

Menninger Perspective

Menninger Perspective is published for Members of Menninger, a non-profit psychiatric center for treatment, research and professional education.

Communications may be sent to:
Menninger
2801 Gessner Drive
PO Box 809045
Houston, Texas 77280
800-288-3950
www.MenningerClinic.com

Copyright 2006
Menninger
(ISSN 0025-9292)

An equal opportunity institution

♻️ Printed on recycled paper.

Illustrations

□ Cover: Sally Swatland, *Early July*.
Courtesy Rehs Galleries, New York.

□ Back cover: Philip Sawyer, *A Rainy Day*, 1940. Courtesy Joyce Kirschner
Fine Arts, New York.

Editor: Roger Verdon

Fine arts consultant:
Steven Diamond, Inc.

□ Unless otherwise noted, patient stories featured in *Perspective* are composites and are used for illustrative purposes only.

Contents

- 2 Coping with depression**
Everyone gets depressed from time to time, but clinical depression can take over a person's life; proper treatment can restore mental health.
- 5 Treating depression: Magnets for the brain**
Depression is often treated through therapy and medication; researchers are probing other methods, including the power of magnets to heal.
- 6 ABCs of mental health through war and life**
During this 80th anniversary year of Menninger's founding, historical reminiscing is appropriate.
- 8 The difference between anxiety and illness**
Anxiety ranges from common daily fears to a full disorder. What's the difference? Using a scenario, an expert shows us.
- 11 Lost and adrift: Jessie, 23**
The director of the Menninger Compas Program for young adults reports on how a team of clinicians treats difficult, long-standing mental and addictive disorders all at once.
- 14 Evaluation, treatment core of new service**
A new assessment for young patients is designed to sort through and address the complexities of illness.
- 15 Defining Menninger**
Our mission, our vision, our values, our motto.
- 16 Endowments support critical work in treatment, research, education**
- 17 We can help**
Charitable giving in your will.
- 18 Glance around**
- 20 Governance**

Coping with depression

By Jon G. Allen, PhD

Everyone gets depressed from time to time, but clinical depression can take over a person's life; proper treatment can restore mental health.

I believe that most of us have the capacity to become depressed in the face of sufficient stress, although we have different levels of stress tolerance. As stress accumulates over a lifetime, the pileup of stress may develop into depression.

Depression is a major health problem worldwide. Depressed persons may not realize that they're ill; if they do recognize it, they may not seek treatment; if they do seek treatment, they may not be diagnosed; if they are diagnosed, they may be under treated; if they are adequately treated, they may not fully respond; and if they do respond, they may experience a recurrence.

Keep this in mind: You are not a statistic. I think the bottom line is this: If you're depressed, you can do something about it.

Taking charge

This brings us to the topic of agency. This is tricky. Agency is the capacity to initiate action for a purpose. To recover from depression, you must take action. Yet depression is an illness that constrains your capacity to take action. I use the concept of catch-22 (from Joseph Heller's book): *All the things you must do to recover from depression are made difficult by the symptoms of depression.*



Jon G. Allen, PhD

Nonetheless, despite some level of illness, you have some remaining agency, some elbowroom. For example, although you have low energy, you still have some energy, and you must use this energy as leverage to get more. In addition, you have some elbowroom in your ability to seek help from others.

Taking agency for the illness is most obvious in relation to recovery: you can learn that you can do something—many things, in fact—to become less depressed.

The challenge is to accept responsibility for the sake of empowerment, not self-blame. The venerable serenity prayer captures the challenge: grant me the serenity to accept the things I cannot change, the courage to change things I can, and the wisdom to tell the difference.

Origins of depression

A large majority of depressed persons experience one or more severe adverse life events prior to the onset of depression. Such life events include losses, such as the death of a loved one, and failures, such as an unsuccessful business venture.

Depression also can be brought on by chronic difficulties, such as severe marital conflicts or serious problems with children. Feeling let down by someone you count on can be a depressing stressor. Because of its extreme nature, traumatic stress is a common precipitant of depression. The subjective experience of stressful events—their meaning—also plays a significant role in depression. When you feel humiliated or trapped, you're especially vulnerable to depression.

Underlying factors

The majority of persons who suffer an episode of major depression have experienced one or more major stressors in the period prior to depression; yet only a minority of persons exposed to stress respond with major depression. Hence we must understand the nature of vulnerability to depression in the face of stress.

Biological factors contribute to this vulnerability; these factors include not only genetic makeup but a history of prior stress, potentially beginning prenatally. Personality factors, such as feelings of inadequacy and low self-esteem also contribute to vulnerability.

A history of childhood maltreat-

Depression

ment is a significant risk factor for adult depression, because it contributes to biological and personality vulnerability as well as a greater likelihood of entering into subsequent stressful relationships. Thus we can view depressive episodes in adulthood as a culmination of a developmental cascade.

Not only do stressful life events and difficulties contribute to the onset of depression but also ongoing stress can prolong the duration of the episode and interfere with response to treatment. Stress also plays a significant role in recurrences of depression.

You'll benefit from identifying anything you're doing that contributes to the stress you experience. Examples include:

- taking on too many responsibilities
- abusing drugs or alcohol
- neglecting your health
- entering into unsupportive relationships
- behaving in ways that contribute to conflict in relationships and
- failing to seek support from others when you need it

Internal stress

In addition to experiencing stressful events in your life, you can create stress in your own mind; thus it's important to take account of the role of your internal world as well as the outer world. Of course, your internal world has the most pervasive influence. We can consider internal stress in the category of self-generated stress. Although I wouldn't want to convey that internal stress is easy to control, you can exert some influence over it; you have some leverage.

Guilt feelings and shame are additional internal stressors that contribute to depression. Although guilt and shame overlap, guilt feelings stem from harm you believe you have done to others whereas shame reflects a pervasive feeling of defectiveness, a sense that your core self is bad. Shame

plays a major role in self-critical depression, and perfectionism contributes powerfully to shame. Unfortunately, guilt and shame tend to promote withdrawal and isolation, which also contribute to depression. To overcome guilt and shame, you will need to go against the grain. You will need to talk about these feelings with someone you trust who can help you see yourself in a more objective and compassionate way.

Overall health

Mental and physical health are thoroughly intertwined, both being linked to stress. One point cannot be overemphasized: your physical health plays a central role in improving your resilience to stress and depression.

You can't force yourself to sleep, and you can't force yourself to feel pleasure, but you can force yourself to be more active: sit up in bed, get out of bed, walk out of your bedroom, and on from there.

Recovery entails small steps—the only way around catch-22. Eventually you can work your way up to exercise, which has been demonstrated to be a good antidepressant and a cornerstone of a healthy lifestyle that can become a foundation of wellness.

Step by step

You can't force pleasure, but you can make an effort to engage in activities that might provide an opportunity for pleasure.

Behavioral treatment for depression involves making a project of scheduling potentially pleasant, satisfying and fulfilling events. You might also make a project of paying attention to positive experiences, being mindful of them rather than letting them slip by without notice.

As you recover, your capacity for pleasure will increase; then you can make a point of enhancing positive experiences further.

Ruminating about problems and failings—going over and over the same

thoughts—is a good example of digging yourself deeper into the hole. Persons who ruminate have the illusion of gaining insight into their problems but, in reality, they're making themselves more depressed.

Hope

Hope is the foundation of recovery from depression. Thinking clearly about hope might help you cultivate it. When you feel hopeless, you're likely to need the support of others who can encourage you and help you see solutions that might not occur to you. You might need to rely on *borrowed hope*—hope that others who are not seeing the world through the lens of depression are able to hold out for you.

Don't give up; imagine the unimaginable.

