irish music.

Pick up holiday tickets for a community theatre to see a local Nutcracker performance. Research shows that people who regularly attend cultural events feel healthier and more vital than those who don't participate.

Seeing
Make a plan to see a movie you have been putting of seeing (Love Actually, Family Stone, Miracle on 24th Street).

Spend time with your college roommate or friends from the past. Simply spending time with a favorite friend increases levels of the hormone progesterone, which can lower feelings of anxiety and stress.

Stargaze—it helps improve concentration and helps facilitate that wonderment and mystery.

Taste
Bust out the crock-pot and try a new recipe. A popular cookbook series is five ingredients or less. Check it out!

Prepare dishes or entrees your family of origin made when you were younger—this can provide comfort of lost loved ones and nostalgia.

Touch
Holding a cup of hot coco or tea has been proven to calm rattled nerves and stimulate the part of the brain called the insula, which helps process both physical temperatures and emotions

Adapted by Prevention's 31 days of Happy, Healthy, Stress-Free Holidays 2010 and Denise Dworakoski MA, LPCC

Substance Use & Abuse is Still Profuse

September 15, 2011—Based on a number of recent epidemiological studies, it is estimated that more than 50 percent of individuals with a severe mental disorder may also have problems with substance use. Without proper screening, it is difficult to recognize when a person with a mental disorder also has a substance use disorder. Thus, substance use disorders frequently go unrecognized and untreated. Psychologists have the skills to provide comprehensive, integrated treatment that can enable stabilization and recovery for those with a dual diagnosis.

Brown, C. H., Bennett, M. E., Li, L., & Bellack, A. S. (2011). Predictors of initiation and engagement in substance abuse treatment among individuals with co-occurring serious mental illness and substance use disorders. Addictive Behaviors, 36(5), 439-447.

Summary
Limited research has assessed the predictors of treatment initiation and subsequent engagement in treatment among individuals with co-occurring serious mental illness (SMI) and substance use disorders (SUDs). This study analyzed data from a randomized trial of a behavioral intervention for people with co-occurring SUD and SMI in order to identify these predictors. Two hundred and fifty one (N=251) participants met all the screening criteria and consented to participate. Treatment initiation was defined as completing the pre-treatment intake assessment phase consisting of two 2.5 hour visits about a week apart and prediction variables for initiating treatment consisted of demographic, mental health diagnosis and substance use information collected during eligibility screening. Treatment engagement was defined as attending at least three treatment sessions and treatment engagement prediction variables included the prediction variables for treatment initiation, as well as psychiatric, family/social, substance abuse, legal trouble, and motivation to change characteristics assessed in the intake assessment. Males and those suffering from a schizophrenia spectrum diagnosis were less likely to initiate treatment and individuals with current drug dependence (versus recent drug dependence) and a recent arrest were associated with a decreased likelihood to engage in treatment. Positive feelings about family relationships were related to greater odds of engaging in treatment.

Implications
In order for an individual with dual SMI and SUDs to receive stable and effective care, he or she must first initiate and engage in substance abuse treatment. It is important to note that the variables identified as significant predictors of non-engagement were not associated with the SMI diagnosis. (Variables associated with the SMI diagnosis include negative symptoms, positive symptoms, past hospitalization and living independently.) These findings raise the possibility that substance abusers with SMI may be similar to other groups of substance abusers in terms of the factors that promote or inhibit engagement in substance abuse treatment. Incentives such

as assistance with legal problems or housing and homelessness may increase the likelihood that these individuals, in particular males with schizophrenia, initiate and engage in substance abuse treatment. In addition, connecting to supportive family members at the start of treatment may help individuals with SMI engage in substance abuse treatment.

Khoury, L.; Tang, Y., Bradley, B., Cubells, J., Ressler, K. (2010.) Substance use, childhood traumatic experience, and posttraumatic stress disorder in an urban civilian population. Depression and Anxiety, 27(12), 1077-1086.

