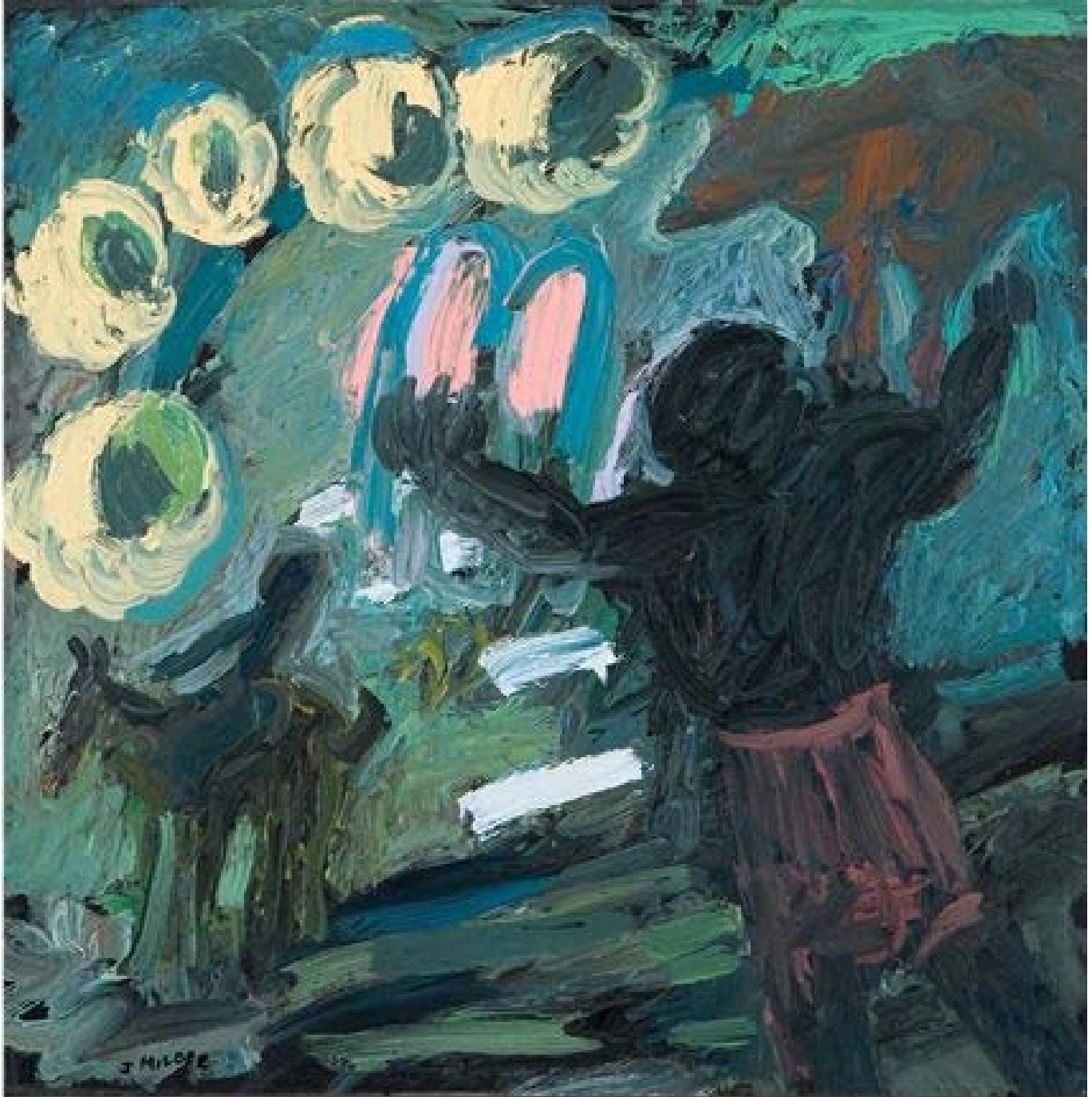


Menninger Perspective

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Contents

- 3 **Butcher, baker...: illness does not discriminate**
After years of treating others a medical professional faces his own journey into depression.
- 6 **Art can soothe the soul and help heal the patient**
Art therapy offers patients visual alternatives for describing illness; insights and healing follow.
- 9 **How to talk to your child about drugs**
Discussing illicit drugs with children is difficult for parents. Here's some useful advice.
- 11 **Research uses eye tracker to develop early autism detector**
Menninger and collaborators put their resources together to study a better way to detect autism in infants.
- 13 **Grateful patients give thanks**
Dear donors: Patients are asked to assess treatment when they leave, while others send notes. Here we share the results of your Menninger giving.
- 15 **New chief of staff brings personality expertise**
Introducing John M. Oldham, MD.
- 17 **Generous individual gifts fund important research**
Donor Betty O'Shaughnessy decided to combat personality disorders through research.
- 18 **Ways of giving**
Charitable gifts can benefit both you and Menninger.
- 20 **Glance around**
- 22 **Governance**

Butcher, baker, candlestick maker: Mental illness does not discriminate

After years of treating others, a medical professional faces his own journey into depression.

