

Menninger Perspective

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

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Menninger
(ISSN 0025-9292)

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☐ Cover: David Aylsworth, *Pungent Perfume*, 2000. Courtesy of the artist and Inman Gallery, Houston.

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Editor: Roger Verdon

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The j-word: When a word is an attitude

By Jon Allen, PhD,
and Richard Munich, MD

Our choice of language can be more harmful than helpful to a person struggling with a mental disorder.

To the depressed person:

- Just think positively.
- Just go out and have some fun.
- Just get more exercise.
- Just stop wallowing in your misery.

To the traumatized person:

- Just put the past behind you.
- Just move on.
- Just get over it.

Most notoriously, to the addict:

- Just say no to drugs.

In summary, just say no to psychiatric disorders. And, while you're at it, just change your brain chemistry.

Used by others, the j-word can be annoying or worse—a fighting word.

But how much do you use it on yourself?

- I just need to relax.
- I just need to control my temper.
- I just need to be more assertive.
- I just need to say no.
- I just need to stop trying to be perfect.
- I just need to be more affectionate toward my wife.

All these admonishments might be valid. But “just” is a *minimizing* word: it minimizes a difficulty or a feeling, making it that much harder to understand clearly the extent of the problem one must address. It minimizes by implying that all these



Allen



Munich

changes are made easily.

The depressed person just needs to stop thinking so negatively—as if this change could be made by a single act of will. Any time you hear the j-word, ask: How? Just relax. How? Just put the past behind you. How? Just forgive. How? Just stop thinking negatively. How?

Of course the depressed person can learn to think more flexibly and reasonably. But this learning process may take many months of hard work with the help of an expert cognitive therapist. The seriously depressed person might also need the help of antidepressant medication to do this hard work of changing thought patterns. And the person whose depression is embedded in emotional and interpersonal conflicts might need the help of extended psychotherapy to make these changes.

We have become so accustomed to hearing the j-word that we say it automatically and unconsciously. We need to pay attention to it.

Listen for it in others' speech and in your own. Listen for it in your thoughts.

Minimizing the difficulty of

making changes is demoralizing—there's no “just” about it. Minimizing the extent of the challenges can deter people from getting the treatment they need and sticking with it when the changes are difficult to make.

We'd best face the seriousness of the problems that we're all too inclined to dismiss with the j-word.

The j-word reflects wishful thinking. In contrast, hope is predicated on facing reality squarely and finding ways of moving forward—often slowly and with considerable effort, making use of help when needed.

About the authors

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(Menninger patients receive an abundant education in various aspects of mental illness through papers like this one. Other articles are available at www.MenningerClinic.com.)

CBT aims at thoughts that provoke troubling behavior

Mental illness sometimes has to do with how we see the world or more precisely, how we see ourselves.

Recovering from a mental illness, anxiety disorders, eating disorders or depression, for example, requires knowledge and practice. One form of treatment that exploits both is cognitive-behavior therapy (CBT), which examines unwanted thoughts or beliefs and attempts to change the resulting behavior.

Just as we make a rut in a rug we travel over too many times, harmful thoughts and behaviors become entrenched over time. Feed enough negative thought into the brain and it leaves a bad impression. With practice and repetition, the brain learns. The good news is what can be learned can also become unlearned.

CBT is one of the many therapies available at Menninger, where professional treaters draw from an eclectic array of therapeutic techniques available in designing individualized treatment.

CBT, an evidence-based approach to recovery, offers a patient the opportunity to approach a problem as a student might. Through disciplined steps the patient learns how to change thoughts and behaviors that have been counterproductive to recovery. Repetition establishes the new thoughts and behaviors in the brain and through clinical guidance and self-discipline, the patient adopts beliefs and behaviors more conducive

to improved mental health.

At Menninger, CBT is a broadly-used approach, sometimes in conjunction with medication, as well as with other therapeutic treatments.

Since beliefs and perceptions shape the way people view the world, CBT attempts to realign thoughts and perceptions in order to adjust harmful behavior.

Though beliefs may not be realistic, it is the belief that determines behavior. Changing behavior requires a shift in the patient's view from global negative thinking, as in: "Everything is wrong with me," to more specific thoughts with neutral judgment, as in: "Although I did not get the job, the interview prepared me for my next opportunity."

Helen's worries

An example of how CBT works involves Helen, a middle-aged woman who was overcome with worry and anxiety. Helen expected her husband, Sam, to arrive home directly after work. When he was late, her anxiety increased as each minute ticked by. Helen was so overwhelmed with worry, she had trouble sleeping, experienced difficulties at work and endlessly argued with Sam.

"It got to the point they were hardly speaking to each other," said John Hart, the Menninger therapist who treated Helen. Mr. Hart is a

licensed clinical professional counselor (LCPC) trained in the application of psychotherapy techniques, including cognitive-behavior therapy. A professional counselor helps patients find new alternatives for old behaviors and feelings that may be causing emotional discomfort.

In treatment teams at Menninger, Mr. Hart's efforts are supported by the expertise of a psychiatrist, psychologist, nurses, social workers, other therapists, an on-site pharmacist, and, if necessary, a doctor of internal medicine.

Finding Helen

Helen had a blended family, that is, children from her former marriage and that of her husband's. One stepdaughter, who was in her 20s and disabled, lived in a nursing home. Helen felt overwhelmed with responsibilities.

Mr. Hart narrowed his focus by asking what specifically was going through Helen's mind at the moment she became anxious. She answered vaguely and directed her vitriol toward Sam's perceived tardiness at the end of the workday: "He knows better," she said. "It worries me when he's late. He should be home," she insisted.

Sam would sometimes run an errand, delaying his arrival home. Helen's insistence that he be home immediately grated on him. Consequently, they were always at odds, with Helen's anxiety affecting every aspect of her life.

Eventually she realized what was really going through her mind as the moment her anxiety heightened: "I'm

afraid he's going to have a car wreck and he's going to be killed," she told Mr. Hart.

"What would be the ramifications of his death?" Mr. Hart asked.

"I'd lose my husband and I love him," Helen admitted, "but I'd also have all these other things to take care of, the kids, my stepdaughter. I'd have to take care of all these things myself and I wouldn't be able to manage it and everything would be falling apart."

