San Gabriel Valley Psychological Association

Analyze This!

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The Official Newsletter of the
San Gabriel Valley Psychological Association

www.SGVPA.org AN OFFICIAL CHAPTER OF CALIFORNIA PSYCHOLOGICAL ASSOCIATION September/October 2010

Upcoming Luncheon Meetings

Date: **September 10th, 2010**
Topic: **Good Intentions are Necessary but Insufficient: Essential Affirmative Psychotherapy for Multicultural Lesbian, Gay, and Bisexual Individuals**
Speaker: **Judy Holloway, PhD**

Date: **October 1st, 2010**
Topic: **Wired Teens**
Speaker: **Kaveri Subrahmanyan, PhD**

PLEASE RSVP NO LATER THAN THE FIRST MONDAY OF THE MONTH TO YOUR INTERNET EVITE, OR TO THE SGVPA VOICE MAIL (626)583-3215. CE credits available for psychologists, LCSWs and MFTs

Monthly luncheons are held on the first Friday of the month at the University Club, 175 N. Oakland Avenue, Pasadena, from 12:00 to 1:45 p.m.

Members Costs:
Luncheon, Service, and Parking Privileges...$22
CE credits...$20
Audit...$10

Non-Member Costs
Luncheon, Service, and Parking Privileges...$27
CE credits...$25
Audit...$15

Please note: Unclaimed lunch reservations will be billed to the individual--So please claim them!

PRESIDENT'S MESSAGE

Dear SGVPA Members,

As summer passes and fall descends, our lives and practices will become more active again. SGVPA has some exciting opportunities coming up you don't want to miss.

When I first opened my office years ago, I learned that there was a seasonal aspect to private practice, which helped when I was planning my budget. That was an early lesson, but across our careers, we can all use such tips on how to manage and grow our practices.

- Be sure to seize that opportunity when author and practitioner, Dr. Larry Waldman presents a workshop on the business of psychology, and how to market our practices, on Sept. 25th.
- SGVPA will cohost an APAIT Risk Management Workshop, along with CPA, to be held at the University of LaVerne in either mid-October or November. This will be a great chance to earn all six ethical CE units required for licensure renewal, as well as to reduce your malpractice insurance cost for a two year period.
- The Bylaws Revision Committee has been hard at work, and will be circulating our proposed new bylaws for your review within the next few months.
- At the Sept. 10th luncheon meeting, Dr. Judy Holloway will present on why good intentions are not enough in affirmative therapy with multicultural gay, lesbian and bisexual clients.
- We will soon be signing up members who are interested in mentoring new career professionals.

Please watch the SGVPA Listerv for announcements on all these upcoming events.So to all our board members, who have been working so hard all year long to make these opportunities possible--thank you! I look forward to seeing all of you at the workshops and the monthly lunch meetings!

Linda Tyrrell
SGVPA President

On Trauma Recovery:

Bringing Mindfulness to the Coping Response

By Joseph B. Dilley, PhD
Disaster Response Chair

In well-intended attempts to please, many of my sociable patients tend to automatically grant others' requests so long as they feel physically capable of performing them; conversely, they need to be on the verge of collapse before they say "no" and give themselves permission to rest. One man recently conveyed his relief upon working through the guilt he had experienced when declining others' appeals for his help *before* he reached his physical breaking point. When patients deny, repress, rationalize, or dissociate from the sensory experience alerting them that they are approaching their physical or mental limits, it is fair to say that they are not being *mindful* of their need for self-care.

Analogously, disaster victims often do not fully realize how traumatized they are, and most do not consider themselves in need of mental health support. As explicated by the Department of Health and Human Services, there are several reasons for this, ranging from denial to the collectively sensed surge of optimism that tends to characterize initial response efforts following large-scale disasters. Without an awareness of the depth to which one is impacted, the victim's trauma experience is ultimately exacerbated, despite the short-term adaptive benefits of compartmentalizing and carrying on. Thus, especially for mental health professionals who are regularly subjected to vicarious traumatization through our work with directly impacted individuals, it is essential to practice being mindful of our *own* trauma response. Doing so not only facilitates proper self-care, it ultimately further sensitizes us to the trauma responses of those around us and re-energizes us to continue helping them.

But with evidence that trauma can literally de-activate certain brain regions, and thus that dissociation is not only a psychological but neurobiological reality (see Judith Herman's 1997 edition of *Trauma and Recovery*), how can we hope to be mindful of our own trauma response? Perhaps we must first be mindful of why we tend to be *un*mindful in the first place in responding to trauma.