Dr. Allen is senior staff psychologist at The Menninger Clinic, Helen Malsin Palley Chair in Mental Health Research and professor of psychiatry in the Menninger Department of Psychiatry & Behavioral Sciences at the Baylor College of Medicine. This material was adapted from Dr. Allen's new book, *Coping with Depression, From Catch-22 to Hope*, released December 2005 and available from American Psychiatric Publishing, Inc., www.appi.org.

More articles are available at www.MenningerClinic.com, Resources page.

Treating depression: Magnets for the brain

Depression is often treated through therapy and medication; researchers are probing other methods, including the power of magnets to heal.

Depression in all of its forms can affect 9.5 percent of the population, or about 18.8 million American adults in any 12-month period. The recommended treatment for severe depression, according to the National Institute of Mental Health, is a combination of cognitive-behavior therapy and medication. But for people who don't respond to these conventional treatments, scientists continue looking for alternatives, which includes the use of non-invasive, pain-free magnets.

Researchers with the Menninger Department of Psychiatry & Behavioral Sciences, Baylor College of Medicine, constitute one of 16 test sites inside and outside the U.S. involved in testing the viability of a hand-held device that produces transcranial magnetic stimulation, or TMS. The device is being used to treat depression in Canada and Israel and early studies show promise. Data collection is completed and researchers are waiting on the results of further analysis.

In an effort to affect the nerve cells that control mood, the technique sends short, stimulating magnetic pulses through the skull to the brain.

Test participants included individuals who have suffered chronic depression for many years and have found

no effective remedies. For them, the device holds out hope for a major life change by controlling a debilitating condition.

Depression may lead to alcohol or drug abuse, heart ailments and suicide. Short of death, it is quite clear that severe, chronic depression causes extreme consequences that may include divorce, loss of employment, loss of friends and family and a diminished lifestyle. While many people receive effective treatment through conventional methods that allow them to escape depressive disorders, other individuals continue to search for answers.

Double-blind test

One TMS test participant in California told a newspaper she became involved in the testing because, "I'm thinking about what I want to do with my life instead of just waiting to die, which is primarily what I had been feeling for years."

Since the trial is a double-blind study, neither test subjects nor researchers knew if they were using the actual device in their sessions. Such a test protocol allows researchers to compare outcomes directly between placebo, or simulated procedures, against valid ones.

The magnet procedure is painless and non-invasive and takes under 40 minutes per session. Test participants say the treatment feels like someone is tapping on their head. Preliminary treatments called for two weekly

procedures with initial results expected after two weeks.

The TMS device works like a mini magnetic resonance imaging (MRI) scan and activates the left prefrontal cortex of the brain, where mood is believed to be controlled. When the magnet hits the exact spot needed for treatment, pulses of energy create an electric field that is intended to restart brain functions that have become lethargic over time.

Much as a low car battery can be revived with a jolt of energy, the magnet reinvigorates nerve cells, which affects brain circuitry and creates new brain chemicals, including serotonin, a neurotransmitter that plays a key role in affecting mood.

The result is that circuits begin firing again as they were designed to function. The improved efficiency of the brain, theoretically, reduces or diminishes depressive symptoms and causes positive mood changes, according to Lauren Marangell, MD, and James M. Martinez, MD, with the Menninger Department of Psychiatry & Behavioral Sciences, Baylor College of Medicine, two of the researchers involved in the study.

The energy delivered to the brain is small and focused and is performed without anesthesia.

This is not the first instance that medical science has exploited the power of magnets to enhance the healing process. Past studies have successfully involved using magnets to treat pain in post-polio patients. Most

people in that study cut the amount of pain in half after magnet therapy.

Pilot studies show promise

Pilot studies of TMS have reported improvement from major depression, mania, posttraumatic stress disorder (PTSD), Parkinson's disease and obsessive compulsive disorder. Major depression has been the most extensively studied of these illnesses, primarily because substantial scientific evidence suggests that the left prefrontal cortex becomes less active during clinical depression and because the prefrontal cortex is easily accessible to TMS stimulation.

The trial's sponsor, Neuronetics,

Inc., is a medical device company that is focused on developing therapies for psychiatric and neurological disorders by using the energy in magnetic fields.

Once completed, the study's results will be provided to the U.S. Food and Drug Administration (FDA) to support regulatory clearance of Neuronetics TMS System for use in treating depression.

In addition to the TMS trials, some of the other research at the Menninger Department of Psychiatry & Behavioral Sciences, Baylor College of Medicine, includes:

- bipolar disorders and cognition
- lithium vs. lamictal in bipolar type II depression

psychological and medical impact of genetic testing for breast and ovarian cancer

randomized double-blind placebo-controlled trial to evaluate the efficacy of Sertraline for menopausal symptoms in women with breast cancer

later-life mania

causes and consequences of aggressive behavior in patients with dementia

treating late-life generalized anxiety disorder in primary care

a cognitive behavioral intervention for depression and anxiety

molecular and cellular biology of chronic alcohol exposure

ABCs of mental health through war and life



Editor's note: During this 80th anniversary year of Menninger's founding, historical reminiscing is appropriate. After service as Chief Consultant in Neuropsychiatry to the Surgeon General, U.S. Army, Menninger co-founder William C. Menninger, MD, wrote about the challenges and the lessons of observing and treating soldiers during WWII. The excerpts below are from Dr. Menninger's two-volume collection of selected papers and from his 1948 book, *Psychiatry in a Troubled World: Yesterday's War and Today's Challenge*. Despite having been published more than 50 years ago, the book remains recommended reading by The National Center for Posttraumatic Stress Disorder (PTSD), which was created within the Department of Veterans Affairs in 1989 in response to a Congressional mandate to address the needs of veterans with military-related PTSD.

There was not a soldier in the Army who was not familiar with and understood the significance of NP, the abbreviation for neuropsychiatric or neuropsychiatry. Along with slang usage of "psycho," it was the abbreviated label applied to men who had emotional difficulties sufficient to cause them to drop out of combat or to go to the mental hygiene clinic or to be sent to the psychiatric service or section of hospitals. Perhaps these casualties became such common knowledge because almost every



William C. Menninger, MD, who rose to the rank of Brigadier General, a first for a psychiatrist.

soldier and officer in the Army was aware of the stress and the strain on his own personality. It was not hard for them to identify with and thus easily understand similar, though more acute distress, in a comrade. Tragic as it was that so many men became psychiatric casualties, there was an intangible benefit in the common knowledge about them. It forced the recognition of the fact that at different times the personality varies in its ability to resist stress, and that different personalities react differently to the same stress. Therefore, the still-integrated person did not

feel he was doomed to crack up and the disintegrated personality gained support from the fact that others had difficulty. Both could find courage to seek increased ability to resist stress.

A kind of "operational fatigue" occurs in civilian life just as it did in the Army. The mere recognition of its existence places us in a more intelligent position to deal with it. An orientation to the fact that it can and does occur in varying degrees in all of us at various times removes in large measure the stigma that for so long was attached to ...illness. For the first time laymen have seemed to learn that the way men feel and think, love and hate, has an effect on their functional efficiency.

For the first time we can hope for the cooperative understanding of millions of people in coming to grips with America's major health problem—mental health.