Mr. Hart explained that in asking a series of questions, he was attempting to assess Helen's automatic thoughts, that is, the ideas that run through her head all the time, the cognitive part of CBT.

"I'm also listening to some assumptions," Mr. Hart said, "that are based on basic beliefs about ourselves in the world. She is saying: 'If my husband died, then I will not be able to manage and my world will collapse.' Part of the problem in dealing with this was that she wouldn't let herself think about what would happen if her husband actually did die. People worry about things happening, but they don't think through the problem completely. They worry up to the problem and worry insulates them from the terrible images."

In search of reality

Mr. Hart's challenge was to find a way for Helen to realize how her worry was a repeating cycle of negative feelings intended to avoid the consequences that stemmed from the potential death of her husband. Dealing with that would require exposure to reality.

People who are anxious tend to overestimate the extent of the threat that worries them. For instance, Mr. Hart suggested to Helen that dying in an automobile crash was a relatively rare event, which established a more realistic baseline from which he could launch his therapy in a clear direction.

"What would you do if your husband died?" he asked. "How would you handle it?" "What evidence do you have he might be killed

in a crash?" "How do you know these questions are true?" "If they are true, what can you do about them?" These queries were meant to narrow the distance between Helen's fears and a more beneficial reality.

In a practical way, Helen listed the steps one might take in the wake of a loved one's fatal accident: announcing the death to family and friends, contacts with funeral home, pastor, insurance, family attorney, etc, all the things she had been worried about, but actually avoided thinking about. But Helen didn't just make a list.

Mr. Hart assigned her to actually visit a funeral home to learn how to make arrangements. And as a way of gaining even more insight, she also spoke with an acquaintance whose husband had recently died.

"This may appear to be morbid business," Mr. Hart said, "but this is the stuff she's been avoiding in her head."

Her assignments grounded Helen and demystified some of the nagging worries that had beguiled and befuddled her.

Helen eventually revealed to Sam why she had been anxious about his coming home: "The reason we're arguing is because I love you and I don't want you to die."

That acknowledgement and her own inquiries concerning the death of a loved one helped Helen gain more control over her thoughts. With her new insights, her self confidence increased, which helped to strengthen her coping skills.

"If you're prepared to solve the problem you're less anxious about it," Mr. Hart said. "She solved a problem that didn't exist yet."

8-year-old Megan

CBT aims to help patients manage their thoughts by sorting through their mental confusion. The therapeutic method is applicable for children as well as adults.

Efrain Bleiberg, MD, a Menninger-trained adult and child psychiatrist who is the medical director of

Menninger's Professionals in Crisis Program and author of *Treating Personality Disorders in Children and Adolescents: A Relational Approach*, tells of treating Megan, an 8-year-old who was completely overwhelmed with rage and anxiety whenever her mother was absent.

Once she became comfortable in private sessions with Dr. Bleiberg, the girl admitted that she was fearful her mother would be killed in a horrific car accident or kidnapped.

Using CBT, doctor and patient worked out a method for Megan to overcome these unrealistic thoughts. The girl posted on her refrigerator a worry chart and an anger thermometer, "where she could record the extent of her angry feelings or worrisome thoughts," Dr. Bleiberg said. In so doing, the girl could see the relationship between her anger and the unrealistic consequences that stemmed from negative and unrealistic thoughts.

43-year-old Mary

CBT is often used in conjunction with other therapeutic treatments, and targets a specific troubling behavior or problem that impedes treatment of associated problems. CBT involves exposing patients to other ways of thinking about their problems. In Mary's case, CBT was used to diminish her fears about eating.

Mary was a 43-year-old homemaker and mother of four who was admitted to Menninger's Eating Disorders Program for anorexia nervosa, a disorder characterized by excessive fear of gaining weight and severely restricted eating. The patient, who had been hospitalized twice before admission to Menninger, weighed 104 pounds. Despite her tendency to over exercise, she used a wheelchair once she came to Menninger.

Because of her weak physical deterioration upon arriving at Menninger, staff members carefully monitored her medical condition. And, as is often the case, Mary's

eating disorder was accompanied by severe depression. Psychodynamic treatment emphasized rooting out family and personal issues, which included exploring a difficult childhood with a disciplinarian father followed by the patient's troubled relationship with her husband, as well as a personal tendency to be rigid and controlling.

A troubled teen

Her first episode with eating problems began at the age of 15, following the death of a family member. She began acting out. As a military brat whose family often relocated, she was taught to be stoic and her anorexia went untreated until much later in life.

Invoking CBT as a part of a complex therapeutic approach, Mary's Menninger treaters escorted her to fast food restaurants to eat. While the food served there is not recommended, exposure to fast food restaurants represents real life, and so, the whole dynamic of traveling, stopping, ordering, eating, etc., could be experienced, an important component of the behavior part of CBT, which is meant to help the patient go through the motions of immersing herself in food and being around food. The therapy was also helpful in teaching Mary how certain thinking patterns about food were causing her symptoms.

Menninger treatment for eating disorders is supplemented by individual and group therapy, medications, and a great deal of dietary and physical education. After 15 weeks at Menninger, Mary was responding: she had gained 37 pounds.

Unfortunately, eating disorders are not just about the weight. The patient was still facing a multitude of hurdles. Her medication also was adjusted for her depression and she continued to improve after leaving Menninger as she lived at an apartment to practice her new, healthier lifestyle.

Mary's success was attributed to creating a psychodynamically-oriented environment that was

integrated with CBT, a powerful combination that eventually sent Mary back home to her family and on to recovery.

Tradition of social work offers rich education

Menninger has a long tradition of elite clinical social work training.

Menninger remains one of the few psychiatric hospitals in the country to offer a social work training experience with the breadth and depth that exists in current fellowship and internship programs.

Menninger was among the first few hospitals to offer clinical social work training in an institutional setting when it began the postmasters fellowship in clinical social work in 1944. Decades later, those programs have only gotten stronger.

“We receive applications from around the country because there is still such a lack of training opportunities for social workers to receive clinically focused training,” said Pamela H. Jones, LCSW, acting director of social work and social work education.

“Graduates can usually find case work, but not the opportunity for intense supervision, clinical case consultation and interdisciplinary teamwork that we offer here.”

Menninger’s fellows are master’s-level social work graduates who care for four or five patients within the treatment program where they are assigned, but their roles on their respective teams offer different experiences.