In his book *A New Species of Trouble: Explorations in Disaster, Trauma, and Community* (1994), Kai Erikson defines trauma as "a blow to the psyche that breaks through one's defenses so suddenly and with such brutal force that one cannot react to it effectively." The compensatory defenses that subsequently kick in are part of what can make our trauma response ineffective. As Dan Siegel explains in 2007's *The Mindful Brain*, the "tension within the mind between what is and what 'should be'…creates stress and leads to suffering." Under this premise, the reason that denial, repression, rationalization, and dissociation do not sufficiently alleviate stress and suffering is because they reduce the tension by dismissing or altering "what is." So it follows that an alternative would be to attend fully to what is, which can be achieved by carefully minding our sensory experience of the present moment. In what I would describe as "mindful coping," the victim is attending to her sensory experience as a barometer of what is—instead of fixating upon how it differs from what "should be"—and *consciously allows* the tension to naturally abate instead of *automatically defending* against it. As a result, pain still exists and may become more salient (given that the victim is no longer numbing to, or detaching from it), but stress and suffering are ameliorated.

Lest the choice to rely on mindful coping itself begin to sound like a Polyannic distortion of what we should expect will actually and "automatically" happen when traumatized, I would submit that attending to one's sensory experience must be practiced *before* any given traumatic event if it is to become a naturally chosen and effective means of coping. Practice can take the form of everything from mindfulness meditation to attending to countertransference during psychotherapy. Like the overcommitted man I alluded to at the beginning of this piece, we are ultimately more helpful to self and other when attending ahead of time to the subtle sensory indicators of our own responses.

To join or to find out more about the DR Committee,
you can reach Joe at (626) 539-2001 or PhDilley@gmail.com

Getting to Know Your Friends and Colleagues in SGVPA

Sheree Bailey, MA

By Suzanne Lake, PsyD

You may recognize Sheree Bailey's name from the bylines of a number of articles in *Analyze This!* in recent months, primarily profiles of members. You may have wondered who she is, so this month, it's Sheree's turn to be profiled.

In fact, although Sheree's current focus is in psychology, Sheree's roots are in journalism, and her journey leading to Southern California, and clinical psychology, is a circuitous and colorful one. Sheree was born in Puerto Rico and lived in Guantanamo Bay, Cuba, during early adolescence. The family eventually settled in Mississippi, where her father retired from the Navy, and became a Southern Baptist minister. Sheree left home to study journalism at the University of Mississippi--known as "Ole Miss."

"I was greatly inspired while at Ole Miss by the many famous writers from Mississippi such as William Faulkner and Eudora Welty," Sheree recalled. "I'm proud of my Southern culture, but I have often experienced the kind of ambivalence toward the region that Faulkner and Welty present very eloquently through their fictional characters."

After college, Sheree moved to New York City for a writing internship with *Folio* magazine. She explained that the boundaries of her worldview exploded outward during this time.

"The food! Culture! Music! Art! Diversity!" she exclaimed. Sheree recalled some of the most memorable moments were being invited to the home of Howell Raines to celebrate his becoming executive editor of the *New York Times,* and seeing *The Seagull* by Chekhov performed in Central Park by a cast of famous actors including Philip Seymour Hoffman, Kevin Kline, and Meryl Streep during the summer series Shakespeare in the Park.

Sheree also met many political activists in New York that led her to think about different ways to use her writing skills. She toyed with the idea of developing public policy in governmental work. When her internship concluded in New York, Sheree craved a "new adventure," so she decided to move to Washington, DC, where she landed a job with the Department of the Navy as a "Budget Analyst," and later, a "Public Affairs Specialist."

"I was earning a great salary, but the job wasn't really a good fit for me," she says. In her spare time, she freelanced as a writer for various publications and volunteered in a Mississippi congressman's office on Capitol Hill. In the midst of the Washington, DC, sniper killing sprees of 2002, Sheree wrote and submitted an article describing the response of native Mississippians living in DC to the shootings. Coincidentally, the piece was set to run the very day that the snipers (John Mohammed and Lee Malvo) were arrested, and thus Sheree's article made page one of the Clarion Ledger. Quite a coup for a budget analyst!

After three years working in civil service for Navy, at age 24, Sheree felt the need for more formal study. Having minored in psychology at Ole Miss, she decided to look into the American School for Professional Psychology in Arlington, Virginia. While there, she met her husband, a forensic computer analyst, at church. As the discoveries of the last four years settled in, Sheree found herself returning to her spiritual roots, in a quest to integrate her broader world view with Christian teachings.

With this in mind, she subsequently decided to apply to graduate programs that offered more opportunity to creatively integrate psychology and spirituality. She found that opportunity though a scholarship to attend Rosemead School of Psychology here in the Southland beginning in 2006.

Sheree now works as a psychological assistant, providing psychological assessment and therapy at two private practices in Torrance and San Pedro. Sheree did mention that she would love for a psychologist in the Pasadena area to hire her as a psychological assistant so she does not have to continue her long commutes to the South Bay area. In addition to this work, Sheree recently completed a One Year Certificate in Psychoanalytic Studies at the Los Angeles Institute and Society of Psychoanalytic Studies. Meanwhile, she has joined SGVPA, and writes frequently for this newsletter!