The decline was slow, a descent that cast a nascent shadow. As the shadow grew, Tom Carter struggled. He struggled with an internal world that was getting darker by the month. There were incidents of auditory hallucination, of hearing things.

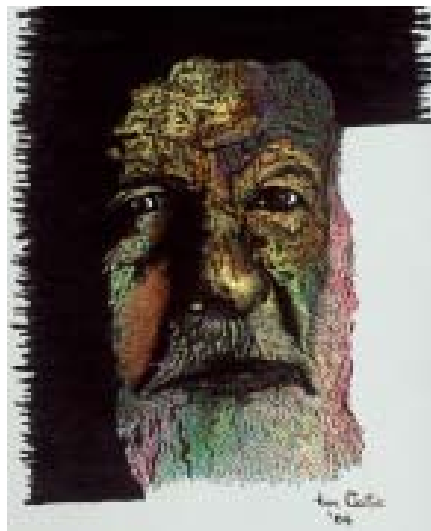
There was a week of hospitalization when he worried his mind would “snap” under the strain of imagining himself in a dark room and the only way out was to risk stumbling over objects and possibly maim or kill himself.

There was the growing joylessness; the reduction in social interactions.

There was, finally, the notion that life was simply not worth living followed by the hope that some awful event or disease would strike him and the pain he endured inside his internal world would end.

His experience was harsh and horrible, but also clinically insightful. For Tom Carter is Thomas Carter, MD, a Menninger-trained child psychiatrist who, for more than 20 years, practiced the art and science of comprehensive psychotherapy and psychopharmacology that resulted in saving the lives of innumerable patients who were overwhelmed with mental illness.

Now Dr. Carter had become a patient himself, no longer detached by an objective professional wall. But how is it possible that a psychiatrist, of all people, could become depressed?



Tom Carter, *Self Portrait* (stippling).

“Because I am human, too,” Dr. Carter said, “and I was so sick I had to talk myself into living.”

A gradual illness

For years, Dr. Carter had a growing awareness of his problem. He felt comfortable and loved working with his patients in his private practice and with his colleagues at the more than a dozen mental health-related agencies where he consulted. However, he found it more and more difficult to face the corresponding paperwork required. It wasn't the burden of writing up individual patient cases that galled him. It was the nature of the paperwork, the tone, the content. Insurance companies were increasingly demanding and restrictive. Dr. Carter found it overly stressful attempting to

square the narrow rules of healthcare bureaucracy with the conflicting realities of treating his patients.

“In one case I spoke with an insurer, a woman who sounded as if she was not beyond adolescence herself,” he recalled. Dr. Carter was trying to talk with the insurer about a young patient, a teen with psychotic symptoms, to authorize further psychotherapy, which Dr. Carter advised and the family supported.

“She was a gatekeeper at a managed care company. I said this patient needed more time, more work with psychotherapy. At one point I remember using the word hallucinations and she asked me how to spell it. Afterward she determined that the teen did not need psychotherapy. So that was difficult.”

He grew frustrated having to justify his professional diagnoses and treatment plans. He began to feel compromised having to navigate through bureaucracies to ensure the care his patients desperately needed. He said he had excellent training at Menninger learning how to write case evaluations, so that was not a problem. But the modern paperwork called for the infusion of buzzwords that meant little or nothing to professional clinicians. Over the years his apprehension and his anxiety grew.

He could feel himself losing the ability to cope. The pressure massed against his sense of self-control. He shut down his private practice and worked half-time, then reduced his work further to quarter time. By 2002, he could not work at all, pledging that



Drawings are by Dr. Tom Carter, the subject of the story that appears below. *The Couple* (left) and *Indifference* (next page).

he would heal himself “by allowing these things to come up in me and to deal with them,” rather than keeping his feelings bottled up and controlled.

Self-treatment

As Dr. Carter’s coping continued to slip, he treated himself, “something I don’t recommend,” he said. He wanted to deal with his problems directly and to open himself as fully as possible to the emerging painful emotions. With the loving support of his family he allowed his feelings to surface.

He began to see a familiar pattern. Years earlier, he published a theoretical paper concerning phases his young patients experienced in residential treatment. They repeatedly cycled

through a sequence of emotional phases, increasingly reaching more effective levels of coping, in an upward spiral process. Eventually they were able to consistently maintain those improvements.

“When I began to let things come up from deep within me, I realized I was going through the same things as my young patients. I was able to see from inside me what I had watched from the outside, empathically, in my patients. Once in a while it would dawn on me, ‘Oh, that’s what they were experiencing.’ A tremendous amount of emotion would surface, and not for all, but for a certain amount of them, I could gain insight and

integrate the awareness productively. It was somewhat reassuring though because I knew the cycles would be less extreme as the phases went on. This is the spiral process I had observed in my patients.”

With this process, he began connecting the dots of his life, which included probing his own childhood recollections, experiences that formed him.