Summary

This study assessed a sample of 587 primary care patients, predominantly African American, to examine the relationships among childhood trauma, adult trauma, substance use and Post-traumatic Stress Disorder (PTSD) symptoms. Participants completed a battery of self-report assessments and follow-up interviews to measure PTSD symptoms, lifetime and childhood trauma, substance use and depression. The use of alcohol, cocaine and marijuana significantly increased for participants reporting childhood trauma across all types of abuse. More specifically, physical abuse was positively correlated with substance use among all participants and all substances. Childhood sexual abuse, on the other hand, correlated with the use of cocaine and marijuana among women only. Positive associations were found among PTSD symptoms, cocaine and childhood trauma. While childhood trauma correlated with increased alcohol and marijuana use regardless of the presence of adult trauma, childhood trauma did not correlate with cocaine use after controlling for adult trauma. Childhood trauma also influenced the severity of PTSD symptoms independent of adult trauma.

Implications

Current substance users, especially cocaine users, have a higher likelihood of histories of childhood physical, sexual and emotional abuse that may result in the presentation of PTSD symptoms. Careful assessment of individuals who appear to be at higher risk for having experienced childhood trauma may more quickly uncover problematic interrelationships, resulting in more comprehensive and appropriate treatment. Additionally, because women report a higher rate of childhood sexual abuse, which is then linked to cocaine and marijuana use, psychologists may want to routinely include substance use assessment and histories when evaluating women who have reported childhood sexual abuse.

Lash, S., Timko, C., Curran, G., McKay, J., Burden, J. (2011.) Implementation of evidence-based substance use disorder continuing care interventions. Psychology of Addictive Behaviors, 25 (2), 238-251.

Summary

The authors conducted a literature review to better understand whether and why evidence-based interventions (EBIs) are used in continuing care for substance use disorder (SUD) treatment. Factors correlated with successful recovery were also reported. Research revealed that both treatment-based and mutual-help group-based (MHG) continuing care positively correlate with improved treatment outcome. Clients are most successful when continuing care lasts a minimum of 12 months, is accessible and the intervention is matched specifically to meet client needs and current levels of functioning. African-Americans, women and clients with more severe SUDs are more likely to engage and remain in continuing care. Those clients with resources for recovery, spiritual beliefs and little or no experience with 12-step groups also were more likely to engage in continuing care. Accessibility, convenience, and affordability are strong factors in a client's decision to seek further care. Strong therapeutic alliances, support and spirituality are highlighted as key factors for client success in MHGs. A clinician's limited knowledge of the effectiveness of interventions and which EBI options are available can be a major barrier for continuing care. Clinicians better facilitate 12-step MHG involvement if they are less concerned about spirituality in treatment, hold no allegiance to a specific 12-step approach and require abstinence during treatment.

Implications

Further research is needed to develop substance abuse EBIs and understand what best facilitates client success in continuing care treatment. Understanding the factors that are correlated with engaging in care and those that are barriers to care will enable clinicians to tailor care more appropriately for the individual.

Laudet, A. B., & Stanick, V. (2010). Predictors of motivation for abstinence at the end of outpatient substance abuse treatment. Journal of Substance Abuse Treatment, 38(4), 317-327.

Summary

Based on a sample of 250 inner-city poly-substance users, this study endeavored to identify predictors of motivation to remain abstinent at end of treatment (EOT). In a previous assessment of this sample, EOT commitment to abstinence significantly enhanced the odds of sustained abstinence over the subsequent year. Using a number of standardized instruments administered at the EOT, the authors found that four domains contributed over 25 percent of the variance in the outcome. Perceived harm of future drug use, abstinence self-efficacy, quality of life (QOL) satisfaction and the number of 12-step members in one's social network were among the four major predictors of motivation.

Implications

Sustained abstinence is frequently a goal of substance use disorder treatment. In terms of increasing abstinence self-efficacy, clinicians can build on clients' success in resisting temptations to use drugs and on success in other challenging situations. This should enable clients to further develop confidence in their ability to make healthy decisions. Further, as social support from non-using peers becomes known as a key factor in substance abuse recovery, clients may be able to build a support network consisting of those with similar goals of abstinence, as well as those with no substance use.

Puleo, C. M., Conner, B. T., Benjamin, C. L., & Kendall, P. C. (2011). CBT for childhood anxiety and substance use at 7.4-year follow-up: A reassessment controlling for known predictors. Journal of Anxiety Disorders, 25(5), 690-696.