"I would describe myself as chronically curious," explained Sheree, who reads about a book a week. "I have a wide variety of interests... I constantly desire new information."

Sheree Bailey, MA can be reached at ShereeCBailey@aol.com.

Body and Beauty Image: What Do Women Want?

By Suzanne Lake, PsyD

Why do women want to be beautiful? And why do some--dare I say *most*--suffer and struggle with obsessive misgivings and insecurities about their looks, no matter how realistically attractive they may actually be?

The first question is more easily answered than the second. To be beautiful is to attract attention and admiration. Beauty is glamorous, promotes idealization from others, and gleans special attention. Beauty is powerful--It gives one an edge, and allows one to persuade, influence, even control others. As Nancy Etkoff explained in *Survival of the Prettiest* (2000), beauty conveys survival benefits by attracting sexual mates, protections, and in the 21st century career, *career advancement*. Subjectively, a sense of beauty gives a woman confidence, well-being, and pleasure.

But unlike Winnicott's reassuring concept of the "good enough mother," there seems no pervasive analogue among women in a concept of being "pretty enough." In my office, I have listened to attractive women who have ceased having sex with their partners, feeling "too fat;" who agonize that they are lopsided, too short, have a pimple, a new wrinkle, belly fat, and so on. The upshot of this preoccupation with magnified "flaws" is the melancholy vista of perfectly attractive women who are blocked from enjoying their looks, and the confidence this would inspire, because they are caught up in a kind of *beauty perfectionism* that inhibits them from doing so.

Why are so many women so insecure, and so frightened of accepting that--while not perfectly beautiful--they possess enough beauty to enjoy themselves more? A hypercritical appraisal of one's appearance on the one hand, and a failure to healthily enjoy one's positive beauty attributes on the other, are the poles between which I maintain that many of our patients (and others) suspend themselves.

Certainly, depression is associated with negative impressions of one's physical self. Freud wrote that too much emphasis on beauty reflects pathological narcissism, which he grouped together with masochism and passivity as a peculiarly feminine problem, and conceived of as a defense against shame and worthlessness.

But I do not think that the phenomena I am attempting to describe among women is limited to dysphoria, or pathological narcissism. Rather, it seems to be rather ubiquitous among average women, who are often remarkably resistant to accepting honest compliments about their appearances, and are quick to discount them. I have observed this resistance to positive evaluations in women from 18 to 80, literally, in my clinical work.

Faced with attempts to bring the conviction of their magnified flaws into the clinical arena, they resist. It is almost as if they are more comfortable remaining in the familiar "cage" of self-devaluation than experimenting with the possibility that they may be distorting and deluding themselves.

Certainly, mass culture is replete with perfectionistic, formulaic images of beauty, with which women are pummelled, literally thousands of times a day. The beauty industry eagerly invites women to compare themselves to these quintissential images, inevitably resulting in a sense of personal inferiority and self-deprecation. In *The Beauty Myth* (2002), Naomi Wolf described the systematic indoctrination of women by the media in this fashion, resulting in a "mass neurosis," by which they are "poisoned," and infected with "a deep vein of self-hatred, physical obsessions, terror of aging, and dread of lost control" in millions.

Clinically, it is a delicate business to enter into the patient's private world of self-image, and the offering of realistic, more positive appraisals runs the risk of seeming gratuitous or--worse--seductive. Yet I believe that women's dysphoria around their distorted self-images is such a common and unfortunate state that it cannot go uninterpreted.

It is possible to break through the hypnotic spell of beauty inadequacy, starting by identifying the problem. In *Authentic Happiness* (2002), Martin Seligman considers the attitudes and practices which promote well-being. He urges us to *savor* the pleasureable, positive aspects and experiences in our lives, including not being afraid of honestly acknowledging our accomplishments and attributes. "Don't be afraid of legitimate pride," he exhorts, suggesting that we make an honest self appraisal in all areas of our endeavors, and relish heartily those in which we deserve to take pleasure.

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Misery as Muse:

Creativity and Balancing the Dark Side

By Lisa A. Riley, LMFT

Revealing the dark side of human nature has been one of the primary purposes of art and literature. As Nietzsche puts it, "*We have art so that we will not die of reality."*

Artists have the reputation of openly expressing the dark aspects of human nature--Not only apparent in the anguishes which torment them, but also clearly depicted in their art. For instance, in the well-known painting, *The Scream*, Edvard Munch captures the moment of walking along a path with friends, and being overtaken by a flood of anxiety. Another example can be clearly seen in work from Picasso's infamous Blue Period. During this time Picasso was fueled by his own struggle with poverty, and grief over the sudden suicide of a close friend. For three years, he painted the suffering of beggars, drunks and prostitutes in a color scheme of blues, blacks, and bluish greens.