The product of a troubled home, Dr. Carter said his harsh upbringing forced him, at some point, “to shove things under” by suppressing traumatic experiences through a lifetime of overachievement. There were also several suicides in his family, including his brother, who took his own life while Dr. Carter was training at Menninger.

Attempting to make sense of his state of mind, he concluded that his interactions with insurers reduced his professional life to a bureaucratic sham. Dr. Carter had equated that perceived dishonesty with what he felt was the parental dishonesty he experienced during his difficult childhood, which was only now emerging from hiding.

The clinical name for his condition is posttraumatic stress disorder (PTSD), a condition that “develops after stress,” writes Jon Allen, PhD, a senior psychologist at Menninger, in his book *Coping with Trauma, Hope Through Understanding*. “It’s a cruel disease, adding insult to injury. Experiencing extremely stressful events induces an illness that renders sufferers vulnerable to continually reliving those experiences in their minds afterwards....”

The condition also breeds depression and can foster thoughts of suicide, as they did in Dr. Carter.

Hence, each time Dr. Carter felt he was manipulating language for insurance on behalf of a patient, that falsely perceived benefit, however well intended, was actually calling up the ghosts of his early troubled life.

Managing symptoms

While Dr. Carter did seek out the services of a psychiatrist, he also did some other things, including activities that resulted, he believes, in unwittingly treating himself.

At 46 years old, he was invited to enter a short foot race, which he did, an event that gradually led to a decade-long interest that inspired participation in more than 400 races and marathons. A bad knee ended that endeavor, but Dr. Carter believes the experience forestalled the onslaught of full-blown PTSD.

While he had journaled for years, Dr. Carter now began to draw, an activity he had not practiced since grade school. The drawing evolved into stippling, a technique that uses multiple dots to create an image. He was entranced by the method. When he worked at the technique, what he thought was the passing of 15 minutes of work was, in reality, three hours. He



was so absorbed, time simply vanished.

He did not always draw in private. Sometimes he would visit coffee shops and people would critique his work. His ball point pen on copy paper turned into a more elaborate ink pen on archival paper. Two years after pursuing stippling, Dr. Carter has more than 150 drawings, some of which have won ribbons at state fairs.

Dr. Carter’s themes range from deep sadness and loneliness to characterizations of the famous, Mother Teresa, for example. Journaling and drawing, especially, have helped him remain on a path to recovery, so much so that he intends to take on some patients next year. He will operate a self-pay practice and won’t work with insurers again. He hopes this approach will help him avoid what he often feels are ethical compromises. Some psychiatric colleagues, he said, are so restricted by managed care limitations that they do little more than prescribe and

manage medication for patients who would otherwise benefit from a combination of talk therapy and medication.

Another important strategy for managing symptoms includes limiting his exposure to mediaviolence.

“I don’t need to be inundated by media to be informed. I have tried to work out a balance where I am exposed to the real world but not overwhelmed by it.”

On the positive side, he found satisfaction this past year working with neighborhood park youth and in a family sports program.

Dr. Carter’s complex personal journey is an odyssey that has been quite difficult, but revealing. While he has had to adjust the circumstances of his life, he has also gained insights and lessons he hopes will eventually benefit his patients.

Even doctors suffer mental illness; they can also come back healthy and engaged in the world again.

Art can soothe the soul and help heal the patient

Art therapy offers patients visual alternatives for describing illness; insights and healing follow.

John Morris could not bear dirt. He could not bear the invisible germs from doorknobs or sinks, nor could he bear dust from walls or the barest grime from a floor. Dirt was a kind of death and he died a little with every smudge.

Mary Smith shared many of John's concerns, but also had her own unique fears. In addition to a phobia of germs and dirt, bacteria of any sort, she needed the things in her life to be symmetrical and organized. A lack of organization disturbed her greatly, a condition known as perfectionism, which is an unquenchable desire for symmetry and order.

Her life was a constant struggle to find order or to create it. Magazines had to be aligned in exact rows, items in drawers needed to be straight. For Mary, the combination of disorganization along with the presence of dirt produced an emotional cocktail that, at times, would undo her and leave her filled with overwhelming anxiety.

John and Mary share a condition, obsessive-compulsive disorder (OCD), treated at Menninger through the OCD Treatment Program, which provides hospital treatment for adolescents, 12 to 17, and for adults, age 18 and older, who have severe OCD, anxiety disorders or OCD spectrum disorders, as well as coexisting conditions.

Many patients, in addition to

“Although patients may enjoy art as a diversion, the exercise is integrated into the broader therapeutic approach.”
— Kim Fountain, rehabilitation therapist

suffering from OCD, struggle with other anxiety symptoms, such as social anxiety and panic, and varying degrees of depression. Other patients seen by Menninger staff also have a diagnosis of one of the OCD-related disorders, such as body dysmorphic disorder, trichotillomania, hypochondriasis or Tourette syndrome.

In art therapy

Considering the nature of their fears and obsessions, how is it possible that John and Mary found themselves engaged in

drawing each other's portraits on large pieces of paper using black chalk, which left a soot-like residue on their hands, smudges that made their fingers appear as though they had rummaged through coal piles? Additionally, why would a Menninger healthcare professional encourage John and Mary to actually go to lunch directly from working on their art, eat lunch and return without washing their hands?