Summary

Many children experience childhood anxiety and evidence suggests that these childhood anxiety disorders frequently precede substance use disorders (SUDs) in adulthood. According to a 7.4 year randomized control study assessing the enduring effects of cognitive behavioral therapy (CBT) for childhood anxiety disorders on future substance use, children who successfully responded to

treatment had reduced substance use and fewer associated problems during follow up compared to children who did not successfully respond to treatment. The present study sought to examine whether other predictors of SUDs and CBT outcomes, not controlled for in the original 7.4 year study, would account for the differences in outcomes among responders and non-responders. The predictors were extracted from previously administered batteries during the initial study and included co-morbid ADHD pathology, perceived negative life events, family history of substance abuse, older child age, additional treatment and severity of internalizing pathology. Despite the significant contributions of these predictors on later drug -use related problems, successful responders to treatment still drank fewer days per month and were less likely to experience aversive interpersonal consequences of their drug use 7.4 years after treatment than participants who retained their principal diagnosis. Of all previously reported associations, only the relationship between unsuccessful treatment and the physical/psychological consequences of drug use were no longer significant.

Implications
Reducing substance related problems in adolescence and young adulthood by successfully treating child anxiety is another benefit of appropriate care. Successful CBT may preclude the use of unhealthy anxiety-management techniques, such as substance use, by providing anxious individuals with alternative adaptive coping skills. Prevention of later substance use problems can occur despite other potential risk factors and targeting non-responders to treatment may lead to the prevention.

Women's Wellbeing

Breast Cancer & Medication Issues

The "Wall Street Journal" placed an article on their site on November 2009:

"Some Antidepressants Cut Tamoxifen's Effectiveness - Study" by Jennifer Corbett Dooren.
The study, led by researchers at Medco Health Solutions, Inc. (MHS), was presented at the annual Meeting of the American Society of Clinical Oncology.

Summary
Clinical Background: Several antidepressants, which are prescribed for depression but also to treat hot flashes that can be caused by tamoxifen, are considered to be so-called CYP2D6 inhibitors. Some antidepressants such as Paxil, Prozac and Zoloft are considered moderate-to-potent CYP2D6 inhibitors while antidepressants like Celexa, Lexapro and Luvox are considered weaker inhibitors. It has been known that "the CYP2D6 inhibitor drugs block the activation of tamoxifen chemically, but this is the first time there's evidence that these drugs are putting women at a much higher risk for recurrent breast cancer," said Robert Epstein, Medco's chief medical officer and one of the study researchers.

The study: 1,300 women, with recent prescriptions of Tamoxifen to treat breast cancer, were subjects between 2003 and 2005 and were monitored for at least two years, with the average time span being 2.7 years.

The Results: Women taking the breast-cancer drug Tamoxifen along with certain antidepressants had more than double the risk of the cancer returning than those taking only Tamoxifen.

Women taking the CYP2D6 inhibitors and Tamoxifen had a breast cancer recurrence rate of 13.9% compared to 7.5% of women taking just Tamoxifen. Researchers then did a separate analysis of women on antidepressants and found those taking Paxil, Prozac or Zoloft had a breast cancer recurrence rate of 16%, or more than double the rate of women on Tamoxifen only. Women taking antidepressants considered to be low CYP2D6 inhibitors like Celexa, Lexapro and Luvox and Tamoxifen had an 8% breast cancer recurrence rate, which researchers said didn't translate into an increased breast cancer recurrence rate.

Contributors to this Issue

Gail Anderson, M.A., LP

Kim Carter, M.A.

Laura Tripet Dodge, M.S., LP

Denise Dworakoski, M.A., LPCC

Kelly O. Finnerty, M.A., LAMFT

Leslie Hong, M.Ed., LPCC, LADC

Ruth Markowitz, M.A., LP, CST

Asha Mukherjee, Ph.D., LP

Lori Ann Wagner, M.A.

Jane Whiteside, Ph.D., LP

Can We Eat to Starve Cancer?

TED Talk: By Mark Frauenfelder at 1:43 pm Tuesday, May 18, 2010.

William Li's TED2010 presentation, "Can we eat to starve cancer?" was impressive. William Li presents a new way to think about treating cancer and other diseases: anti-angiogenesis, preventing the growth of blood vessels that feed a tumor. The crucial first (and best) step: Eating cancer-fighting foods that cut off the supply lines and beat cancer at its own game.