Whether the artist suffers from depression, anxiety, obsessions or alienation, he or she develops an intimate relationship with primeval emotions. A willingness to dance with aspects of human nature, otherwise suppressed by the average person, enables the artist to access raw material.

In his article, *How Inner Torment Feeds The Creative Spirit* published in the New York Times, Samuel G. Freedman, quotes Dr. Barry M. Panter, an associate professor of psychiatry at the University of Southern California and the director of the annual conference, *Creativity and Madness*:

''The material artists use for their art,'' Dr. Panter said, ''comes from the primitive levels of their inner lives - aggression, sexual fantasy, polymorphous sexuality. What we know about the development of personality is that we all go through these stages and have these primitive drives within us. As we mature and are 'civilized,' we suppress them. But the artist stays in touch with and struggles to understand them. And to remain so in touch with that primitive self is to be on the fine line between sanity and madness.''

Although the dark side may provide a deeper well of meaning for the creative process, does this leave the artist vulnerable to being consumed by such forces? Or could the artist benefit by learning how to harmonize both positive and negative facets of them selves?

In his book *Anger, Madness and the Daimonic, The Psychological Genesis of Violence, Evil and Creativity,* Dr. Stephan Diamond, a clinical and forensic psychologist, introduces what he calls "benevolent possession"--a voluntary choice to invite in the dark forces to serve as a positive and constructive influence in the creative process. He writes:

"The artist allows herself or himself to be swept up in the raging current of primordial images, ideas, intuitions, and emotions emanating from the daimonic; while, at the same time, retaining sufficient conscious control to render this raw energy or prima material into some new creative form...it involves the total person, with the subconscious and unconscious acting in unity with the conscious."

David Richo, a psychotherapist and writer, also understands the importance of befriending all parts of the self. In his book, *Shadow Dance: Liberating the Power & Creativity of Your Dark Side,* he states:

"The challenge is in accepting ourselves all the way to the bottom: admitting and holding rather than denying and eschewing our arrogance, our self-centeredness, our will to coerce others, and any other dark truths we cannot face about ourselves. All these constitute our negative shadow side, which can turn out to be not so much a threat as a promise: we can find the best in us in what is bad in us…acknowledging and accessing the creative powers we have never believed we possessed and have never put to use. This is our darkened positive shadow side."

The courage to access the shadow enables the artist to produce artwork that is deeply moving. By integrating all aspects of the self, artists can keep from being slowly devoured by their sufferings, and in becoming a whole person, lead to a more authentic self-expression. Perhaps, the idea that the artistic personality is necessarily accompanied by misery and madness needs to ne reevaluated.

Lisa A. Riley, LMFT, can be reached at theartofmind@gmail.com

Really Demanding

By Lina Ponder, MA
Student Representative to CPA

"You mean to tell me that your view of therapy is that it is a *real* relationship?" How many times have I myself wrestled with this question, throughout my own doctorate training program, from both the therapeutic chair and couch? Flashbacks of my first semester at Rosemead School of Psychology rushed back to me, of the forty page paper on my view of personhood (a psychologist trainee, newborn, at that point). I attempted to explain some of the dynamics of the transferential relationship in response to my friend's query a few days ago, and the fact that I do bring my genuine self into the therapy room. "So, they're paying to have a friend," he concluded. "No, not quite, mate…"

Being aware, at the beginning of my seminary studies in the Spiritual Formation and Soul Care program, of my desire to become a clinical psychologist, I began to meet with professionals in the field, and was given a strong recommendation to quit seminary and quickly apply to doctorate programs, due to the length of training ahead. I knew that my training to become a Spiritual Director would very much prepare me for my eventual role as a therapist, though, as my seminary program was designed to facilitate deep personal transformation via relationship with self, others and God. What I had signed up for was a journey of deep discovery and integration of *who I am*.

Coming to know who I particularly am has demanded acknowledging my own uniqueness, as well as integrating my personal spirituality with psychology. While my roles and "techniques" as a spiritual director and therapist vary (with spiritual direction placing the facilitating focus on the directee's relationship with God), who I am remains a constant. In both arenas I offer, and help foster, acceptance, compassion, genuineness, growth in relational capacities (relying on knowledge base of object relations, attachment theory and mindfulness), etc. My aim in both these roles is to value the health, growth, and freedom of another human being moving towards "aliveness," and I have discovered that my ability to help guide others in that direction seems to have a heavy dependence on how much it is true of myself.