What is mental health? By far the most comprehensive, accurate, yet simple definition that I know is given in *The Human Mind* (written by brother Karl Menninger, MD):

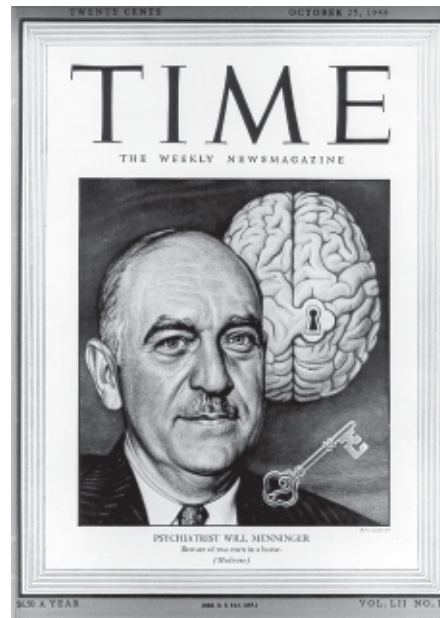
"Mental health is an adjustment of human beings to the world and to each other with a maximum of effectiveness and happiness. Not just efficiency, or just contentment—or the grace of obeying the rules of the game cheerfully. It is all of these together. It is the ability to maintain an even temper, an alert intelligence, socially considered behavior, and a happy disposition. This, I think, is a healthy mind."

Most of us do not reach that ideal. Our minds vary in their healthiness. The hope is that we will find the ways whereby to make ourselves more happy, more efficient, and more able to follow the rules of the game. It has been (my purpose) to set forth some of the ways and means of achieving that end as we saw them operate in the lives of soldiers. We know that they have equal validity and application to all people in civilian life.

In my attempt to present the emotional reactions created by the war I have had in mind the everyday problems facing you and me and our attempts to adjust our attitudes and our living to meet them. Every one of us has felt keenly, in some way or other, emotional stress related to the war effort.

We must expect more pressure, which will demand greater readjustments for each of us. I have attempted to point out some of the casual factors, which as a practicing psychiatrist, I have seen disturb the morale of the individual. Believing that these, at least in principle, are applicable to the masses, I have attempted to apply them to the war situation: the increased environmental demands for which an individual feels there is no solution; the threat to one's security; the results of a lack of information and the damaging effect of misinformation; the threatened or real loss of an object of special emotional value; the belief that one is being misunderstood or mistreated or unfairly treated; and the misdirection of our emotional feelings, particularly our hostile feelings.

Even more important than understanding the possible causes of demoralization, and often applicable even when we do not understand the causes, are the treatment methods. It has been my desire to present these in terms that are familiar to the layman, even though I have taken them from psychiatric experience with the treatment of individuals. They might be regarded as the ABC's for the maintenance of morale, the mainte-



By 1948, Dr. Will's work was being widely noticed and *TIME* magazine featured him on its cover.

nance of one's individual well-being, and in wartime they are particularly desirable for adoption by every individual.

□ First, we should consider our physical health, the avoidance of fatigue, the need for physical endurance, adequate rest.

□ Second, we need to develop confidence, to spread confidence, and to be motivated wholly by the will-to-fight and the will-to-win. We need to understand what we are doing, what our individual part is; we can profit-

ably give special thoughts to what we mean by "democratic ideals and practices," with sufficient self-analysis to discover our own undemocratic methods... We need to maintain our social relationships, to intensify them and make them more valuable to us.

□ And finally, and most important, those of us who are parents have a major job in maintaining the morale of our children.

It is perhaps one of the most common psychiatric findings that maladjustment in children occurs because the parents expect them to be miniature adults. In considering our reactions to war, we should be keenly aware of our influence upon our children. They have far fewer inner resources and less experience to call on than we adults.

...I wish one might always know how to explain things to them, how much we should explain to them. I wish we knew how we could best allay their fears and anxieties; but we do have a genuine guiding principle gained from child psychiatry—that we should attempt to explain to them all that they can understand, and certainly we should answer all their questions in as forthright and honest a manner as we can. Most important is the example we set.



Years after the war, Dr. Will's advice to President John F. Kennedy influenced the establishment of community mental health centers across the nation.

The difference between anxiety and illness

Anxiety ranges from common daily fears to a full disorder. What's the difference? Using the following scenario, an expert shows us.

On the day she was scheduled for a job interview, Pat was overcome with extreme worry. The notion of going to the interview was difficult enough, but the prospect of facing interstate traffic unsettled her to such an extent she felt numb. Her extreme feelings were new to her and her emotions were worrisome.

She was 35, had done well in her career and considered herself a successful, well-adjusted person. But here she was, frozen in fright. What was she going to do? Without an interview, there was no hope for a new job, a position she desperately wanted.

She had slept less than usual in the week leading up to the interview. She was eating little and drinking large doses of coffee. Now, she sat in her driveway feeling helpless. She felt close to tears.

The clock on the dashboard showed she had plenty of time to get downtown. But 10 minutes passed. And then 20. She knew with any traffic delays at all she would be late, not a good showing if she hoped to have a successful job interview.

Her mind raced. She was filled with doubts. Why was she even trying for another job? Even with all of her skills and years of experience, she was suddenly convinced she wouldn't get the job. And even if she did get on the



Thröstur Björgvinsson, PhD

highway, she was scared her car would break down, she would get lost or she would get into an accident. She felt frozen, sitting in her car parked in the driveway.

What was Pat to do? Was her anxiety a sign of real illness or simply common fear, a feeling anyone might have from time to time?

Anxiety issues

"In Pat's case, thus far in your scenario, she may just be reacting in the extreme to circumstances that might make any one of us anxious," said Thröstur Björgvinsson, PhD, director of the Obsessive-Compulsive Disorder (OCD) Treatment Program. Dr. Björgvinsson is an international expert who specializes in applying evidence-based treatment for anxiety

disorders.

"What she eventually did next would determine whether she (or her potential therapist) should be concerned or not that her behavior is a warning sign of deeper problems that might interfere with her daily life.

"It is important, however, to emphasize that generalized anxiety disorder (GAD) is a real illness,"

As program director for the OCD Treatment Program, Dr. Björgvinsson oversees the implementation of cognitive behavioral therapy for adolescents and adults with a range of severe anxiety disorders, including generalized anxiety disorder, obsessive-compulsive disorder, social phobia, specific phobia, panic disorder with or without agoraphobia, and posttraumatic stress disorder.

Along with specific diagnostic criteria for each type of anxiety disorder, clinicians determine whether an individual's anxiety requires clinical intervention based on how much distress the individual's symptoms are causing and the level of interference in daily functioning the person is experiencing.

The diagnostic criteria that mental health professionals use to determine whether a level of anxiety requires clinical intervention would include some of the following examples:

- Excessive anxiety and worry (apprehensive expectation) occurring more days than not for at least six months, about a number of events or activities (such as work or school

performance).

The person finds it difficult to control the worry.

The anxiety and worry are associated with three (or more) of the following six symptoms with at least some symptoms present for more days than not for the past six months:

- restlessness or feeling keyed up or on edge
- being easily fatigued
- difficulty concentrating or mind going blank
- irritability
- muscle tension
- sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep)

Some anxiety can be beneficial

What is the difference between common anxiety and something more pathological?

“Everybody experiences anxiety,” Dr. Björgvinsson said. “A healthy dose of anxiety helps your ability to perform. If you go into an interview a little anxious, but prepared and rested, you can hit the *on* button and be completely on. In that circumstance, anxiety enhances performance.”

Dr. Björgvinsson described anxiety as a normal human behavior, not only in modern times, but since humans first appeared on the planet. When confronted with the presence of a danger from a predator, for instance, human behavior reverts to a “fight or flight” mode, in which a normal physiological arousal (or stress response) takes place that enables humans to react in a way that assures survival. Anxiety in this instance may enhance survivability. Anticipating any risk or danger naturally raises a sense of nervousness.

Defining illness

The distinction between a normal reaction and behavior that indicates a disorder depends on the intensity of the emotional arousal, how long the feelings last, and whether anxieties

limit or disable activities and interfere with everyday performance of daily functions like family and social life, work or school.