Rebecca Whitson, MSW, the social work fellow in the Hope Adult Program, fills the role of primary clinician.

At the Adolescent Treatment Program, fellow Ginger O’Neal, MSW, works as a family therapist. And fellow Melanie Flint, MSW, is training as a cognitive behavior therapist working with adolescents and adults at the Obsessive-Compulsive Disorders (OCD) Treatment Program.

A priceless education

“The learning experience has been priceless,” Ms. Whitson said. “I remember when I first learned I would be training in Menninger’s fellowship program. I realized that some of the textbooks in grad school were written by people who work here.

“Training in an environment with staff who are noted in this field and who believe in a psychodynamic framework that I strongly adhere to has been very rewarding and affirming.”

The fellows work in a rich patient care environment that offers significant experience with other treatment team members—psychiatrists, psychologists, nurses, mental health counselors, and others—as well as interdisciplinary group supervision led by Chief of Staff Richard Munich, MD, senior psychologist Jon Allen, PhD, and other senior Clinic staff.

A newly re-established internship program also is part of The Clinic’s social work education. John Dietrich, MSW, assigned to the Professionals in Crisis Program and Terrie Emel, MSW, with the Eating Disorders

Program, complete The Clinic’s first class of social work interns since its move to Houston in 2003.

Ms. Jones said the social work department has re-established a developing a relationship with Smith College in North Hampton, Massachusetts, to have the college’s social work master’s students intern at The Clinic. Menninger has a long history with Smith College—Ms. O’Neal and Ms. Whitson’s alma mater—because the College has a reputation of maintaining a strong, psychodynamic social work program.

Everyone learns

While participants in the fellowship and internship programs might seem to reap the most rewards from their experiences at Menninger, Ms. Jones emphasizes how staff and patients benefit from the fellows and interns.

“They have a fresh perspective... a keen observation,” Ms. Jones said. “They bring their own current knowledge, views and thoughts, and they challenge the system.

“They hold us accountable to social work ethics and values and bring up issues of social justice, and they hold us accountable to continue learning and seeking out resources to provide to them, which strengthens their experience and ours as well.

“We learn as we teach, and it continues the long tradition of a strong, rich social work program here at Menninger.”

Gambling behaviors complicate illness

By Anissa Anderson Orr

Addiction often serves to mask other difficulty; a new type of addiction incorporates use of the Internet.

Tom Alexander was in over his head. After watching the “World Series of Poker” on television, the 45-year-old business owner and father started playing “Texas Hold ‘Em,” a variation of no-limit poker. The game was a way to be with his friends and to let off steam. He quickly graduated to Internet poker and played constantly—excluding virtually every other activity in his life.

In the beginning, Tom played well and made some money. Then he started losing and losing big. Determined to win his money back, Tom played more frequently. He often played three or four games at a time on different gambling Web sites. Over the course of a year, he fell further into debt and began to spend more time away from work and at home on his gambling.

By the time he was nearly \$250,000 in debt, the bank threatened foreclosure on his house and his marriage was in trouble. Counseling sessions with a psychiatrist did not seem to help. At his wife’s urging, Tom sought treatment at The Menninger Clinic’s Professionals in Crisis (PIC) program.

People in crisis

The PIC program treats men and women in business ownership, upper management, medicine, sports, law,

entertainment, education and other high-performance fields who are experiencing difficulty managing their career and relationships because of a psychiatric disorder, addiction, demands and stressors. The program also treats individuals who have been in treatment elsewhere, but have not made the desired progress.

Tom was depressed and ashamed about what he had put his family through, although he was more concerned about his debt than the seriousness of his clinical addiction to gambling. That would have to change.

“We needed to teach him about the addictive process and how the gambling had really taken a life of its own,” said Toby Haslam-Hopwood, PsyD, the primary clinician responsible for overseeing the PIC treatment team’s focus on the patient’s needs and goals.

Discovery

Shortly after Tom checked into Menninger, Dr. Haslam-Hopwood interviewed Tom and his wife, Meredith, about what led him to his current situation.

On the surface, Tom’s life seemed to be going well. A year earlier, he had started his own business. At about the same time, his wife gave birth to their first child—a son.

As the interview progressed, more intimate details emerged. Tom confessed that the previous year was difficult and stressful. His business

mentor died, leaving Tom to learn how to manage his business on his own. He was still reeling from the loss. Tom also felt that Meredith devoted all her time and energy to the new baby, leaving little for him.

His wife was initially quiet in the meeting, said Dr. Haslam-Hopwood, “But as we got to talking about his marital difficulties, she started to speak up. It was clear that she had a great deal of anger toward her husband. The family was in a considerable amount of debt. She had found out only recently that a second mortgage had been taken out on the house. The first she heard about it was in a letter from the mortgage company, saying the firm was going to foreclose on the house.”

Tom told his wife that the letter was a mistake and that he would sort it out. Two days later, Meredith received another letter. This time she called the mortgage company herself. The representative confirmed that Tom had taken out a second mortgage and was behind on payments. The bank was going to foreclose on the house.

The news shocked Meredith. She knew that Tom spent an inordinate amount of time on the Internet, but assumed it was for his business. Meredith felt Tom had severely betrayed her trust, but she also recognized that Tom needed help. Tom admitted that he had a problem, but was resistant to going into treatment.

“He was a guy used to being independent, a self-starter and self-motivator,” Dr. Haslam-Hopwood said. “He was used to being in control and getting things done. Letting go of some of that control was difficult for him. He had to recognize the powerlessness he had over his addiction and that he and his family were not alone in facing gambling and its effects.”

A glamorous addiction

Like any addictive substance or behavior, Internet gambling packs a powerful high by stimulating the pleasure centers, or reward pathways, of the brain. Once the initial high wears off, players gamble more and more to try to recreate that rush. But there’s good news. Not everyone who scratches off a lottery ticket, or plays poker with his or her friends, is destined to become a gambling addict.

The road to addiction is complicated, said addictions counselor and PIC program director, John O’Neill, LCSW, LCDC, CSAT.

“I believe a combination of factors causes addiction,” Mr. O’Neill said. “The genetic make-up of your family plays a great role if members of your family have addiction problems. Also, your family environment and the coping strategies you have developed in life help determine what you need to make you feel better.”