John Ortberg, a graduate of Fuller's Clinical Psychology program, now a pastor at Menlo Park Presbyterian Church, writes that, "What people take from our church is the hidden curriculum always." The hidden curriculum is the existing internal dynamics that inevitably present themselves in the *implicit*messages through teaching and lifestyle. Ortberg notes the prevalence of the hidden curriculum, and how "it just leaks out of me." Is that not also true of the therapist/client relationship? Carl Jung said that, "…the patient demands all the resources of the doctor's personality and not technical tricks." It certainly is not either personality *or* technique for me, as self and technique are inevitably integrated. Sometimes the techniques have acted as training wheels, while other times the "gut" of my implicit relational knowledge base has been the compass. One or the other may seem to take the lead at varying points, but they never truly leave one another. If my hope for my clients is for the integration of their personhood, does it not follow that I demand the same of myself? And if there is this "hidden" relational interplay in addition to my overt relational therapeutic techniques, is this not a real relationship?

Lina Ponder, MA,is a psychological assistant, and a practicing spiritual director.
She can be reached at linasong@gmail.com, or (408) 396-8079.

WELCOME NEW MEMBERS

Licensed:
Romie Staneslavesky, PhD

Associate:
Carolyn Buckley, MSW
Janet Chunn, MSW

Student:
Rebecca Wriedt, MA

What is a Research Psychoanalyst?

By Anne B. Simpson, PhD

As a candidate at the New Center for Psychoanalysis, and as an English professor, I am on the path to becoming a research psychoanalyst. For members of the mental health community, this title may be mystifying. Sometimes I'm asked, "What *is* a research psychoanalyst?" in tones ranging from the mildly puzzled to the directly challenging. I understand why--and I'd like to try to clear up the confusion.

To begin with a definition: a research psychoanalyst has earned a PhD in a field other than psychology, holds a full-time university position, and chooses to attain a second Ph D, in psychoanalysis. Analytic institutes seek out prospective research analysts because they will contribute complex perspectives from other disciplines, developed through years of research and writing, and thereby enrich analytic thought. For the candidate, the decision to embark on training as a research analyst is a major one; it represents a commitment to a profound, experience-near, engagement.

Like classmates with backgrounds in mental health, the research candidate attends seminars at a psychoanalytic institute to discuss readings dating from the beginnings of psychoanalysis to its latest permutations. Simultaneously, he or she spends the first years of training interning at a mental health clinic, learning the nuts-and-bolts of treating patients and the nuances of therapeutic relationships while also participating in extensive supervision. During my internship, I was in supervision at my clinic as well as outside supervision with two psychoanalysts every week.

The prospective research analyst, like all candidates in training, engages in a personal analysis. This entails hundreds of hours of office visits, not to mention the equivalent of a second mortgage, but the experience is crucial. It enables the candidate to understand, as only personal immersion does, the unique possibilities for growth offered by psychoanalytic treatment.

Programs vary in further requirements for research analysts. Because my institute is affiliated with the American Psychoanalytic Association, our research student applies for a "waiver" from APsaA before beginning analytic work. My waiver request was 130 pages, including in-depth case reports on two clinic patients whom I had seen in intensive therapy and a long essay about the other patients I had treated: adolescents, children, couples, and adults from diverse backgrounds. I submitted an autobiography exploring psychodynamics of my history; samples of my publications; letters of recommendation from three supervisors; and endorsements from New Center faculty. This document was assessed at the national meeting of APsaA. Additionally, like all research psychoanalysts, I was board-certified through the Medical Board of California. Only then, after this rigorous evaluation, was I given the go-ahead to see "control cases."

While the next phase of analytic education duplicates the training of every candidate, a difference is that the research student maintains all usual work commitments at the university, with ongoing teaching, publishing, and administrative responsibilities. During this busy period, she or he becomes involved in the analytic process with three patients, meeting with each for four to five hours per week and conferring with a separate supervisor on each case for fifty meetings or more. It is not unusual to have three control cases, and supervision with three supervisors, all happening concurrently.

Typically, the research student concludes analytic training by composing a PhD thesis that demonstrates critical as well as clinical acumen and should merit publication. Research psychoanalysts have written groundbreaking analytic works. Nancy Chodorow, author of revisionary studies of female development, is also a sociologist. Christopher Bollas, prime mover in object relations theory, is an English professor by background.

Research psychoanalysts continue in their university positions while simultaneously dedicating themselves to those who come to them for help through analytic treatment. The academic choosing to have more than an academic grasp of psychoanalysis learns, above all else, *to be an analyst*. A research psychoanalyst has honed the skill of compassionate listening, achieved the felt understanding of unconscious needs and conflicts, and developed an attuned respect for the vicissitudes of everyday life. A research psychoanalyst has committed to those who seek deeper knowledge of themselves and richer opportunities for choice. Maybe the best way to put it is, simply, this: a research psychoanalyst is someone who embodies, through disciplined and also passionate engagement, a sustained devotion to the enterprise of psychoanalysis.