Generalized anxiety disorder (GAD) (a mixture of frequent, excessive worry and physical symptoms of anxiety) is far different from an anxiety that can be described as intermittent or nervousness that surfaces during a difficult life experience.

An anxiety can cover many behaviors, from a momentary fearful feeling to phobias that restrict interaction with activities like driving or flying.

Nervousness before a plane trip is considered fairly normal. Having a panic attack, which might be accompanied by heart palpitations, and distress that incapacitates an individual, is considered irregular behavior and would likely benefit from effective, evidence-based cognitive behavioral therapy interventions.

Back to Pat—dealing with anxiety

In the event that Pat was dealing with common anxiety, what might she be able to do for herself?

Dr. Björgvinsson recommends that Pat separate her fears and identify her exact worries. What is worrying her? What is her fear? The drive or the interview? Or is a lack of self-esteem also an issue? Compartmentalizing her fears is one step.

According to Dr. Björgvinsson, Pat might benefit from breathing retraining, a technique to increase her awareness of her breathing as she attempts to calm herself and gain control over the situation. Relaxed breathing can help in two ways: by slowing her breathing rate and inducing the body’s relaxation response and by focusing her thoughts on a healthy coping tool (rather than on her worries).

Also, Pat will likely be less anxious if she tries to “stay in the moment,” that is, concentrate on the task at hand and what is important, rather than the possibility of future failure.

The priority for Pat is to “do the

behavior first.” So rather than concentrate on potential failings or the long drive or the job interview, she must put first things first—the behavior. Turn the key and leave the driveway.

“She needs to focus on what she can control,” Dr. Björgvinsson said.

Given the facts of the scenario, Dr. Björgvinsson said, Pat also needs to reduce her ruminating, a fairly common practice that surrounds persons coping with anxiety on any level.

“People have a notion that worry provides safety, Dr. Björgvinsson said. “In that sense ruminating might keep a person sane when they use rumination as a safety mechanism, but it’s the first thing Pat should give up. In fact, when it comes to rumination, one worry generally leads to another and another. What we say in therapy is that when you’re in a hole and digging and you want to get out of a hole, the first thing you have to do is stop digging.”

On the road

Luckily, Pat’s emotions were momentary. While she was feeling desperate for a new job, she eventually realized that there were other jobs available in the event this opportunity fell through.

She understood that she should have gotten more sleep in the week before her interview, and she could have done with far less coffee. She might have also gotten her car tuned up, something she had been thinking about for some time. All of these actions might have diminished her subsequent anxiety.

Although she was still nervous about the trip and the interview, she successfully reframed her thoughts and was able to finally get out of the driveway and onto the road. She used the trip to prepare answers to potential questions.

By the time she arrived downtown, she had gotten a second wind of

confidence. She was less anxious.

Heading for the elevator, Pat concentrated on the task at hand. She felt prepared for her interview. She also determined that if the same level of anxiety ever returned, she would seek advice from an expert in ways to manage anxiety.

“It is not abnormal to worry about things which threaten our safety or our ideals or our plans. It is because of this capacity to see ahead, to anticipate certain dangers and to avoid them, that man has achieved what he has. In this sense, worry is one of the earmarks of civilization.”

—Karl Menninger, MD, *The Human Mind*, 1930

If you have anxiety

If anxiety is dominating your life, there are many treatments available. If fears constantly overwhelm your mind, you might consider speaking with your personal physician or with a mental health professional.

Whatever you choose to do, inaction is not a remedy. The better course is to be good to yourself, your family and your friends, and follow Dr. William Menninger’s advice to seek “relative freedom from symptoms that are produced by tensions and anxieties,” one premise from *The Criteria of Emotional Maturity*, which captures Dr. Will’s guide to a healthy emotional life.

A different look at Pat’s anxiety

Dr. Björgvinsson said he would be concerned if Pat (see the scenario in the previous article) remained in her car looking at the clock every two minutes to check the time until nightfall.

He would also be concerned if she continued to worry about driving because of “what ifs”—what if she ran into someone while driving?—and she continued to ruminate over similar scenarios.

Ruminating is common among individuals with anxiety disorders, and specifically among individuals coping with obsessive-compulsive disorder (OCD), which ordinarily is treated at Menninger through cognitive behavioral therapy (CBT).

The National Institute of Mental Health reports that OCD affects about 3.3 million adult Americans.

The disorder is ranked among the world’s 10 most disabling medical conditions by the World Health Organization.

OCD is generally characterized by irrational, recurrent or unwanted thoughts (obsessions) and an urge to relieve the distress by some joyless and excessive activity (compulsion).

Constant checking is a typical compulsive behavior, whereby an OCD sufferer repeatedly returns home to check if the stove is on or whether the bathtub is running, despite having already checked innumerable times. The compulsive behavior is driven by the fear and anxiety caused by the obsessions; this is true even when the person realizes the obsession is senseless.

A patient with OCD may suffer intrusive violent, sexual or religious images. The disorder also may involve compulsions, usually behaviors (or even mental rituals such as

prayers or list making) aimed at reducing the fear or the anxiety triggered by the intrusions.

Sometimes the patient spends hours washing his or her hands due to fear of contamination (germs), or being plagued by unfounded fears or irrational anxieties in anticipation of pending personal danger or danger to others.

The key treatment element of effective CBT for OCD is exposure and response prevention. This is a type of behavior therapy that asks patients to expose themselves gradually to the feared items or situations without engaging in any subsequent rituals or compulsive behaviors; what happens is that patients become less anxious about the feared situation over time.

Both the patient and the clinician work as colleagues in a series of steps to help the patient confront his or her fears without doing the typical compulsive behaviors; this eventually changes the thought patterns and behaviors of the patient.

Exposure and response treatment targets the patient’s personal anxiety. Therapist and patient collaborate on creating a hierarchy of exposures that will be done.

Individuals fearful of germs, for instance, might touch things they fear are contaminated with germs starting with items that are moderately anxiety-arousing and working up to touching items that cause severe anxiety.

Imagine fearing death from germs only to learn that you are still alive 30 minutes after such an exposure?

Anxiety and fear of catastrophic consequences diminish.

Patients are also instructed on response prevention, which is resisting and stopping the compulsion such as washing their hands. Disciplining themselves against these responses, patients soon learn the consequences are less dire than they feared.

Eventually, some OCD-like behaviors may remain, though the levels of anxiety lessen to a degree that no longer interfere with daily life, as they once did.

Lost and adrift: Jessie, 23

By April Stein, PhD

The director of the Menninger Compas Program for young adults reports on how a team of clinicians treats difficult, long-standing mental and addictive disorders all at once.

Jessie, a 23-year-old with a long history of psychiatric problems and addictions, was referred to Menninger's Compas Program for young adults as "a last chance." She had been in more than six psychiatric treatment facilities since age 12 and had been in and out of therapy, in her words, "for as long as I can remember."

She described having no idea about what had happened to her life. Her parents reported feeling "lost and out of control" and fed up with years of acting out.

Adolescence, early adult years

Around age 12, Jessie began to revolt by dressing wildly, piercing parts of her body and neglecting schoolwork. Additionally, she began using drugs and drinking, reporting she had "done enough Ecstasy and crystal meth to screw up my brain forever."

None of the psychiatric rehabilitation programs Jessie was sent to between ages 14 and 23, helped for long and both patient and parents came to Menninger as the last resort. No one in the family could clearly identify the problem or trust one another.