Kim Fountain, a rehabilitation therapist at The Menninger Clinic, has seen many people with OCD engage in the creation of art and forget or ignore temporarily the very issues that have brought them to The Clinic for treatment.

“In therapy, where patients may stay for months and are in treatment 24 hours a day, seven days a week, art becomes a welcome respite,” Ms. Fountain said. Patients may not realize it, but the respite is more than a break from treatment.

“Although patients may enjoy art as a diversion, the exercise is integrated into the broader therapeutic approach.”

Menninger first established art therapy programs in the 1930s. The Menninger Clinic employed a number of artists in residence in the following years and the hospital was considered a leader in the art therapy movement through the 1950s and 60s. The first journal in the field, *The Bulletin of Art Therapy*, began in 1961 and the The American Art Therapy Association (AATA), a national regula-

tory organization for art therapy professionals, was established in 1969.

No erasers

John and Mary were exposed to the contamination of chalk and dirt, in other words, to the very things that made them anxious. Additionally, Mary had to contend with the messiness and the disorganization of the materials in the art room where she was surrounded by uneven stacks of dog-eared magazines, the clutter of art materials and works in various stages of progress. She also couldn't work with the precision of a pencil since pencils are not allowed, a way of dissuading detail-oriented patients from pursuing perfection. Worse still for patients with obsessions, erasers are nowhere in sight.

As she drew, Mary criticized her own mistakes, her lack of ability, her imperfections. Fellow patients were helpful in praising her, part of the pact for participation in this form of therapy: patients agree not to criticize one another. In the event a criticism slips out, several compliments must follow. Art therapy brings a permissive atmosphere of experimentation and self-expression, a place one enters after leaving artistic inhibitions outside the door.

Behavioral therapy

Art therapy offers more than the opportunity to engage in cognitive-behavior therapy (CBT), which examines unwanted thoughts or beliefs and attempts to change the resulting behavior. Since beliefs and perceptions shape the way people view the world, CBT attempts to realign thoughts and perceptions in order to adjust behavior and a patient's world view.

Though beliefs may not be realistic, it is the belief that determines behavior. Through disciplined steps the patient learns how to undo behaviors that have been counterproductive to recovery.

CBT is one of the many therapies available at Menninger, where professional treaters draw from an eclectic array of therapeutic tech-

“ I get a lot of understanding about what’s going on with them from looking at their artwork.”
— Ms. Fountain said, “so it’s a learning experience for me as well as for the individual patient.”

niques available in designing individualized treatment plans.

Picturing pain, illness

For instance, patients who cannot articulate their illness in words, find their language through the art itself.

What does an illness look like?

This question is often the basis of an art assignment for Menninger OCD patients.

How does one describe depression or obsession? What do these disorders actually look like?

A young woman with anxiety issues that resulted in hair-pulling (trichotillomania) described her illness in clay when she produced an eerie-looking spiked tree. The horrifying image proved to be a place to begin discussing the nature of her illness.

“Sometimes people come in and they don’t have a lot of personal awareness,” Ms. Fountain said. “Art therapy offers a way to analyze themselves from a detached view-

point. Art also forces individuals to make decisions, something we may avoid in the middle of a mental illness.

“I often leave assignments open-ended as far as my directives are concerned,” she continued. “A lot of people, especially those with OCD, have problems making choices. They have a lot of self-doubt. They are not sure what to do. What I do is I leave a lot of things open to interpretation. I say, ‘Here’s what I’m going for now; you interpret it anyway you want—you make the choices.’ Usually they need a lot of support with that.”

The visual image of the art inspires talk and is more immediate than the words one reaches for in verbally describing how an illness works internally. By creating a visceral image, one sees an illness in its most profound state.

“I get a lot of understanding about what’s going on with them from looking at their artwork,” Ms. Fountain said, “and I’m often surprised at some of the things they put down on their drawings so it’s a learning experience for me as well as for the individual patient.”

Art also offers patients the opportunity to learn about themselves and each other. Since a patient’s peers are important to the therapeutic process, art serves as a way of discussing an image or concept conversationally, a less formal approach than individual or group therapy.

“I had one patient recently who was a very concrete thinker but he loved art,” Ms. Fountain said. “I had individual sessions with him and we discussed the abstract nature of his artwork and what made his artwork more powerful.”

The patient’s work was not studied or professional, but stood out because of the patient’s individualized technique, which raised the quality of the images.

That was a way for Ms. Fountain and the patient to engage in discussion, talking about abstract art in concrete terms, and a way also of enhancing the thinking process.

Art therapy

Art is supportive

For those patients who find it difficult to express themselves in paint, chalk or clay, they may ease themselves into the sessions by creating paper collages from scenes cut out of magazines, which is considered a safer approach.

“I’ve had patients who have been alarmed at what they have drawn or painted, at the product they see on the paper. I can see that something developmental is going on, something else is going on for them. Sometimes they take a look at their drawing and they have to take an emotional step back. Usually, I’ll push them toward some other type of visual expression.”