Anne B. Simpson, PhD has a private practice in Pasadena, where she sees patients in analytic treatment. For further information, contact Dr. Simpson at (626) 375-9733 or annebsimpson@gmail.com.

Addressing the Myth of Motherhood:
Recognition and Treatment of Maternal Mental Illness

By Emily Dossett, MD
Reproductive Psychiatrist

"Postpartum depression" has become a well-known phrase to most Americans in the past few years, but misconceptions and misinformation about this common condition persist. Roughly 15% of new mothers experience depressive or anxious symptoms – including panic attacks or obsessions – during pregnancy, or within the first few months after delivery. However, this is also a time when many women, their husbands and families, and our culture at large believe that women should be the happiest. This "myth of motherhood" prevents many new mothers from seeking the care that they need because of pressure to live up to that myth and the fear of stigma if they don't. The result is unacknowledged, untreated mental illness.

"Perinatal mood and anxiety disorders" – or PMADs, in the latest lingo – is the focus of reproductive psychiatry. Reproductive psychiatry, as a specialty, focuses on pregnant and postpartum women who suffer from unmanageable moods, anxiety, or disordered thoughts. As a reproductive psychiatrist, I am convinced of how vital healthy mothering truly is, and I know most mental health professionals would agree. Nothing is more distressing than a depressed mother, burdened by guilt and shame, unable to even look at her child because of her great sadness. Nothing is more painful than a husband or partner who calls me to say, "My spouse is lost – she hasn't been the same since the baby came, and I can't reach her." And nothing is more frightening than a mother having intrusive thoughts of harming her child, voluntarily or involuntarily, and suffering in silence because she is too terrified to admit these to anyone. I have come to believe that helping mothers such as these become as emotionally healthy as possible is essential, not only to themselves, but to their family, children, and future generations. In other words, "reproductive psychiatry" is the closest thing we have to "preventive psychiatry."

Often by the time a woman arrives at my office door, she has tried multiple other paths to wellness: psychotherapy, exercise, lifestyle changes, and social support. These remain vital elements of her treatment, but unfortunately, for some women, they may not be enough. No pregnant or nursing mother is excited about taking psychotropic medications. Those who need them are desperate for relief and are often in fear for their very lives. In fact, suicide is the second leading cause of death in mothers during their first year postpartum.

One of the biggest dilemmas these women often face is well-intended advice to stop all medications once they are pregnant or nursing. For some women, this is appropriate. For others, it means relapse into depression or substance use, with all the health risks these involve. A woman feels tremendous pressure, both internally and externally, to be a "good mother" – even if that means jeopardizing her own health. The irony is that we have more evidence documenting the negative effects of untreated maternal depression on birth outcomes, early attachment, and child development than on the risks conveyed by most medications.

An essential part of my work is education and support with the expecting or new mother, her family or partner, and her medical team, including obstetricians, pediatricians, and therapists. I see myself as less of a "doctor," and more of a teacher or coach; we review all the pertinent information on medication use versus risk of untreated depression during pregnancy or lactation. Different women may take this same information and make very different choices. Within the bounds of safety, that's fine, and my role is to help each mother make significantly difficult decisions as easily as possible.

The result? Frequently, we have a "happy ending." Pregnancies are uncomplicated, births less traumatic, and new motherhood less of a struggle, though it's not perfect for anyone (and don't believe them if they say it is!). There are medical issues at times, and certainly stress and anxiety around whatever choices regarding mental health care are made, but in general, it's a happy field – one where mothers can push through stigma, shame, and despair in order to promote health and wellness for the next generation.

Emily Dossett, MD can be reached at edossett@gmail.com

Psychology and Family Law

By Mark Baer, Esq.

Historically, a lawyer's role was peacefully resolving disputes, not creating them. In fact, the Anglo-American tradition of lawyering (including litigation) was created as a substitute for trial by battle. A reversal of that role seems to have occurred as a result of a change in the type of individuals entering law school.

It is well documented that since approximately the 1960's, those individuals interested in practicing law do so to pursue wealth and power and not for the historical purpose of addressing social issues and problems or helping others. Research also shows that law students tend to be insecure, uncooperative, insensitive, aloof, immature, asocial, and less concerned about justice than established principles of behavior. They also place too much emphasis on objective reasoning in evaluating resolutions to situations and fail to properly consider the ultimate consequences of their actions. This emotional disconnect deepens as a result of their training in law school.

In 2002, the Section of Litigation of the American Bar Association prepared a report entitled, "Public Perceptions of Lawyers Consumer Research Findings." The findings were as follows: "Americans say that lawyers are greedy, manipulative, and corrupt…. In fact, "the legal profession is among the least reputed institutions in American society…. Lawyers have a reputation for winning at all costs, and for being driven by profit and self-interest, rather than client interest." Lawyers "are believed to manipulate both the system and the truth…. Lawyers' tactics are said to border on the unethical, and even illegal. This idea does not just come from the media. Personal experiences bear it out."