Compas Program

The Compas Program is designed to serve young adults, ages 18 to 30,



April Stein, PhD

who are having difficulty making the transition from adolescence to adulthood. The program is designed for these transitional adults who struggle with a range of psychiatric disorders that may include:

- mood disorders (depression, bipolar disorder)
- anger
- personality disorders (borderline, narcissism)
- adult attention deficit disorder (ADD)
- adjustment disorder
- self-harm behavior or past suicide attempts or thoughts
- self-esteem issues

Patients may also suffer from dual disorders such as drug or alcohol addiction in addition to a psychiatric issue.

Treatment addresses the specific needs of young adults. Patients in the program learn how they can function more effectively in their community, in their family and for themselves.

The team's approach

It is with Jessie's history and Menninger's core treatment principles in mind that the team began to formulate an individualized treatment plan for Jessie and her family.

Jessie was admitted with a dual diagnosis involving dependence on multiple drugs and bipolar disorder, a condition in which a person's mood cycles from a manic high to a depressive low. She came to Menninger during a depressive cycle.

However, it quickly became apparent she struggled with significant character issues, suggesting borderline personality disorder, an unpredictable and difficult-to-treat condition. Her relationships were also in crisis and she had so alienated family and friends that she felt quite isolated and alone.

The family

It was the Compas team's belief that without family work and addressing the quality of her relationships with family members, that the patient had little chance of breaking her cycle of self-destructiveness. Members of the treatment team noted that difficulties in Jessie's family life pervaded all facets of her life. Jessie had not reached developmental milestones in

the same way other adolescents do, and in her rebellion she had missed what clinicians call a typical separation-individuation, that is, leaving the nest with a distinct sense of self. In effect, the team saw the patient as having never successfully developed a sense of identity and that she needed a firmer sense of her family foundation so that she had something to individuate from.

Because of differing family values and each member's response to these differences, the patient was unable to feel safe enough to emancipate or leave them while maintaining an individual identity. Instead, Jessie acted out her hostility toward family members while at the same time showing them her profound dependence.

Her struggles with her family affected her other relationships. She believed that she couldn't trust anyone to hear her (particularly adults), and these difficulties had led her to use illicit drugs in order to self-medicate an increasingly paralyzing sense of depression, helplessness and hopelessness.

Over time, substance abuse ceased to be purely self-medicating and became a serious problem in its own right. In turn, solving problems by acting out and abusing substances led to stunted personal development. Jessie had failed to learn mentalizing skills, the sense we have of ourselves and others, the ability to understand how we are according to how we see ourselves perceived and other adaptive psychosocial capacities. In effect, Jessie, and her parents, began to view her as a damaged and broken child with no future and no way to help herself.

The team approach

By using a team approach, Compas clinicians helped the patient and her family explore and understand these negative frames of reference in the context of her personal, medical and mental history. Although the team's medical director adjusted Jessie's medication, the treatment was focused

on what was going wrong in all aspects of her life.

Team members approached Jessie's chemical dependency issues by entering her in dual diagnosis groups and providing her with an addiction counselor whom she met with twice weekly. Jessie also attended daily 12-step meetings.

Additionally, the team prescribed groups specific to her developmental issues. The groups emphasized the learning of coping, affect regulation, or how the quality of her relationships affect her ability to cope, and distress tolerance skills. She also participated in dialectical behavior therapy training to help her recognize the relationship between her thoughts and actions.

Also, Jessie was referred to individual and family therapy, both with the intention of helping the patient and her family develop a greater sense of self and self-confidence in confronting illness, while at the same time promoting mentalizing.

Moving forward

At Menninger, treatment teams work within the program to identify the primary issues that the patient struggles with in daily life. Issues are explored as a means by which a patient's behavior and biopsychosocial system can be understood. Since the patient was experiencing most of her problems in her family system, it was expected (by therapist and patient alike) that the most intense feelings would be felt in family therapy—where the problems were being confronted. It was also expected that the team, as a microcosm of the patient's family and world, would play out and experience similar problems.

Compas staff members observed that in Jessie's relationships on the unit, she mimicked other relationships in her life, specifically her relationship with her parents.

Team members discussed how they saw Jessie, and explored the intensity of their reactions and feelings toward her and her family. In the process, they shared a piece of Jessie's com-

partmentalized history.

By using themselves as measures of the patient's and parents' experiences, they were able to help the patient and her family identify and speak to the issues that had led to the patient's treatment. In family therapy and in visits to their daughter in the Compas program, family members felt and saw firsthand the effects of their behaviors and interactions both in themselves and on others.

A giving community

The community of patients and staff serves as not only a microcosm of the real world, but also as a transitional space in which patients show the team the problems that brought them to Menninger (and work on dealing with them), but also practice having real supportive connections to people rather than substances.

Most dual diagnosis patients struggle to feel part of the world, having missed out on real life and real relationships. In Compas, this struggle is allowed to come to the fore. The team provides a setting where real life problems around relationships, self-worth and life development can be identified and managed.

The Compas Program helps patients through modeling of direct and honest communications, acceptance of conflict and a comfort level in dealing with conflicts. Once that is accomplished, members of the treatment team can model and help the patient develop a capacity for reflective functions, form psychological mindedness to mentalization and, in that process, develop more of a sense of agency or personal confidence in coping with mental illness.

In such a manner, the patient develops a better understanding of himself or herself in relationship to others and also of the internal/unconscious dynamics that influence those relationships.

Postscript: Jessie's recovery has progressed since she returned home. She is sober and attends school. She is

involved in a long-term relationship, and she keeps in touch with her mother. All indications point to her continuation on a positive, ever improving path.

April Stein, PhD, is director of the Compas Program for young adults. She is an assistant professor at the Menninger Department of Psychiatry & Behavioral Sciences, Baylor College of Medicine, and has been on staff at Menninger since 1993. She is a graduate of the Karl Menninger School of Psychiatry & Mental Health Sciences, where she was awarded the David Rapaport Award for Excellence in Teaching.

Evaluation, treatment core of new service

A new assessment for young patients is designed to sort through and address the complexities of illness.

Young patients and their families who come to The Menninger Clinic are usually clear about their aims. Frequently, despite having attempted treatment in an assortment of venues, they have not yet attained proper recovery. They seek out Menninger with specific aims and make a commitment to treatment.

For others, things are not so clear. Perhaps a patient has received several differing diagnoses, none of which has responded to previous treatment. Both patient and family remain confused and frustrated, yet they are reluctant to make a commitment to treatment without more clarity. In order to help those patients, Menninger has designed an assessment service, a second opinion, if you will.

Called the Adolescent Treatment Program's Inpatient Evaluation & Brief Treatment, this diagnostic service provides a family with specific treatment and community support recommendations for their adolescent.

During the three weeks, the adolescent and their family receive:

- a comprehensive understanding of the patient and contributors to the complex or recurring problems
- brief treatment to address current distress experienced by the adolescent and family
- a plan for continued treatment that is supported by the patient, family and

treatment providers

- support and education
- expansion of communication and healthy collaboration
- recommendations for follow-up and consultation
- renewed hope

Why consider this service?

An inpatient evaluation suits adolescents who are not making the desired progress in other treatment settings, are seeking a second opinion or are experiencing little relief from medication or interventions.

The Adolescent Treatment Program offers this evaluation process based on years of success with a structured and systematic approach to assessment utilizing the combined expertise of the team members during a focused, brief hospital stay. This process leads to a greater understanding of the difficult-to-treat disorders and complications that are of concern to the family and adolescent as well as the factors affecting progress in treatment.

Staff have found that the intensive work over three weeks presents the opportunity for engagement and collaboration between the adolescent, family and team. Inclusion of active treatment during the diagnostic process is aimed at reducing symptoms and gaining knowledge about what works and what doesn't. The team brings together these findings with what is gained from talking with prior treaters, the patient and the

family to complete the comprehensive diagnostic picture and develop treatment recommendations.