Patients are also guided toward expressive drills. One exercise involves drawing a bridge that spans a point in the patient’s past to a point in the future. The patient is then asked to place him or herself somewhere on the bridge between the two points that mark the past and the future.

Follow up questions are designed to probe deeply: Are there bridge supports? What does the bridge look like? How strong is the bridge? Does the bridge have dangerous items on it? Can you fall off the bridge?

“One patient drew a swimming pool on one side and a plane on the other. The patient spent most of her treatment consumed with the idea that she was missing a summer of swimming at home. Consequently, she did not get the most out of her treatment.”

Perfectionists will be asked to draw with the non-dominant hand as an exercise in challenging their sense of order.

Patients with difficulties about their body images will be encouraged to draw themselves and their ideal image.

Another exercise involves masks. Patients are asked to paint one mask that reflects who they appear to be on the outside; then they are asked to produce one that reflects how they feel

about themselves on the inside.

Despite the troubling and disabling disorders that involve compulsions or obsessions, patients are so involved with their illnesses there is often some trepidation about recovery. Instead of viewing recovery in a positive light, some patients worry about who they will become once the OCD part of their lives goes away and disappears forever. Art therapy can help.

“One female patient was very afraid of giving up her OCD symptoms because she didn’t know what would take their place,” Ms. Fountain said. “Her life was taken up with the symptoms. She spent so much time on OCD and it controlled her so much that she wanted to know who she would be. Consequently, she was encouraged to create a collage that recorded her treatment process, a roadmap that gave the patient a visual outcome to a happier place.”

How to talk to your child about drugs

By Anissa Anderson Orr

Discussing illicit drugs with children is difficult for parents. Staff share some useful advice.

Parents should talk to their children about drugs long before they become teenagers, not an easy task for many parents. Addictions experts at The Menninger Clinic suggest ways to overcome the fear of broaching the subject.

Pre-teens are experimenting with drugs and alcohol as early as age 11, catching parents by surprise, say addiction experts at The Menninger Clinic. Because many parents don't expect their children to have access to drugs until later in their teens, they don't recognize the signs and symptoms of substance abuse in their children.

"The kids we treat have been using for quite some time before their parents figure it out," said Norma Clarke, MD, medical director of Menninger's Adolescent Treatment Program, which treats young adults age 12 to 17. "They convince their parents that they are not using, because their parents don't want to believe they are using. Also, primary care doctors often don't ask about drug use, and most psychiatrists don't ask."

Doctors may diagnose the mood swings caused by drug use as symptoms of bipolar disorder or a mood disorder, preventing adolescent patients from getting the addictions treatment they need.

Parents unaware of abuse

So why are parents in the dark?

"Before your child becomes a teenager—at around age 10 to 12—it is important to change and improve your communication with them."

— Lynn D'Antoni, LCDC, addictions counselor

Spotting substance abuse in pre-teens can be tricky. Pre-teens beginning to experiment with drugs may cope well with the physical side effects of drugs or alcohol because their bodies are strong and because they haven't yet developed a physical dependence.

Some pre-teens may still excel academically while using drugs or alcohol. Or they may use substances such as prescription drugs or inhalants that are easily accessible and easily concealed, compared to illegal drugs,

like marijuana and heroin.

Also, parents may not want to believe their children are using drugs or alcohol, or they believe their children when they say they aren't using, even when evidence points to the contrary.

Talk to your kids

Fortunately, parents have more influence on whether their children will try drugs than they may think. Children who learn about the risks of drugs at home are up to 50 percent less likely to use drugs, according to a 2005 study released by the Partnership for a Drug-Free America.

The key is to talk to your child before they get to middle school, when they are most likely to encounter drugs for the first time, said Lynn D'Antoni, LCDC, a Menninger addictions counselor.

"Before your child becomes a teenager—at around age 10 to 12—it is important to change and improve your communication with them," Ms. D'Antoni says.

"During adolescence, teenagers developmentally move from the immediate family to a larger social circle where they begin to define their own identity."

Ms. D'Antoni suggests the following tips to help parents talk to their children about drugs and alcohol and to discourage them from using substances to get high.

■ **Educate yourself.** Learn what you can about the latest trends in drugs

Talking to kids

and alcohol, so you know what your children are dealing with. Three out of five parents in the 2005 Partnership for a Drug-Free America study reported discussing drugs like marijuana “a lot” with their children, but only a third of parents reported discussing the risks of using prescription medicines or non-prescription cold or cough medicine to get high.

However, today’s pre-teens are more likely to abuse prescription and over-the-counter medications than illegal drugs.

■ **Keep it simple.** When talking to your pre-teen about drugs, simple messages work best, according to the National Office of Drug Control Policy. Tell your child that you do not want them to use any toxic substance such as alcohol or tobacco, or drugs such as marijuana, ecstasy, opiates, prescription drugs or over-the-counter drugs such as cough medicine. Parents can also take advantage of teachable moments when watching television or

a movie together, for example, when a character uses drugs or alcohol.