In 2005, a UCLA School of Law Public Law & Legal Theory Research article entitled, "Perception of Lawyers – A Transnational Study of Student Views on the Image of Law and Lawyers" was published in the International Journal of the Legal Profession. According to that article, only 21% of the students at UCLA Law School believed that **lawyers** are trustworthy and ethical. "Students were not told the purpose of the survey until after they had responded..., the questionnaires were anonymous..., and the response rate was extremely high... between 95% and 98%" of the students in the classes.

People who are disturbed by their opinion of attorneys have no interest in joining the profession. Don't become too disheartened because 21% of those incoming law students did believe that lawyers were honest and ethical. Moreover, some of those who believed otherwise may have been idealistic and felt that they would be different as lawyers than those currently in the field. Unfortunately, research shows that such individuals tend to be a small percentage of the student body population of a law school from the outset, drop out of law school at a higher rate than their ruthless counterparts and tend to quickly leave the profession.

According to the 2005 article from UCLA School of Law Public Law & Legal Theory Research, in the United States, "lawyers are among the most distrusted professionals…. In the US a recent Gallup poll reiterated the same dismal results as numerous other surveys: the public image of US lawyers is extremely poor. Lawyers are distrusted more than such normally suspect groups as journalists, politicians, and business executives…. Journalists and politicians are rated as having higher levels of honesty and ethical standards…." It seems that as the public's perception of lawyers' behavior worsens, those individuals who enter the field have an increasing lack of honesty, ethics and integrity.

Be that as it may, the circumstances surrounding my applying to and attending law school were atypical because it was never my intention to practice law. After graduation, career counselors told me that the degree was only useful for the practice of law. I then reluctantly began my career as an attorney, but soon realized that I actually enjoyed the practice of law, was successful in the results I obtained for my clients and that clients appreciated having an attorney who was a healer and not a creator of conflict. In doing the research for and actually writing this article, I have realized that I am an old school attorney. Most other such attorneys I have met during my legal career have also been trained in mediation and other forms of alternative dispute resolution.

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Obsessive Ruminations

In the Room the Women Come and Go, Talking of Michelangelo: Counter-transference and the Termination Process

By Alan Karbelnig, PhD, ABPP

Bolstered by Soren Kirkegaard's lament that "ours is a paltry age because it lacks passion," Dr. Alan Karbelnig writes this regular column to provoke thoughtful reaction from his SGVPA colleagues. He practices psychoanalytic psychotherapy and forensic psychology in South Pasadena.

Perhaps the ebb and flow of relationships, including the therapist-patient relationship, is what TS Eliot meant by these lines in *The Love Song of J. Alfred Prufrock*. Not only women, of course, but all those who consult us naturally come and go. They may leave psychotherapy weeks after beginning the process, or years after, with warning or without, improved or not. Since we cannot help but become intimately involved with our patients, we must exercise caution in managing our feelings as termination approaches.

The termination process in fact elicits any number of intense emotions in us, many of which might be viewed as shameful or unprofessional. Who among us has not felt deeply hurt, even abandoned, by the unexpected decision by a patient to suddenly leave the psychotherapy process? And what of the even darker emotions rarely discussed: Anger at patients' leaving during some crucial phase of the therapy relationship; relief to be away from those we find too frustrating; fear that they may seriously mishandle some aspect of their lives without our help; sadness that we will deeply miss patients that we have come to love; worry that we will suffer financially because of lost income. Because psychotherapy is an intensely personal process—more a structured transformation than a "treatment"—many complex feelings are to be expected during its end.

What then are we to do with such emotions, particularly the ones that strike us most powerfully? We process them as we would any strong counter-transference feeling encountered as part of psychoanalytic psychotherapy. We endeavor to derive the meaning that is beneficial for the patient and then to deliver it via confrontation, interpretation, or empathy.

But perhaps even more importantly, we must be on guard for the likelihood that our feelings as the relationship winds to an end often have more to do with our own psychology. Generally, counter-transference is elicited by a combination of our and our patients' feelings, a manifestation of the so-called two-person model of psychoanalytic psychotherapy. But some counter-transference is more localized in the therapist alone, and terminations are particularly prone to this. This is because therapists find themselves in the more vulnerable role of the party being left; for most of the relationship, patients are in the more vulnerable position.