Mr. O’Neill said computer convenience increases opportunities for players to become addicted to gambling.

“You can gamble on the road. You can gamble on the fly. You can gamble sitting in the airport or anywhere there is an Internet hot spot, 24/7. But gambling on the Internet is very different than going to a casino. People are less inhibited when they are at home or on their computer.”

An estimated two million people are pathological, or problem, gamblers, according to the National Council on Problem Gambling, although few statistics yet exist concerning widespread abuse of

Internet gambling.

“On the Internet, gambling and paying with credit cards—which doesn’t really feel like you are handing out that \$20 bill—is a powerful mix,” Mr. O’Neill said. “You think, ‘What’s \$20 on my credit card? I will pay it off.’ Next thing you know it is \$50, then \$100 and then you don’t care how much you spend. You’re focused on winning it back.”

Like Tom, many people who gamble on the Internet don’t think they have a problem until their time spent online sends them into serious debt, ruins a relationship, or causes them to lose their jobs.

Mr. O’Neill said the screening process used by the PIC program staff often uncovers gambling problems in patients who are admitted for other psychiatric or behavioral problems, such as depression. They begin gambling over the Internet to cope with their depression and escape the stress and struggles of their daily lives.

Fact finding

Over the next three or four days of Tom’s stay at Menninger, members of his treatment team went on a fact-finding mission to help them craft their master treatment plan. They called or spoke with mental health professionals who treated Tom before coming to Menninger. They learned that Meredith, fearing her husband was having an affair, had successfully urged Tom to participate in couples’ therapy. Tom had also sought clinical help for his depression, but had not made progress, according to his psychiatrist.

“We often see patients here who have been in treatment before, but they are stuck or not making progress,” Dr. Haslam-Hopwood said. “Our goal here is to try to understand why that outpatient treatment didn’t work. In many ways we are giving them an extended consultation, and trial of treatment. We support them with new skill development, treatment methods and

opportunity to learn about their illness and how to manage forward.”

Tom’s psychiatrist was treating him for his depression, but he didn’t know that Tom also had a gambling addiction. Since Tom kept his problems a secret, the treatment was unsuccessful. Tom’s debt continued to mount, causing him more depression and shame.

Addictions

The treatment team learned that Tom had a genetic vulnerability to addiction. Tom’s father and maternal grandfather had a history of drinking and were addicted to alcohol. Tom was addicted to gambling, but could easily have been addicted to alcohol or another addictive substance or behavior.

“Addictions jump around,” Mr. O’Neill said. “Someone might come in with an alcohol addiction and as they enter recovery, they might find another addiction to make them feel better. The shift is not always a conscious one for the patient. The brain is saying, ‘I need something to make me feel better. I can’t gamble, but no one told me not to overeat.’” The treatment team also determined that the loss of Tom’s mentor greatly contributed to his depression.

In terms of relationships, renowned psychologist Sidney Blatt has identified two basic forms of depression: dependent and self-critical. Individuals like Tom who suffer from dependent depression are highly sensitive to separation and loss. When his mentor died, Tom lost not only a good friend, but also a critical part of his support system.

Without his mentor’s support, and emotionally distant from his wife, Tom lacked the resilience necessary to cope with the growing challenges in his life. He turned to gambling to fill in the gap.

Data in hand, the treatment team worked together with Tom to develop a plan for recovery.

“From our perspective there were a number of issues we needed to consider,”

Dr. Haslam-Hopwood said. “We needed to target his depression. He needed to have a consultation with one of our addictions specialists who focused on gambling. We also wanted to root out other behavioral issues or disorders. Additionally, we needed to focus on the stress the gambling caused in his marriage and how the loss of his mentor affected him.”

Treatment

The team recommended a six-week treatment program for Tom involving support groups for both Tom and Meredith and one-on-one counseling with an addictions counselor. To help both Tom and Meredith learn more about mental illness, the couple was enrolled in psychoeducational groups and participated in Menninger’s Family Workshop. Tom was also prescribed antidepressants.

Tom started attending Gamblers Anonymous meetings and found a temporary sponsor in Houston. Later, he could get a more permanent sponsor in his hometown. He began attending several psychoeducational groups to teach him about depression and addiction. He learned the origins of his genetic vulnerability to addiction which was linked to a family history of alcoholism. He also met one-on-one with an addictions specialist to determine what triggered his harmful behavior and learned how to reduce his urge to gamble.

Through his participation in these groups, Tom began to realize that he gambled to cover up his depression from problems in his marriage and the loss of his mentor.

While Tom was in treatment, Meredith worked with a credit counseling service and the mortgage company to develop a plan to pay off their debt. She became more involved in handling the family’s finances and returned to work to earn money that she could apply to the debt.

The couple began to communicate more openly about how their roles in the marriage had changed

since the birth of their son. In therapy, Tom admitted he often had a hard time telling Meredith when he was struggling with issues or feelings.

Going home

Tom progressed well in his treatment and was ready to go home at the end of the six weeks. He agreed to continue his 12-step Gambler Anonymous meetings after discharge and to see a psychiatrist on an outpatient basis.

The following year was a struggle for Tom and Meredith, but both felt they had made tremendous progress since Tom’s stay at Menninger. Deciding that he was better suited working for someone other than himself, Tom sold his business and went back to work for a company. Slowly, but steadily, he began to dig his way out of debt.

Tom used new skills and support to manage the temptation to gamble, trying hard to stay out of situations that triggered his addiction. He stopped playing poker with his friends. He also invested in software that blocked specific Web sites and limited his time on the Internet.

Tom and Meredith’s relationship improved greatly, as they continued to communicate more freely. Tom became more aware of how his own thoughts and feelings affected those around him, especially his wife. He came to understand that sharing when he was lonely or sad didn’t make him weak.

On the whole, life improved for the couple and Meredith became pregnant with their second child.

“We are hopeful again for the future,” said Meredith in a letter she sent to the treatment team. “Just a year ago, I couldn’t have said that.”

Losing your self can lead to stress

By Roy W. Menninger, MD

Physicians often have hectic lives that lead to anxiety and burnout. A renowned psychiatrist suggests ways doctors and the rest of us can change.

Why or how did I come to write this article?