Another teachable moment could be talking about another child’s or adult’s experiences with substance abuse.

■ **Practice saying “no.”** The Office of National Drug Control Policy suggests parents role play with their child how to “say no” to drugs when they are confronted by someone offering them. “No thanks, it’s not for me,” or “That’s illegal. I could get into trouble or get kicked off the team” are examples of ways to say “no” to drugs.

■ **Get involved.** Know what your children are doing, including their activities and how they spend their time. You have the right to set rules about what they watch on TV, what movies they go to and songs they listen to. Let your children know you are monitoring their time on the Internet and what Web sites they are browsing out of concern for them.

■ **Listen.** “Learning to listen without judgment or criticism is an important part in healthy communication with your child,” Ms. D’Antoni says. “This opens the opportunity for them to share what’s really going on in their lives without fear of being criticized or judged by you.”

Telltale signs of drug use

- Chronic eye redness, sore throat or dry cough
- Stealing or chronic lying, especially about whereabouts
- Deteriorating relationships with family members; changes in friends
- Wild mood swings, hostility or abusive behavior
- Chronic fatigue, withdrawal or carelessness about personal grooming
- Major changes in eating or sleeping
- Loss of interest in favorite activities, hobbies, sports; school problems; slipping grades, absenteeism

(Source: Partnership for a Drug-Free America)

Research uses eye tracker to develop early autism detector

Menninger and collaborators put their resources together to study a better way to detect autism in infants.

In a collaborative research project concerning the early detection of autism the Menninger Child & Family Program, directed by Peter Fonagy, PhD, is working with Diane E. Treadwell-Deering, MD, of Texas Children's Hospital, the largest pediatric hospital in the country.

Dr. Treadwell-Deering is the hospital's chief of Psychiatry and Psychology Service, chief of the Pediatric Psychopharmacology Clinic and an assistant professor at the Menninger Department of Psychiatry & Behavioral Sciences, Baylor College of Medicine (BCM).

Autism Spectrum Disorders cause severe impairment in thinking, feeling, language skills and difficulty relating to others. Another term is mindblindness, which is the opposite of mentalizing, a healthy state of mind that is central to Menninger's research-oriented clinical mission.

Because children with autism often respond well to specialized programs, the sooner a diagnosis is made the better. Since early intervention is so critical, Menninger researchers and their collaborators are attempting to develop assessment procedures that will be able to detect autism within months of birth.

The project will involve the screening of more than 600 children and adolescents who are brought to



Peter Fonagy, PhD

Texas Children's Hospital (TCH). Each participating child will undergo a series of behavioral and developmental assessments, administered by trained clinicians and overseen by Dr. Treadwell-Deering, who is also chief of the Clinic for Autism Spectrum Disorders at TCH.

Less severe forms of autism include Asperger's syndrome and two rare disorders, Rett syndrome and childhood disintegrative disorder. Diagnosis of these problems often occurs in early childhood, frequently after parents notice irregular behaviors in their child compared with other children of the same age.

According to the National Institute of Mental Health, a recent study estimated that three of every 1,000 children three- to 10- years-old had autism.

Eye tracker

The study will rely upon a Swedish-made Tobii eye tracker, an expensive and complex piece of computer-driven, eye-movement monitoring equipment. The tracker is essentially a combination of a display monitor and a camera that records and processes eye movements in relation to visual displays. It is sometimes used by advertising agencies interested in how consumers respond to particular products, but also by scientists studying dyslexia and for an assortment of other clinical purposes.

Monitoring infants

For the autism research project, prominent Hungarian researcher Gyorgy Gergely, PhD, a Menninger collaborator, has developed a unique adaptation of the eye tracker for studying the sensitivity of autistic individuals to displays that change in relation to the movement of the child's eyes. This permits studies of the reactions of infants as young as three to four months with non-invasive, non-distressing apparatus.

The specially programmed device, which does not require head gear, prohibitive equipment in a child so young, records the infants' eye movements by measuring and tracking reflection of harmless infrared light.

The device will provide "online feedback about where the person is looking," Dr. Fonagy said, "which allows us to modify the information

we present to them and test their sensitivity to the way the pictures they see are associated with the movements of their eyes.” This is a key result for an age group that is otherwise unable to respond voluntarily to instruction.

The research will attempt to understand the neuropsychological problems that lie behind autism. In addition to developing an earlier test for the disorder, the research may culminate in improving the effectiveness of interventions for autistic children. Finding out what creates mindblindness will offer a back door view of mentalizing.

Mentalizing

Mentalizing allows us to automatically interpret behavior based on mental states, such as desires, beliefs and feelings.

“A shorthand idea for mentalizing is *keeping mind in mind*,” writes senior Menninger psychologist Jon Allen, PhD. “Mentalizing requires attention and takes mental effort; it’s a form of mindfulness, that is, being mindful of what others are thinking and feeling as well as being mindful of your own thoughts and feelings.”

“The main problem with mentalizing,” Dr. Allen continues, “is not lacking the basic ability but rather failing to cultivate it and put it to use.”