Evaluation steps

To begin the process, the patient is admitted to The Menninger Clinic's Adolescent Treatment Program for three weeks. The parents or guardians are encouraged to stay for the first two days to:

- meet with the various evaluation team members, providing information about the patient and family's experience
- establish common goals
- review the three-week schedule and communication of progress

Senior staff members on the evaluation team represent various clinical perspectives. Members include a psychologist as the team leader, child psychiatrist, social worker, internist, activity therapist, chemical dependency and addictions specialist, nurses and mental health counselors.

Additional Menninger clinicians join the team to address the patient's specific issues such as eating disorders, obsessive-compulsive disorders, anxiety, educational problems and learning disabilities.

The patient's physical symptoms and diagnoses, past and present, are assessed. The team also looks for whether the teen may be vulnerable to certain disorders because of inherited characteristics or illnesses.



Menninger®

Defining Menninger

Our mission

Menninger is the international psychiatric center of excellence, restoring hope to each person through innovative programs in treatment, research and education.

Our vision

Menninger will be the world leader in psychiatric treatment, research and education.

Our values

- Excellence—The best people doing their best work
- Teamwork—Accountable to each other to do our best
- Hope—Inspiring people to reach their potential
- Integrity—Doing the right thing
- Caring—Respect and compassion for self and others

Our motto

Discovering hope, one life at a time.

Endowments support critical work in treatment, research, education

Chairs in The Menninger Department of Psychiatry & Behavioral Sciences at Baylor College of Medicine are funded through generous donations from Menninger supporters.

The Chairs are established to support the Menninger mission which includes psychiatric treatment, education and research. Often the work of the outstanding individuals named to Chairs touches on all three aspects of the mission. Menninger Chairs are acknowledged leaders in their disciplines. Here are four of them.

□ **Jon Allen, PhD, Helen Malsin Palley Chair in Mental Health Research**

One of the foremost trauma experts in his field, Dr. Allen is professor of psychology in the Menninger Department of Psychiatry & Behavioral Sciences at Baylor College of Medicine and senior staff psychologist at The Menninger Clinic.

He is a prolific writer in the field of trauma and related problems, depression, psychotherapy, hospital treatment, the therapeutic alliance, psychological testing, neuropsychology and emotion.

The Palley Chair was established in 1983 through the Malsin Foundation, which first began supporting Menninger in 1952, by Mrs. Palley of New York, whose family owned Lane Bryant Inc., the women's clothing chain.

□ **Efrain Bleiberg, MD, Alicia Townsend Friedman Chair in Psychiatry and Developmental Pathology**
Dr. Bleiberg is vice chair, Child and Adolescent Services, Menninger Department of Psychiatry & Behavioral Sciences at Baylor College of Medicine and medical director for the Professionals in Crisis Program at The



Allen



Bleiberg



Lomax



Munich

Menninger Clinic. He is nationally recognized as a leader in child and adolescent psychiatry. He also oversees Menninger research.

The Friedman Chair was established by Alicia Townsend Friedman and her husband, William, a Chicago attorney and businessman. Among other ventures, his firm was involved in the merger of Chicago's famous "elevated" train systems with surface lines and was a part of a group that once purchased the Empire State Building. He was a Menninger Trustee.

□ **James Lomax, MD, Karl Menninger Chair for Psychiatric Education**

Dr. Lomax is professor and associate chairman in the Menninger Department of Psychiatry & Behavioral Sciences, Baylor College of Medicine, and director of educational programs.

His clinical work involves psychotherapeutic and psychoanalytic treatment of individuals with anxiety, mood and personality disorders, as well as those with certain reactive disorders, such as complicated grief.

His work as a faculty member of the Institute for Religion and Health explores the interface of psychiatry, religion and spirituality. The Menninger Chair was established through gifts that honor the late Karl Menninger, co-founder of Menninger.

A legendary figure in the field of psychiatry, Dr. Karl was a visionary whose efforts over a lifetime contributed to improved care and treatment of people suffering mental illness. His clear and concise writing helped general readers better understand the complexities of human behavior. He is often called the Dean of American Psychiatry.

□ **Richard Munich, MD, Bessie Walker Callaway Distinguished Professor of Psychiatry and Education**

Dr. Munich is vice president and chief of staff at The Menninger Clinic; professor and vice chairman at the Menninger Department of Psychiatry & Behavioral Sciences at Baylor College of Medicine. Dr. Munich, a noted analyst who is widely published in the fields of severe mental illness and hospital psychiatry, oversees all clinical matters related to The Menninger Clinic.

The Callaway professorship was established by the late Menninger Trustee Ely Callaway in memory of his sister, who suffered from depression prior to her death in Georgia in 1954. The late Mr. Callaway, of Carlsbad, California, was a Menninger Trustee. He was chairman of Callaway Golf Company, which he founded in 1982.

We can help

Charitable giving in your will

When you plan for the distribution of your estate, you may consider making charitable gifts as part of that distribution. We share with you the following ideas to help you more effectively plan your charitable giving.

- Make sure that pledges you have made during your lifetime will be completed through your will. A simple paragraph in your will can guarantee that your gift will be completed.
- Consider giving a percentage of your estate rather than a fixed dollar amount. Since you have no assurance of what the value of your estate will be at death, percentage distributions will adjust as the value of your estate increases or decreases.
- Combine income support to family members with your charitable gifts. Family members who are dependent upon you for support in their older age may not want management responsibility of additional property. You can make a gift to a charitable organiza-

tion and the organization will pay annual income to named individuals for their lifetimes. This provides an ideal way to care for those who are dependent upon you for income and your charitable interests.

- Many parents of adult children like to “give it twice.” Property is placed in trust after death. The trust pays income to family members until they receive the total value of the estate. Then, the trust terminates and the remainder is distributed to charity.
- A satisfying gift can be created by giving the percentage of the estate that would have been inherited by a predeceased child to establish a memorial fund.

There are many other charitable giving concepts you might consider. Some individuals distribute 100 percent of their estates to charitable work; others split their estates equally between charitable and personal beneficiaries. Some families have considered a charitable organization

equal to their three children and distributed 25 percent of their estate to each.

Whatever your situation, we present these ideas for your thoughtful consideration.

Conclusion

It is important to have an up-to-date will.

We trust that these ideas have encouraged you as you review your existing will. Or if you do not have a will, we trust that this information may help motivate you to have one drafted. And we want to help. We have prepared a special *Guide to Planning Your Estate*, designed especially to help you review or plan your will or a more complete estate plan, as appropriate. It is our gift to you, and there is no cost or obligation. Please take time now to write or call for your free copy. We look forward to hearing from you.

Please send me a free *Guide to Planning Your Estate*. I understand that there is no obligation. For additional information on estate tax and business planning, please indicate if:

- Your estate is over \$1 million You own your own business.
(Appropriate information will be included.)

Name _____

Address _____

City _____

State _____

Zip _____

Home phone _____

Work phone _____

E-mail _____

Date of birth _____

Spouse's date of birth _____

- I have remembered Menninger in my estate plan.

Menninger Development, PO Box 809045, Houston, TX 77280-9045 Phone: 800-288-3950

Glance around

National symposium spotlights advancements in BPD

Mental health professionals, consumers and families across the country assembled in Houston for a one-day continuing education symposium focusing on borderline personality disorder (BPD) March 4.

Co-sponsored by Menninger, morning sessions highlighted the scientific advancements in understanding BPD, including developmental issues, neuroimaging and neurobiology. Afternoon presenters focused on the similarities and differences in contemporary treatment methods, including family perspectives. Presenters included national experts plus consumers and family panelists. An interactive panel luncheon discussion and concluding professional dialogue enriched the second-annual symposium.