My psychiatric work with stressed physicians has shown me the cost of failing to give enough attention to the needs of the self. My work also made me realize that I talk a better game of meeting these self needs than I play. Recognizing my own shortcomings in this area intensified my efforts to help others do better. This recognition has also improved my own stress-management strategies.

Environmental stresses, such as workload and litigation, that affect doctors are great and getting more intense. They are responsible for doctors' loss of enthusiasm for medicine and their reduced satisfaction with their practice.

But these external stresses are only part of the problem. A critical element contributing to physician stress that many of us experience is internal: our self-generated expectations for high performance, combined with a nagging apprehension that we haven't read enough, don't know enough or are not working hard enough.

The irony is that this compulsiveness can be an asset for the conscientious doctor. It encourages thoroughness and attention to detail. But it also comes at a cost. Compulsivity can lead to doubt, guilt feelings and a chronic sense of



Roy W. Menninger, MD

inadequacy. The drive for perfection can make it hard to set limits, hard to relax, cause an exaggerated sense of responsibility and generate increasingly deeper guilt feelings about taking time away from our practice.

How we live

We physicians don't often examine our own lives: we tend to look into the lives of others rather than our own. Looking into our self and at the ways we manage stress is the first step in dealing with it. I've suggested four areas to look into:

1. Setting your goals and objectives.

Most of us have not set life goals or objectives. We say that we are too busy practicing medicine to think

about such things. And so our future becomes a mindless extension of our hectic daily routine. It is then our patients, family, colleagues and "society" that set our goals. This can make us feel victimized and exploited. But it is really the result of our own failure to answer some vital questions:

- What do I want to achieve?
- Where do I want to go, to do?
- And perhaps most importantly:
- What kind of a person am I?
- What kind of a person do I want to become?
- What do I want to be remembered for?

2. Setting your priorities for time and money.

Since most of us doctors are focused on the needs of others, our priorities often reflect those of others, not our own. Examining the ways we spend our time can demonstrate our priorities as we actually live them—the proportion of time dedicated to our practice versus time spent with our families versus time given to ourselves. This proportion illustrates our real priorities, not what we say (or think) they are.

For example, how often do your weekly or monthly schedules include time to do things you enjoy? Regularly? Seldom? Not at all? When was your last vacation? What was the last non-medical book you read, and how long ago?

3. Examining the quality and the character of our relationships.

The demands of practice commonly compromise the time and attention available to those who are closest to you. This can leave them feeling that they play second-fiddle to your profession and that you take them for granted. Often that's very true.

Too often our relationships are immature and exploitative; the giving and taking is asymmetrical. It is not mutual or genuinely reciprocal. A mature relationship should offer mutual respect and basic trust, allow open communication and encourage an intimacy characterized by shared giving and receiving. But these characteristics are often distressingly infrequent in our relationships.

Communication is limited and laconic. Establishing *genuine* intimacy—i.e., something more than occasional sexual contact—is a rare achievement in the medical marriage, but is a goal that should be part of every close relationship. A relationship without it is not a mature one.

John and Mary

John, a 45-year-old cardiac surgeon, was a driven, compulsive doctor, dedicated to his work. When his wife, Mary, suggested that they take a vacation to celebrate his graduation from medical school, he objected, saying that the immediate start of his postgraduate training made that impossible. So she bided her time, tolerating the unremitting grind of residency and specialty training until he finished.

Then she again suggested taking a bit of extended time together. Again he refused, citing the demands of starting a practice, promising that they would take that long delayed vacation together, "Just as soon as I have established my practice." The automatic nature of this response was clear when subsequent proposals to do something were met with new reasons: "Just as soon as I have a partner to cover during my absence." Then, "As soon as our group practice is well established."

Ultimately Mary quit asking, backed away from the relationship, and developed a professional life of her own.

4. Examining your relationship with yourself.

How well are you doing in meeting your own needs? Doctors customarily deny their own needs by focusing on the needs of their patients. Neglecting your own needs is a sure recipe for feeling stressed and burned out. How much time do you spend doing the things you enjoy? Or are you feeling guilty about taking time off, and so you postpone that as well?

So...?

Time spent thinking about these areas does not guarantee peace from the inner demands of very high standards and a strong conscience or ensure an improvement in your important relationships with others and with yourself. But any progress at all in that direction depends on adding two essential elements; firstly, recognizing that you must think about these questions of goals, priorities, and relationships, and secondly, that you must be willing to talk about them with your nearest and dearest.

The absence of either element will condemn the doctor to unremitting internal stress and a chronic vulnerability to a mindless acceptance of every new demand at work. Taking conscious control over the many choices that confront us physicians each day will help to minimize the destructive impact of the external forces that beset us.

Making changes

Think about and then write down your personal life goals. Make them clear, realistic and essential. Consider existential ones: What kind of a person am I? What kind do I want to be? How do I want to be remembered? Take a test by writing your own epitaph; make it terse, focused, accurate.

Decide what parts of your world and your activities have the highest

priority. Then check that list against reality: How did I actually spend my time last week? What activity got the most time? The least? And what favorite, most satisfying activity didn't get even five minutes last week?

Schedule these activities, just like an appointment for a patient.

Develop a greater tolerance for your inevitable performance shortfalls and your inevitable failure to reach perfection.

Expand your repertoire of interesting, pleasurable, fulfilling activities: hobbies, travel, music, reading, art. Avoid becoming a dull, uninteresting monochromatic physician who knows and cares about nothing but medicine.

Make lifetime learning and continued intellectual and emotional growth a priority. The person who ceases to learn is dead and just hasn't fallen over yet.

Focus on your significant relationships: find ways to expand your mutual satisfactions, identify time you will spend together in shared activities, and then protect it.

Editor's note:

One physician who read Dr. Roy's article had this to say:

After reading this article I felt as though the author was writing an appraisal of me. Had someone been secretly observing me for the past six months? Had I become a contestant on a reality TV show without my knowledge?

...In my heart of hearts I've known that I have been suffering from depression for quite some time. It runs in my family. I've been there before. I even know that I've been denying to myself just how sick I am. Roy Menninger has made me aware of the reasons why.

Handling stress

A lot is written about why we ask for help and where we can go to find it. But this article is different in that it sets out to explain why some of us find ourselves at the point where we are asking “how could it have gotten so bad?”

I have finally realized that the world is not against me and that I’m not being exploited by those close to me. I feel as though this article has unlocked a closed door, which will in some way help me towards my happier future.