Children with autism, for example, are often unresponsive to others and do not mimic the actions of those around them. The children are also slow in learning how to interpret actions, one of the key elements of healthy human interaction.

“Failing to mentalize can contribute to serious problems in relationships,” Dr. Allen writes. “Your friends, family members or spouse will be unhappy if you’re oblivious to their needs and feelings or you continually misinterpret their actions. Psychiatric disorders such as depression and substance abuse notoriously interfere with mentalizing. When such problems arise, you can benefit from learning about mentalizing, paying greater attention to doing it, and becoming more skillful at it.”

In infants with autism, the inability to mentalize exhibits itself in the child’s disconnect from the parent, in the baby’s inability to appreciate or understand a mother’s loving smile and to emulate it. Hence, autism is a condition that clearly shows the absence of mentalizing. Understanding more about autism, therefore, may offer important insights into this vital and healthy communication between people.

“Basically, the ultimate aim of the autism research,” Dr. Fonagy said, “is to try and understand what it is that is going wrong with these children. Our hypothesis about it is that their capacity to detect contingencies between their responses and what’s happening in their environments is not working properly.”

Dr. Fonagy’s team

Dr. Fonagy and his team, which includes Lane Strathearn, MBBS, in the Department of Pediatrics at BCM and Robin Kochel, PhD, in the Department of Molecular and Human Genetics at BCM, are interested in learning more about visual preferences among children and adolescents with different developmental and behavioral conditions. There is some evidence to suggest that the ways in which individuals respond to visual stimuli may predict social communication deficits seen in disorders like autism.

Through a series of experiments using non-invasive eye movement tracking, the Fonagy team aims to test this idea, comparing individuals with autism, Down syndrome, attention-deficit hyperactivity disorder (ADHD), and those who are typically developing, to see if there are important differences.

The team hopes that this methodology may someday be used as a way to detect autism at earlier ages and distinguish it from other developmental disabilities.

Following these assessments, children will participate in a series of eye-tracking experiments at the Human Neuroimaging Laboratory at BCM. The eye-tracking tasks are completely noninvasive, and children

will be asked to play a “computer game” that involves their watching various stimuli on a computer monitor.

Each eye-tracking session may last between 30 and 60 minutes, and families may be asked to participate in more than one session. Because the Fonagy team has proposed a range of variations of the basic experiments, the entire course of the study is estimated to run five years.

Dr. Gergely

Dr. Gergely, who is head of the Department of Developmental Research of the Institute for Psychological Research of the Hungarian Academy of Sciences, has published widely in major journals.

He has published two scholarly books with Dr. Fonagy and other researchers and he has received many international honors for scientific excellence.

During the autism research project, Dr. Gergely also will work with John Watson, PhD, University of California, Berkeley, a pioneer in the study of contingency perception and a consultant on the project.

Contingency perception is understanding that an action has a consequent effect.

Texas Children’s Hospital

Texas Children’s Hospital, which is affiliated with Baylor College of Medicine as its primary pediatric training site, is an internationally recognized full-care pediatric hospital located in the Texas Medical Center in Houston. Texas Children’s Hospital is dedicated to providing the finest possible pediatric patient care, education and research. Since opening its doors in 1954, the hospital has cared for more than one million children from every corner of the world.

The hospital is nationally ranked in the top five among children’s hospitals by both *Child* magazine and *U.S. News & World Report*.

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Dear donors: Patients are asked to assess treatment when they leave, while others send notes from home. We wanted to share with you positive results of your Menninger giving.

■ Thank you for giving me the will to live and to enjoy life.

■ Three months on Hope. This is where I truly started to rebuild my life. After isolating from everything and everybody in the world, except my family, for so long, something amazing happened—I started to connect with people again.

I cannot put into words how wonderful the staff was. I could truly tell that they were there to help and I took advantage of their knowledge and expertise in helping people. They were some of the most caring and professional people I will ever know in my life. I also started to connect with the other patients. I made friends—lots of them.

As you know, people bond quickly at psych hospitals. I still keep in touch with some people today. I worked diligently to start rebuilding my life. I was given so many new tools and so much useful information through my treatment team, groups and other patients.

■ Keep it up, but don't be afraid to change (for the better, hopefully). The Menninger model is the best I have ever experienced.

■ Although I am a healthcare provider, it was my turn to be ill and I

“I am leaving here with a higher self-esteem and feeling stronger and more comfortable with myself and in dealing with others than I have ever experienced in my life.” _ Former Menninger patient

feel I had the very best in nursing care. All of you were so gentle and respectful of me as my depression and anxiety lifted. Thank you for six wonderful weeks of care.

■ It's been an incredible life changing-experience! I'm very glad I had the opportunity to come here.

■ When I came into Menninger, my

life was a mess and I was impulsive and wanted to hurt myself. Now that I have gone through the Compass Program I have good self-esteem, I no longer want to hurt myself and I feel hopeful about the future.

I only wish everyone who needed this program could have access to it. I truly believe that this program and the staff who run it have changed my life and my outlook on the world. Thank you so much to everyone who has worked on Compass during my stay. I owe my progress all to you. Thank you from the bottom of my heart!