The best way to proceed when faced with feelings about a termination is to look inside and determine what nerves are being struck within us. Once we have delved into our own psychology, then our attention should turn back to that two-person model. The therapeutic dyad should then mutually explore the meaning of the desire for the termination. Here it is crucial to place most weight on the autonomous functioning of the patient. In my view, we should err on the side of honoring the patient's desire to terminate. But, in consonance with every phase of the work, we also explore the meanings of the decision, which range from an accurate assessment that a piece of therapeutic work is completed to any number of destructive reasons for early termination. Sometimes patients quit in order to avoid encountering a particularly painful aspect of themselves, their relationships, or some other aspect of their lives. Sometimes they leave masochistically, having achieved all the positive gains that they can tolerate. Sometimes they grow tired of exposing and exploring their vulnerability.

Managing the termination phase requires great skill by the therapist: We must identify our own vulnerability; we must actively engage the patient in exploring the possible meanings of their decision; we must allow patients' their autonomy at a time when we may disagree with, and be highly emotionally impacted by, their desire to leave. We are left alone with some of our most intense emotions, ranging from triumph to defeat, from loss to joy, from anger to relief. Having invested heavily in time, love and care for these individuals, we end up alone. Here we should be seeking solace from our connections with our colleagues, our friends, and our family members. Perhaps we should apply the Buddhist ideals of neither clinging nor craving, thereby more freely allowing our patients, in TS Eliot's words, "come and go, talking of Michelangelo."

Dr. Alan Karbelnig can be reached at AMKarbelnig@gmail.com

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Sept 24	Suicide as the wish to die	Assigned psychoanalytic articles
Oct 8	Suicide as the wish to kill	Hamlet
Oct 22	Suicide as the wish to be killed	Hamlet
Nov 5	Aggression and self-destruction	Madame Bovary
Nov 19	Complex emotion and death	Madame Bovary
Dec 3	Suicide in the context of family	Anna Karenina
Dec 17	Love, betrayal, and suicide	Anna Karenina
Jan 14	Politics, culture, and suicide	Anna Karenina
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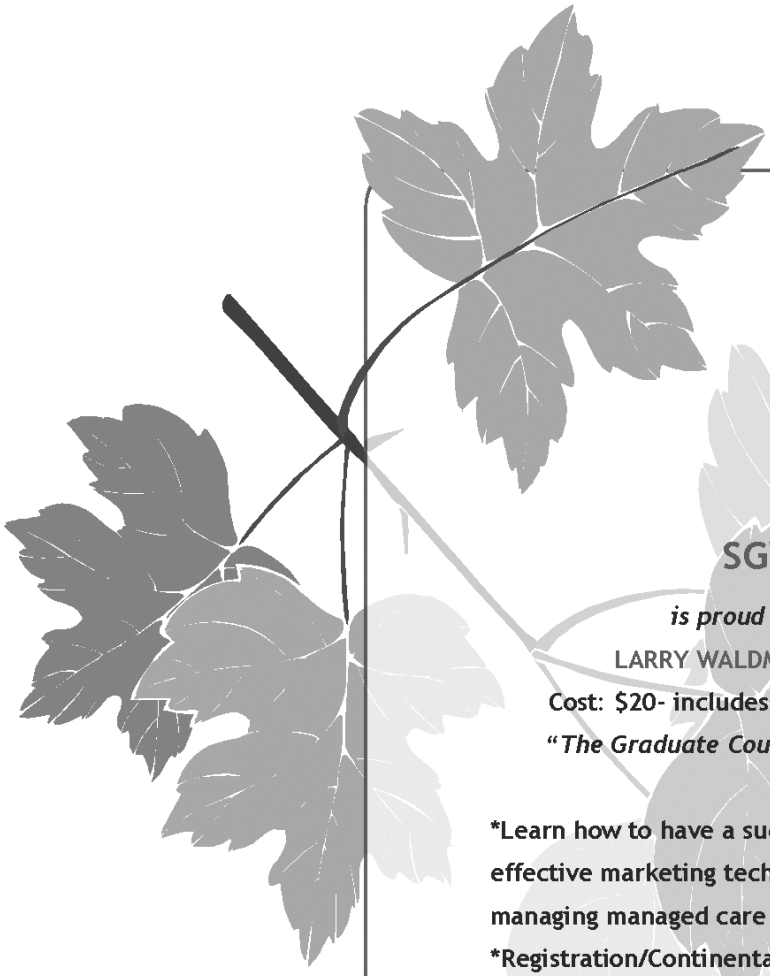

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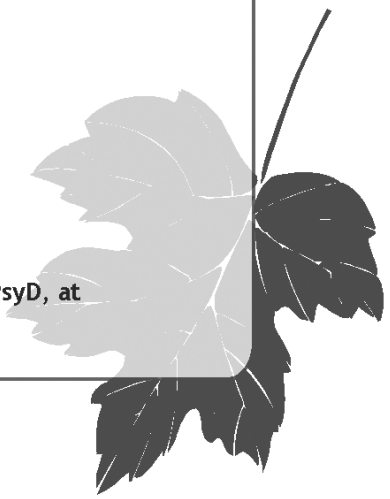

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