About the author

Psychiatrist Roy W. Menninger, MD, served as the fourth president of Menninger from 1967 until 1993 and has provided expertise and leadership in numerous board positions since he began practicing psychiatry at Menninger in 1961.

Dr. Menninger also served as director of the Division of the School of Mental Health and director of the Department of Preventive Psychiatry.

Dr. Menninger is a national spokesman on mental health and on human rights.

He is the eldest son of the late Dr. William C. Menninger and the nephew of the late Dr. Karl A. Menninger, both of whom co-founded Menninger with their father, Dr. C.F. Menninger.

Dr. Roy Menninger’s professional interests focus on the psychology of the physician and the physician’s marriage; group psychotherapy and group process dynamics; and the psychological aspects of management and leadership.

His avocational interests include world history, 18th century English literary figures (Samuel Johnson), stamp collecting, computers and music (former cellist with the Topeka Symphony Orchestra.)

The life and (interesting) times of a psychiatric nurse

By Angela Hudson

Having satisfied a lifelong goal of working at Menninger, a nursing veteran reaps her just rewards.

With a nursing career spanning more than five decades and a journey that's taken her all over the world, 72-year-old psychiatric nurse Elizabeth Turrentine is entering retirement, familiar territory she has visited many times before.

Ms. Turrentine joined Menninger in 2000 and leaves as charge nurse with the Professionals in Crisis Program.

"I'd always heard about Menninger throughout my whole career," she said, "and I always said before I retire, I wanted to come to Menninger to learn how to do it right. Menninger practices psychiatric care the way it's supposed to be practiced."

To say Ms. Turrentine has seen tremendous changes in her career spreading over 50 years is an understatement.

"In the three years I have known Elizabeth - I have always been amazed, at her constant striving to learn more— even after 50 years as a nurse," said Pam Greene, ARNP, PhD vice president of Patient Care Services. "She probably earned more continuing education credits than just about any other nurse. She read, she engaged in scholarly dialogue, she explored new ways of approaching care—always searching for ways to be a better nurse. She is really



Elizabeth Turrentine

an inspiration and lives the saying 'life - long learner.'"

As a nurse who still remembers the days when nurses had to stand when a doctor entered the unit, one of the changes she's been most grateful to have witnessed is the evolution of the nursing profession.

"The nursing profession has come such a long way in complexity of the care we are able to offer," she said. "It has become a much more respected profession. Nurses have always been appreciated, but not always respected."

She began her fascinating career after graduating from the Vanderbilt School of Nursing in Nashville, Tennessee. Shortly thereafter, she married and started her family. She worked eight years in medical/surgery and labor and delivery before moving

with her family to St. Louis, Missouri, where she taught obstetric nursing and neonatal nursing at the Barnes Hospital School of Nursing.

During the 1960s, Ms. Turrentine even played a role in President Lyndon Johnson's War on Poverty.

"I worked two years as supervisor of a pediatric and ob-gyn clinic in a neighborhood health center during Johnson's War on Poverty initiative," she said. "Part of the mission was to educate and train the hard-core unemployed. So I taught nurses aides, many of whom had never worked. It was the most fulfilling experience."

Afterward, Ms. Turrentine retired for four years. And what a difference four years can make. Before returning to nursing, she took a refresher course. She was amazed at the changes that had occurred in such a short time.

"The most amazing thing was that everything was disposable," she said and laughed. "Before, we had autoclaves for sterilizing instruments and sterilization hoppers for the bed pans.

"When I returned, everything was paper or plastic. We'd gone from glass IV bottles to bags. All of the real cloths and metal had been replaced."

Ms. Turrentine eased back into nursing working at a Kaiser Permanente pediatric clinic before moving on to a small, 30-bed hospital near Steamboat Springs, Colorado, where she was director of nursing. While there, she said she began to

think about moving into psychiatric nursing.

“I made my best grades in psych when I was in nursing school,” she said. “I always loved psych. And then, during the years of my divorce (in the early 1970s), I was in outpatient psychotherapy for three years trying to get through this huge change in my life.

“My children were in therapy as well, and I saw the miracles that can happen with psychotherapy.”

But then Ms. Turrentine took a distant detour to Saudi Arabia where she worked from 1981 to 1984 for ARAMCO oil company, supervising the nurses at a large clinic where some 75 physicians treated 900 to 1,000 patients each day.

Then she retired a second time. During her retirement from nursing, she worked as a business broker, selling small businesses, including a bookstore, a dry cleaning company, a beauty salon and a large trucking company.

“I was earning a six-figure salary, but it was the late 80s and the economy was uncertain,” she said.

So she returned to nursing, and this time she followed her long-held notion—she went into psychiatric nursing at a Denver, Colorado, hospital. But her employment there was short lived, as the hospital was among the first casualties of managed care.

“I was without a job, as were many nurses in the city,” she said.

“And then one day I saw an ad for nursing jobs in Honolulu.”

And off she went. Ms. Turrentine worked in Hawaii for a year before getting married and retiring again. That was No. 3. She and her new beau spent two years sailing the South Pacific between Honolulu and New Zealand in his 47-foot trimaran. The two visited Fiji, Samoa and the Tonga islands before an amicable divorce.

After spending another two years back in Tennessee to help care for her brother who was suffering with Alzheimer’s disease, she returned to Honolulu to work four years. While

there, she spotted an ad for nursing positions at Menninger.

“And the rest is history,” she said.

“I am so happy and proud of our nursing leaders today. Both Mary Wentworth, (former vice president of Patient Care Services) and Pam Greene, are remarkable. Mary was such a guiding force, and Pam is taking Menninger to the next level.”

Menninger’s nurses will have to go to that next level without Ms. Turrentine. She’s got other plans. She recently bought a recreational vehicle in which she plans to travel the country to spots she’s not yet visited.

Undoubtedly, she’ll also be visiting her children—two live in Denver, one lives in Tulsa, Oklahoma, and another lives in London. But where’s her first stop?

“Disney World,” she said with a smile as wide as any child anticipating the magical trip. “Me and one of my friends from high school used to save up our money to go to the state fair. She was the only one who’d ride the scary rides with me. Well, now we’re going to Disney World.”

The bruise of stigma

Stigma concerning mental illness stems from ignorance and bias to lack of funding and lack of hope.