William Li heads the Angiogenesis Foundation, a nonprofit that is re-conceptualizing global disease fighting.

A portion from Li's talk:
"Autopsy studies from people who died in car accidents have shown that about 40 percent of women between the ages of 40 and 50 actually have microscopic cancers in their breasts. About 50 percent of men in their 50s and 60s have microscopic prostate cancers. And virtually 100 percent of us, by the time we reach our 70s, will have microscopic cancers growing in our thyroid. Yet, without a blood supply, most of these cancers will never become dangerous. Dr. Judah Folkman, who was my mentor, and who was the pioneer of the angiogenesis field, once called this "cancer without disease."

So the body's ability to balance angiogenesis, when it's working properly, prevents blood vessels from feeding cancers. And this turns out to be one of our most important defense mechanisms against cancer. In fact, if you actually block angiogenesis and prevent blood vessels from ever reaching cancer cells, tumors simply can't grow up".

Reprinted from http://boingboing.net/2010/05/18/ted-talk-can-we-eat.html

Multicultural Matters

Book Reviews

"The Invisible Bridge"
by Julie Orringer (2010)

This is a historical novel from Hitler's time about a very nice Jewish young man, Andras Le'vi who lived in 1937 Hungary and France. As a dedicated architecture student from a not well-to-do family, his delight in obtaining a scholarship to study architecture in France is accompanied with guilt about the older brother not getting a scholarship and sadness about leaving the younger brother behind feeling abandoned. In France he falls in love with a children's dance teacher, to later discover that she was from his own hometown, Jewish and living under a new name as a French woman! Her history is full of amazing mysteries but their bond survives it. The story continues to reveal wartime separations, meetings and survival of Jewish individuals , families, friends, brothers, parents, wives and fiancées. It shows the shattering of young people's aspirations, dreams, hopes and wishes. The straightforward must learn intrigue for survival. Very commendable is the characters' bravery, noble sacrifices, and adjustments in their times and their world, a very complex reality of their environment and life.

by Asha Mukherjee, Ph.D., LP

"Major Pettigrew's Last Stand"
by Helen Simonson

This book is a traditional as well as modern (all rolled in one) story of a middle- aged, retired major, stereotyped by others in the English countryside and alienated by his modern young son. He is characterized humorously as courtly, wry, inflexible, fond of two things only (his tea and his late father's gift of a treasure, i.e., a polished pair of rare guns!). His values are honor, duty, loyalty and decorum and his plan is to live a quiet asocial life in memories of his deceased wife. However, life would have it another way. He is lifted from his gloom and his depression by the positive and therapeutic contact of a lovely lady from Pakistan, Mrs. Jesmina Ali, and 'chemistry' takes over. "The rest was history" would be an apt description in a personal way but not in the rural social environment. The book illustrates a variety of reactions from the community, as well as sensitivity and depth of feeling in relationships.

by Asha Mukherjee, Ph.D., LP

MWP Welcomes Its New Members

Jenna M. Bemis Ph.D., LP

Terry Campbell

Jenna K. Frantz

Leslie Hong LPCC, LADC

Theresa Jurisch

Christine Larson M.A., M.S.

Cindy K. Lea M.A., MAMFT

Bonnie S McMillin LP

Erin Milkie

Amber J. Pone LICSW

Michelle L. Purtle Psy.D.

Louise I. Quinn M.A., LP

Eva S. Reed Psy.D., LP

Jane T Salem M.A.

Jessica M. Van Berkum

Lori Ann Wagner M.A.

Lisa Tetsugan Zummach MSW, LGSW

Winter Workshops

1) Suicide: Treating the Self Destructive Client:
featuring Lisa Firestone, Ph.D.

Roseville	02/16/12
Bloomington	02/17/12
Live Video Webcast	02/17/12

By Premier Education Solutions: www.pesi.com

2) Compassion Fatigue:
featuring J. Eric Gentry, Ph.D., LMHC

St. Cloud	Monday	02/20/12
Roseville	Tuesday	0/21/12
Bloomington	Wednesday	02/2/12

By Premier Education Solutions: www.pesi.com

3) Children with Emotional & Behavioral Problems:
featuring Steven Olivas, PhD, HSP