Menninger sponsored the symposium along with Baylor College of Medicine, NAMI Metropolitan Houston and the National Education Alliance for Borderline Personality Disorder.

Menninger Trustee honored as an icon of American entertainment

Longtime Menninger Trustee David Brown received the inaugural Muybridge Award for outstanding contributions to entertainment from Stanford University, Mr. Brown's alma mater. He received the award along with friend, business partner and



In search of safer schools, doctor visits Jamaica classrooms

Stuart Twemlow, MD, above, visited Jamaica Oct. 28-Nov. 2, 2006, to organize a research project designed to increase mentalizing in schools by promoting Internet exchanges between U.S. and Jamaican school children. Several Houston and Massachusetts schools were invited to participate. Dr. Twemlow, medical director of the Menninger Hope treatment program, is no stranger to Jamaica. As an expert in community violence, he consulted with the prime minister of Jamaica on problems of peace and violence and completed a successful project to reduce violence and improve the quality of life in a mid-sized community there. He has also advised the FBI



on threat assessment and school violence. He has consulted with several cities on workplace climate, school climate and threat assessment, and has mediated disputes for cities. Dr. Twemlow is one of the principal architects behind Menninger's Peaceful Schools Program, which encourages more stable, safer and productive classroom environments.

fellow Stanford alum Richard D. Zanuck. Mr. Brown, a Menninger Trustee since 1992, is a Hollywood icon, having produced such movies as *Jaws*, *Patton*, *The Sting*, as well as *A Few Good Men*, *Driving Miss Daisy*, *Chocolat* and *Along Came a Spider*.

The New York resident has also been involved with television and Broadway productions and has penned several best selling books, including the critically acclaimed *Brown's Guide to Growing Gray*, *Let Me Entertain You* and *The Rest of Your Life is the Best of Your Life*. He's also an occasional contributor to *The New Yorker*. The Muybridge Award is named for Eadweard Muybridge, the photographer who, with Leland Stanford, created the first true motion picture.

Before meeting his wife, Helen Gurley Brown, he was managing editor of *Cosmopolitan*, the magazine she edited for 32 years. Mrs. Brown is now editor-in-chief of *Cosmopolitan's* 40 International editions.

Menninger saddened by death of eating disorders program director

Carolyn Cochrane, PhD, RN, CS, who directed Menninger's Eating Disorders Program, died unexpectedly in late January. Initial reports indicate she suffered a heart attack.

Dr. Cochrane joined The Menninger Clinic in 2003 and was integral in the transfer of the nationally prominent program during the relocation of The Clinic from Topeka to Houston the same year.

Dr. Cochrane was a national expert on eating disorders and served in a number of prestigious leadership positions, including as a board member with the National Task Force for the American Psychiatric Nurses Association. In addition to earning numerous recognitions during her career, Dr. Cochrane published many papers on eating disorders and presented at prestigious universities and conferences in the U.S. and abroad.



Cochrane



Hoover

Artwork activity healthy in wake of natural disaster

A Menninger psychologist praised efforts to use artwork as a way to help children in the aftermath of a disaster, like hurricane Katrina. In a report in *The Washington Post* and elsewhere in the nation via Associated Press (AP), Daniel Hoover, PhD, a child psychologist with The Menninger Clinic and a Menninger graduate, told the AP that art therapy was a useful way for young survivors of natural disaster to express their emotions. "Many times, children are less likely to say things in words but will express things through art or play," he said.

Dr. Hoover was commenting on a public display of drawings in Houston, most of them created in crayon and magic marker, by young survivors of hurricane Katrina. The images in the drawings portrayed the terrible damage to people and property, but also contained glimmers of hope, as well. For mental health professionals volunteering to help hurricane victims, the artwork served as a way to initiate conversations and to begin therapeutic interventions aimed at diminishing the effects of trauma through improved coping skills.

Longtime board member dies

David S. Kruidenier, a Life Trustee of the Menninger Board and a retired publisher of *The Des Moines Register*, died in January. He was 84. Mr. Kruidenier was a third generation member of the Cowles family that came to Des Moines in 1903 to enter

the newspaper business. The family later expanded its newspaper holdings to Minneapolis, and one branch of the family left Des Moines to operate the newspapers there. In time, the family holdings expanded to newspaper, magazine and broadcast interests throughout the nation. Mr. Kruidenier was involved in Menninger since 1952 when he met co-founders Drs. Karl and Will Menninger. The visit encouraged a lifelong interest in mental health and human behavior.

Menninger at upcoming national conferences

Menninger representatives will be present at various conferences in the near future including, the Psychotherapy Networker Conference concerning *The Creative Leap: Practice & Imagination in the Process of Change* in Washington, DC, and the Anxiety Disorders Association of America's Annual Conference in Miami, Florida, both in March. In April, Menninger representatives will appear at the Houston Group Psychotherapy Society's Annual Institutes to speak about trauma and mentalizing.

Menninger professionals publish paper on bullying behaviors

Stuart Twemlow, MD, and Peter Fonagy, PhD, and others, published a paper on bullies in the prestigious *International Journal of Social Psychiatry*. The paper, which appears in the March issue, is titled, "Teachers who bully students: a hidden trauma."

Dr. Twemlow is director of the Menninger Hope Program and Dr. Fonagy is director of the Menninger Child & Family Program.

Governance

Directors, Menninger-Baylor College of Medicine-Methodist Hospital Foundation Board



Hill A. Feinberg,
Dallas, TX,
chair

Daniel C. Arnold, Houston, TX
John F. Bookout Jr., Houston, TX
Marc Boom, MD, Houston, TX
Philip J. Burguières, Houston, TX
John E. Hagale, Houston, TX
Howard M. Koff, Malibu, CA
Harvey Kurzweil, New York, NY
John McKelvey, Leawood, KS
Corbin J. Robertson Jr., Houston, TX
Norman C. Schultz, San Francisco, CA
Peter G. Traber, MD, Houston, TX

Directors, The Menninger Clinic Board



John McKelvey,
Leawood, KS,
chair

Marc Boom, MD, Houston, TX
Wayne H. Holtzman, PhD, Austin, TX
Roy Menninger, MD, Topeka, KS
Robert Michels, MD, New York, NY
Ann Scanlon McGinity, PhD, RN, Houston, TX
Robert C. Wilson III, Houston, TX
Stuart Yudofsky, MD, Houston, TX

Board of Visitors Menninger-Baylor College of Medicine-Methodist Hospital Foundation



Philip J. Burguières,
Houston, TX,
chair



John A. Fibiger,
Moultonboro, NH,
vice chair



Maureen Hackett,
Houston, TX,
executive director

Alan Abramson, Malibu, CA
Morrie & Rolaine Abramson, Houston, TX
Joan & Stanford J. Alexander, Houston, TX
Bolivar C. Andrews, Houston, TX
Daniel C. Arnold, Houston, TX
Mr. & Mrs. John Beckworth, Houston, TX
Ben Bergeron, Houston, TX
Alberta B. Blecke, Miami, FL
Ralph Bodine, Houston, TX
Marc Boom, MD, Houston, TX
John F. Bookout Jr., Houston, TX
Beppy & Alfred Deaton III, Houston, TX
Michael E. DeBakey, MD, Houston, TX
Janie & Dick DeGuerin, Houston, TX
John C. Dicus, Topeka, KS
Leonard J. Duhl, MD, Berkeley, CA
Eliza & John Duncan, Houston, TX
Ruth Edelman, Chicago, IL
Hill A. Feinberg, Dallas, TX
Barbara Fibiger, Moultonboro, NH
Jerry & Nanette Finger, Houston, TX
Marvy A. Finger, Houston, TX
Archbishop Joseph Fiorenza, Houston, TX
Francy Fondren, Houston, TX
Mr. & Mrs. Walter Fondren III, Houston, TX