Despite educational efforts by many mental health advocates, stigma sadly remains an obstacle for too many people. Here are some reflections:

“Unfortunately, mentally ill patients are too often stigmatized even after they are well.”—William Menninger, MD, 1962

“There are probably more misconceptions about mental health than about any other type of sickness.”—Menninger co-founder William Menninger, MD, 1931

“All the mentally sick do not require hospital treatment...a great many who need hospital care never are given help.”—William Menninger, MD, 1931

“Today, the majority of those who need mental health treatment do not seek it.”—U.S. Surgeon General report, 2006

“...Every individual shows recurring minor attacks of mental ill health just as he does physical ill health.”—William Menninger, MD, 1944

“The psychology of schizophrenia is, in my opinion, as much in the mind of the observers as in the mind of the patient. We must change before he can change. He has long been incurable because we have been hopeless.”—Menninger co-founder Karl Menninger, MD, 1957

“We live in an era of stigma regarding psychiatric illness, psychiatric patients and psychiatric treatments.... Indeed, psychotherapy is often viewed as a form of hand-holding rather than a ‘real’

treatment. ...With advances in the neurosciences, and especially in imaging techniques, we stand at the threshold of demonstrating that psychotherapy is a powerful intervention that affects the brain. ...Documentation of these changes may go a long way toward removing the stigma currently attached to psychotherapy.”—Glen Gabbard, MD, professor, Menninger Department of Psychiatry and Behavioral Sciences, Baylor College of Medicine, 1998

“There were times when mental hospitals in the United States charged admission so the public could gawk at the mentally ill. So we have this tradition of looking at the mentally ill as strange, exotic and totally different than Me.”—Glen Gabbard, MD, 2002

“Posttraumatic stress disorder (PTSD) is not a little old ‘adjustment disorder’ that is ‘all in the veteran’s head’; it is not a hyped-up myth; it is a persistent, dangerous biological condition that maims the body as well as the mind, the brain as well as social relationships. It strikes the brave: the more combat you see, the more intense is your PTSD.”—Thomas Horvath, MD, FRACP, chief of staff Houston Michael E. DeBakey Veteran’s Administration Medical Clinic, professor, Menninger Department of Psychiatry and Behavioral Sciences, Baylor College of Medicine, testifying before Congress on why PTSD should not be considered a personal weakness, 2004

“Nearly four in five service members returning from the wars in Iraq and Afghanistan who were found to be at risk for posttraumatic stress disorder (PTSD) were never referred by government clinicians for further help, according to a Government Accountability Office report...”
—*N.Y. Times*, 2006



Carla Sharp, PhD, assistant professor with the Menninger Child & Family Program; Jim Hall, family mental health educator, Houston; Efrain Bleiberg, MD, medical director of the Menninger Professionals in Crisis Program; Brooks King-Casas, PhD, Fellow, Brown Foundation Human Neuroimaging Laboratory; and Richard Munich, MD, Menninger chief of staff and moderator, at a panel to discuss the role of families in the treatment of BPD.

Clinicians and families join in BPD symposium

Nearly 200 mental health professionals, consumers and family members attended an educational symposium in March focusing on borderline personality disorder (BPD). The symposium was jointly sponsored by Menninger and others and was held at the Texas Medical Center in Houston.

Titled “Recent Scientific & Treatment Advances in Borderline Personality Disorders,” the program featured presentations on current research, developmental issues, pharmacotherapy, neuroimaging, treatment methods and perspectives of patients and families.

Menninger staff were among the mental health experts who presented new research and insight into borderline personality disorder.

Other sponsors included Baylor College of Medicine, the National Education Alliance for Borderline Personality Disorder and the National Alliance on Mental Illness, Metropolitan Houston chapter.

People with borderline personality disorder often experience unstable



Symposium participants gathered to learn about advances in treatment.

relationships, emotional disconnection from family, friends and loved ones and a distorted sense of reality. Although the cause is unknown, both environmental and genetic factors may predispose patients to borderline personality disorder. Studies show that many, but not all individuals with borderline personality disorder, report abuse, neglect or separation as young children.

Borderline personality disorder is less well known than schizophrenia or bipolar disorder (manic-depression), but more common, affecting two percent of adults, mostly young women. Individuals with the disorder need extensive mental health services and account for 20 percent of psychiatric hospitalizations. With help, many people suffering BPD can lead productive lives.



Clockwise from top left:
 Ian Aitken, Menninger president and CEO, Efrain Bleiberg, MD, Richard Munich, MD, and Frank Yeomans, MD, PhD; Glen Gabbard, MD, director of the Baylor Psychiatry Clinic; interested participants visit one of the numerous mental health information sites; at podium, Perry Hoffman, PhD, president, National Education Alliance for BPD; and Stuart Yudofsky, MD, chair of the Menninger Department of Psychiatry & Behavioral Sciences.

Support is rooted in legacy of excellence

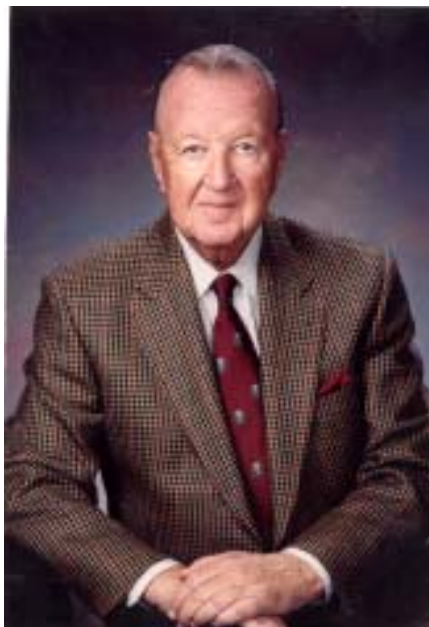
Hendrik Vietor has witnessed the advance of psychiatry and sees a bright future for breakthroughs.

Hendrik Vietor's philosophy of life reflects an attitude of optimism. It comes as no surprise that in spite of current world turmoil he is convinced that the future of mankind looks increasingly bright. He is also convinced that life should be lived to the fullest. In spite of his octogenarian status, he continues to play tennis twice weekly under the glow of the Florida sun!