Roseville	02/20/2012
Bloomington	02/21/2012

www.pesi.com

4) Minnesota Mental Health and the Law 2012

Roseville	02/24/2012

www.health.ed.com

5) Assessment & management of Pediatric behavioral Sleep Disorders
by Abbott Northwest Hospital's Neuroscience Institute
Pettingill Hall, Allina Commons, Minneapolis 03/16/2012

Mark Your 2012 Calendar

Wednesday, January 11
Executive Committee—7:00-9:00 PM
FFI: Laura—Laura@LauraTripetDodge.com

Saturday, January 14
Private Practice Group—9:00-11:00 AM
Black Bear Coffee House, (upstairs) St. Paul
FFI: Karen—karen@benevolentjourney.com

Wednesday, February 8
Executive/All Committees—7:00-9:00 PM
FFI: Laura—Laura@LauraTripetDodge.com

Saturday, February 11
Private Practice Group—9:00-11:00 AM
Black Bear Coffee House, (upstairs) St. Paul
FFI: Karen—karen@benevolentjourney.com

Tuesday, February 28
Quarterly Growth Series—7:00-9:00 PM
"Kinesthetic Empathy"
Presenter: Barbara Nordstrom-Loeb
Location to be announced
FFI: Ruth—rumark@aol.com

Thursday, March 1
Spring Newsletter Submission Deadline
Email Asha: Dr.Asha.Mukherjee@gmail.com

Saturday, March 10
Private Practice Group—9:00-11:00 AM
Black Bear Coffee House, (upstairs) St. Paul
FFI: Karen—karen@benevolentjourney.com

Saturday, March 10
Social Action Book Group—1:30-3:30 PM
Black Bear Coffee House, (upstairs) St. Paul
FFI: Jane—janewhiteside@earthlink.net

Wednesday, March 14
Executive Committee—7:00-9:00 PM
FFI: Laura—Laura@LauraTripetDodge.com

Editor's Enquiries

Having been an editor for the MWP newsletter for 15 months (five issues) now, I wish to thank you all for your patience. Special thanks are to the Executive Committee Members and many other professional personalities (past chair Dawn Brennan and Ferris Fletcher, PhD, LP, in particular) of MWP for their kind support and help. This is something I had never done before and I am still learning, which brings me to the point that I need help from you all.

It has recently dawned on me that while there has been positive feedback and encouragement, I do not really know what the membership wishes to see in the newsletter. We try to report the organization's activities, any current events, and some professional-information material (in various areas). I have felt that the last couple of newsletter have been more adequate and informing for the MWP membership in doing the above, but this perspective is limited (mine and a few other members). I need to know what you all want from your newsletter.

Here are my BURNING questions.

1. What is not included yet in the newsletter that you would like to see in future?
2. What would you rather not see among the things included?
3. Is there too much or too little in any particular areas that can be adjusted?
4. In your view, what are the ideal size and format of a newsletter?

I would very much like to make efforts to have a newsletter more suitable to your needs. As members of MWP, this is your right. Remember the dues you paid? (only a joke!) Together, let us make the newsletter more suitable in 2012. Happy New Year to all!

Asha Mukherjee, PhD, LP

(Please note: Please reply via email. If you wish to send attachments of your response, please make it in Microsoft Word. Thank you. Happy Holidays!)

Corrections in Technical MWP Information

Please Note

Regular Membership in MWP is available to women who hold either a Master's or doctoral degree in one of the fields of psychology or a related field (e.g. counseling & guidance, marriage & family studies, human services, social work, psychiatric nursing, etc) from a regionally accredited institution or have been licensed in Minnesota in one of the fields of psychology. This includes Psychologists, Social Workers, Marriage & Family Therapists, Licensed Professional Counselors, Licensed Professional Clinical Counselors, School Psychologists and Counselors, and Clinical Nurse Specialists.

Student Membership is available to women in graduate programs in one of the fields of mental health. Student members are able to fully participate, but do not have voting privileges.

Annual dues are based on a sliding scale according to the annual income of the member, currently ranging from $30 to $80 per year. Membership applications are available by calling the MWP office, 612.296.4060 or email at WmPsychlgy@aol.com or on the website at www.mnwomeninpsychology.org.

by Laura Tripet Dodge, M.S., LP

In This Issue . . .

Minnesota Women in Psychology

5244 114th Ave
Clear Lake, MN 55319

Dated Materials: January 1, 2012