Howard R. Fricke, Topeka, KS
Dr. & Mrs. Jerry R. Grammer, Austin, TX
John E. Hagale, Houston, TX
Donald W. Hammersley, MD, Bethesda, MD
Kitty Carlisle Hart, New York, NY
Dr. & Mrs. Wayne Holtzman, Austin, TX
Dr. Robert R. Ivany, Houston, TX
Mrs. Robert Jenney, Houston, TX
Craig Johnson, PhD, Tulsa, OK
Mr. & Mrs. Raleigh W. Johnson Jr., Houston, TX
Melvyn N. Klein, Corpus Christi, TX
Howard M. Koff, Malibu, CA
Mr. & Mrs. Ronald Krist, Kemah, TX
Harvey Kurzweil, New York, NY
Charles A. LeMaistre, MD, San Antonio, TX
Gary Levering, Houston, TX
Diana T. MacArthur, Santa Fe, NM
Mr. & Mrs. William K. McGee Jr., Houston, TX
Ann Scanlon McGinity, PhD, RN, Houston, TX
Sandra McHenry, Houston, TX
Mr. & Mrs. Jim McIngvale, Houston, TX
John McKelvey, Kansas City, MO
Roy W. Menninger, MD, Topeka, KS

W. Walter Menninger, MD, Topeka, KS
Robert Michels, MD, New York, NY
Mr. & Mrs. Walter M. Mischer Jr., Houston, TX
Christine & Shea Morenz, Houston, TX
The Honorable Sheila Murphy, Chicago, IL
John P. Murray, PhD, Manhattan, KS
Dr. Carol C. Nadelson, Brookline, MA
Maconda B. O'Connor, PhD, Houston, TX
Staman Ogilvie, Houston, TX
John M. O'Quinn, Houston, TX
Brad Raffle, Houston, TX
Michael O. Rich, MD/MPH, Boston, MA
Rev. Dr. Douglas Richnow, Houston, TX
Barbara & Corbin J. Robertson Jr., Houston, TX
George R. Schrader, Dallas, TX
Lynn Schroth, DrPH, Houston, TX
Norman C. Schultz, San Francisco, CA
Marc J. Shapiro, Houston, TX
Susan Silver, Montclair, NJ
Stephanie Sale Singleton, College Station, TX
Michael Solar, Houston, TX
Mitchell Taylor, Bay Harbor, FL
Shirley & David Toomin, Houston, TX
Peter G. Traber, MD, Houston, TX
Ann G. Trammell and
C. Eugene Carlton, MD, Houston, TX
Mr. & Mrs. Donald H. Tranin, Kansas City, MO
James Weaver, Houston, TX
Ty Whitcomb, Houston, TX
Joseph L. White, PhD, Los Angeles, CA
Sue T. Whitfield, Houston, TX
Robert C. Wilson III, Houston, TX
Marie & Bill Wise, Houston, TX
Roberta & Jean M. Worsham, Houston, TX
Drs. Stuart & Beth Yudofsky, Houston, TX

Trustees, The Menninger Foundation, Topeka, KS



W. Walter
Menninger, MD,
Topeka, KS,
chair



Roy W.
Menninger, MD,
Topeka, KS,
chair emeritus

Alan Abramson, Malibu, CA
 *Sue Anschutz-Rodgers, Denver, CO
 *John B. Bean, Naples, FL
 Alberta B. Blecke, Miami, FL
 David Brown, New York, NY
 *I.B. Chapman II, Ft. Worth, TX
 Jacqueline H. Clapp, Georgetown, Kentucky
 Constance E. Clayton, EDD,
 Philadelphia, PA
 Thomas R. Clevenger, Wichita, KS
 John B. Coleman, New York, NY
 Harry W. Craig Jr., Topeka, KS
 Jean Deacy, Mission, KS
 John C. Dicus, Topeka, KS
 Takeo Doi, MD, Tokyo, Japan
 Hugh M. Downs, Paradise Valley, AZ
 Leonard J. Duhl, MD, Berkeley, CA
 Joseph T. English, MD, Bronxville, NY
 Timothy N. Etzel, Topeka, KS
 Rosemary Hall Evans, Sugar Hill, NH
 Hill A. Feinberg, Dallas, TX
 Saul Feldman, DPA, San Francisco, CA
 John A. Fibiger, Moultonboro, NH
 Howard R. Fricke, Topeka, KS
 Booth Gardner, Seattle, WA
 Julia M. Gottesman, Sierra Madre, CA
 Benjamin Griffin, DMin,
 Newton Centre, MA
 George Gund III, San Francisco, CA

Donald W. Hammersley, MD, Bethesda, MD
 Kitty Carlisle Hart, New York, NY
 John E. Hayes Jr., Belleair Shore, FL
 Wayne H. Holtzman, PhD, Austin, TX
 Lucy Rosenberry Jones, Wayzata, MN
 Otto Kernberg, MD, White Plains, NY
 Howard M. Koff, Malibu, CA
 Alan M. Kraft, MD, Albany, NY
 *Geraldine Kunstader, New York, NY
 Harvey Kurzweil, New York, NY
 Richard A. LeBlond II, New York, NY
 †Charles A. LeMaistre, MD,
 San Antonio, TX
 Diana T. MacArthur, Santa Fe, NM
 Cathleen Dodson Macauley, Lake
 Lotawana, MO
 Karl Malden, Los Angeles, CA
 John McKelvey, Leawood, KS
 Karl A. Menninger II, Columbia, MO
 Philip B. Menninger, Topeka, KS
 Robert G. Menninger, MD, Topeka, KS
 Roy W. Menninger, MD, Topeka, KS
 W. Walter Menninger, MD, Topeka, KS
 Mildred Mitchell-Bateman, MD,
 Charleston, WV
 John P. Murray, PhD, Manhattan, KS
 Carol C. Nadelson, MD, Boston, MA
 Richard D. O'Connor, Bloomfield Hills, MI
 Ethel Spector Person, MD, New York, NY
 Andrea L. Pozez, MD, Richmond, VA

Louis Pozez, Tucson, AZ
 Mrs. Paul Putman, Charleston, SC
 *Rex R. Reed, Kiawah Island, SC
 Stewart A. Resnick, Los Angeles, CA
 *Alan W. Rolley, Santa Fe, NM
 Paula Dozier Rome, Rochester, MN
 Charles W. Rosenberry II, Vashon, WA
 Melvin Sabshin, MD, District of Columbia
 David Samuel, PhD, Rehovot, Israel
 Charles A. Sanders, MD, Durham, NC
 Charles I. Schneider, Beverley, Hills
 George R. Schrader, Dallas, TX
 Norman C. Schultz, San Francisco, CA
 Laura Macdonell Seeley, Fort Collins, CO
 †Irving Sheffel, Topeka, KS
 Dolph C. Simons Jr., Lawrence, KS
 *Mrs. Sarah-Maud J. Sivertsen, St. Paul, MN
 *Benson R. Snyder, MD, Cambridge, MA
 Mrs. Lyle M. Spencer, Palm Springs, CA
 Stanley H. Stauffer, Topeka, KS
 *Deborah Szekely, San Diego, CA
 Donald H. Tranin, Kansas City, MO
 William E. Wall, Seattle, WA
 *Robert S. Wallerstein, MD,
 Belvidere, CA
 Joseph L. White, PhD, Irvine, CA

*Life Trustee
 †Honorary Trustee