After World War II service in the U.S. Army, Mr. Vietor led a successful career in the investment business (securities and commodity futures). In 1991, he established a \$500,000 charitable gift annuity at Menninger in memory of his late sister Jeanne.

The annuity is structured to provide Mr. Vietor annual payments throughout his lifetime. Upon his death the annuity will establish the Jeanne Vietor Endowment to be used for psychiatry treatment, education and research related to mental illness.

As a member of the Charles F. Menninger Society since 1977, Mr. Vietor admits that psychiatry in that time seemed at best to be a dubious enterprise. His thoughts were based on the experience of his sister Jeanne who at an early age was diagnosed as suffering from schizophrenia followed by a lifetime of treatments and hospitalizations without significant improvement.



Hendrik Vietor

In the intervening years Mr. Vietor said he "has become increasingly aware of the substantial progress which has been achieved in the field of psychiatry thanks to the pioneering efforts of Menninger." He is convinced that continued emphasis on treatment, education and research will lead to ever-increasing success in an environment of proven excellence.

The quality of excellence is not new to Mr. Vietor. His mother, Alba Rosa Vietor, born and schooled in Italy was an accomplished classical musician. Her career as a concert violinist, composer and teacher spanned more than seven decades and covered three continents. In recent

years and with the cooperation of the Frost School of Music at the University of Miami, arrangements have been made by Mr. Vietor to convert handwritten music manuscripts to the printed format through computer assisted engraving process.

"The process has provided broader access to my mother's music. I did not want her life's work to gather dust on a shelf. Through performances of the music it is as if my mother's life is being extended."

In a similar way, Mr. Vietor's present support of Menninger will also extend well into the future.

Long after Mr. Vietor has passed on, his generosity to Menninger will serve to underwrite crucial work in the ongoing endeavor to improve treatment of the tragic disease that affected his sister's life.

Many ways exist to help Menninger mental health programs. Some gift opportunities can provide lifetime income for donors. To learn more please contact:

Development Office
PO Box 809045
Houston, TX 77280-9045
developmentoffice@menninger.edu
www.MenningerClinic.com
713-333-3320
800-288-3950

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

Former dean receives national exemplary award

John Sargent, MD, a professor of psychiatry and pediatrics at the Menninger Department of Psychiatry & Behavioral Sciences, Baylor College of Medicine, has been awarded the National Alliance on Mental Illness (NAMI) 2006 Exemplary Psychiatrist Award for his efforts to help evacuees in the aftermath of hurricane Katrina.

Dr. Sargent was among numerous Houston-area volunteers who spent long hours working with traumatized hurricane victims. Dr. Sargent is the former director of Education and Research and Dean of the Karl Menninger School of Psychiatry & Mental Health Sciences.

Pulitzer Prize winner delivers William C. Menninger lecture

Journalist David K. Shipler presented the William C. Menninger Memorial Lecture at the Convocation of Fellows during the American Psychiatric Association's annual conference in May. He discussed his experiences as a writer involved in covering racial and economic disparities. Mr. Shipler won the Pulitzer Prize in 1987 for his nonfiction book, *Wounded Spirits, Arab and Jew in the Promised Land*. The book was born out of his experiences as a *New York Times* correspondent in Jerusalem.

Paulina Kernberg, MD, Menninger graduate, dies in New York

Menninger alumnae Paulina F. Kernberg, MD, a child psychiatrist at Cornell University and an authority on personality disorders who helped evaluate Elián González, the 6-year-old Cuban boy at the epicenter of an international custody battle in 2000, died in April at New York-Presbyterian/Weill Cornell Hospital in Manhattan. She was 71.

Dr. Kernberg, who studied the emotional effects of divorce, considered the trauma from divorce second only to a parent's death, and she helped found a clinical program for children of divorced families at New York-Presbyterian/Westchester Hospital. She was married to Otto Kernberg, MD, a renowned psychiatrist who is also a Menninger graduate.

Staff and collaborators present at Yale Child Study Center

Five Menninger professionals presented at the Yale Child Study Center in March during a two-day conference that brought together clinicians and investigators from the Anna Freud Centre and Menninger. Both Yale and the Freud Centre are significant research collaborators with Menninger. In inaugurating the conference, Peter Fonagy PhD, FBA, director of Menninger's Child & Family program, gave The Muriel

Gardiner Lecture in Psychoanalysis and the Humanities. His presentation was titled, "The rooting of the mind in the body: New links between attachment theory and psychoanalytic thought." Also presenting at Yale from the Menninger and the Baylor College of Medicine's Menninger Department of Psychiatry & Behavioral Sciences, were Jon Allen, PhD, Toby Haslam-Hopwood, PhD, Glen Gabbard, MD, and Efrain Bleiberg, MD.

Familiar voices included in Freud anniversary issue of *Newsweek*

Newsweek magazine in March noted Freud's 150th birthday anniversary in a series of stories under the rubric: "Freud in our Midst." The magazine sought out a variety of professional voices on various issues related to psychiatry and the contemporary applications of psychoanalysis. Not surprisingly, psychoanalysts Glen Gabbard, MD, and Peter Fonagy, PhD, FBA, were noted in the story. Dr. Gabbard, a Menninger graduate, heads the Outpatient Psychiatric Clinic at Baylor College of Medicine and Dr. Fonagy directs the Child & Family Program, both of which are in the Menninger Department of Psychiatry & Behavioral Sciences, Baylor College of Medicine.



Best-selling author Andrew Solomon, seated, signs a book for Jim McIngvale, a member of the Board of Visitors.



Left photo: Robert C. Wilson III, right, Board of Visitors, chats with the author.

Above: Nearly 175 guests attended Menninger's first book & author luncheon featuring National Book Award winner Andrew Solomon.

Audience receptive to depression book author

Menninger's first book and author luncheon in May featured National Book Award winner Andrew Solomon, who recovered from major depression and wrote about the topic in the acclaimed book, *The Noonday Demon: An Atlas of Depression*.

"Once again, the community, our

Board of Visitors, our business associates and our staff have demonstrated overwhelming enthusiasm for Menninger and for learning about depression and the challenges of people with mental illness," said Ian Aitken, president and CEO. "We are fortunate to have so much support to

kick off our series of annual educational events. The results are heartwarming."

Following Mr. Solomon's address, he graciously spent an hour signing books and chatting with some of the 175 participants.

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