■ I have difficulty expressing my feelings about The Menninger Clinic without tears welling up in my eyes. I was expecting a country club atmosphere when I arrived, and I was certain I was going to be pumped full of phoney affirmations to be sent back out with a false sense of wellness. Nothing could be further from the truth.

I have never been challenged in such a way in my life. There were days I thought I was being emotionally dragged behind a truck. It was not exactly fun. However, I had not cried an honest tear in over 10 years when I admitted myself here. I was completely out of touch with my feelings, detached from people and I had exceptionally poor boundaries.

The work involved in becoming mentally healthy can be equated to that of someone learning to walk

Giving thanks

again after say, a bad accident. It is painful. There is suffering and anguish.

The reward for the discoveries I mentioned is equally equated to having the ability to walk again or spending my life in an emotional wheelchair.

■ I think the staff was wonderful. I believe that the way the staff interacted with me was to my benefit. I may not have heard everything that I wanted to hear, and I would have wished that things could have been presented to me differently. But I am an adult and I did come here for help with dealings with life. Thank you!

■ I am walking out of Menninger as a better person, thanks to staff and peers. My recovery is ongoing but Menninger was a great first step. Thank You.

■ I was able to work my way through and face many issues that I was unable or unwilling to look at before. Together we developed solutions and plans to aid me in dealing with future problems as they arise.

I am leaving here with a higher self-esteem and feeling stronger and more comfortable with myself and in dealing with others than I have ever experienced in my life.

■ The program works. I have been pleased with both the caring and tough treatment that I have undergone. I hope to be able to report back continuing good news from my life.

When I came here, I was hanging on a slim thread of hope. I am no longer in that space and am excited about the opportunities before me, which Menninger has opened for me.

“When I came here, I was hanging on a slim thread of hope. I am no longer in that space and am excited about the opportunities before me, which Menninger has opened for me.”
— Former Menninger patient

■ This was a great, powerful, difficult, rewarding experience for me. I connected to the staff at every level, felt understood and communicated to, and most importantly, felt supported.

■ The Eating Disorders Program team and staff truly care for the patients and interact with support and compassion and encouragement. They are readily accessible and encourage us to talk about our feelings and ask for help. I felt cared about as a person, not just as someone who “needed to get healthy.” They really took the

time to get to know the real me. They will be greatly missed because of the attachments I have made. Thank you, Menninger, for saving my life.

■ Enjoyed experiencing the Menninger team concept of healing, educating, evaluating and empowering patients. I found the community atmosphere and total rehabilitating process excellent. I appreciate your networking for Menninger-trained specialists in my home area.

Thanks so much for all your help, expertise, professionalism, and educational process, teaching me skills I did not know existed. I value this experience and consider it life-changing for me as well as very supportive for my family. Thanks again!

■ This has been a life-saving experience for me.

■ I am extremely satisfied with my treatment. Menninger staff saved my life. I was hopeless when I came in and now I have lifetime changes and skills to cope. For that, I feel most grateful. Thank you.

■ I have gained more than I could have hoped for. I feel happy that I have my life back. I’m looking forward to tomorrow.

New chief of staff brings personality expertise

Internationally recognized psychiatrist John Oldham, MD, MS, is the new chief of staff of The Menninger Clinic. He will also serve as a senior vice president for The Clinic and as executive vice chair for Clinical Affairs and Development and professor in the Menninger Department of Psychiatry & Behavioral Sciences at Baylor College of Medicine (BCM).

Dr. Oldham will also serve as executive vice-chair for clinical affairs and development and as a professor in the Menninger Department of Psychiatry & Behavioral Sciences at BCM. He begins January 1, 2007.

His appointment was jointly announced by The Menninger Clinic, and Baylor College of Medicine through Ian Aitken, Menninger Clinic president and chief executive officer, and Dr. Stuart Yudofsky, D.C. and Irene Ellwood professor and chairman of The Menninger Department of Psychiatry & Behavioral Sciences, Baylor College of Medicine.

“Dr. Oldham brings to Menninger a wealth of clinical expertise and experience working with complex medical and psychiatric systems,” Mr. Aitken said. “His international reputation as a leader in psychiatric medicine and specialization in personality disorders is a tremendous asset to The Clinic and our affiliation with Baylor and Methodist.”

Dr. Oldham, an authority on personality disorders and a psychoanalyst, is a BCM graduate. He is professor and chair of Psychiatry & Behav-



John M. Oldham, MD, MS

ioral Sciences and executive director of the Institute of Psychiatry at the prestigious Medical University of South Carolina (MUSC), said he accepted the position because, “The Menninger Clinic is a landmark institution in American psychiatry. All of us in the field have been influenced by the pioneering work at The Clinic, and many of my teachers and professional colleagues have been Menninger-trained or have participated in the work of The Clinic. It is a privilege to have the opportunity to join the leadership team at Menninger.”

Dr. Munich retires

Dr. Oldham follows Richard L. Munich, MD, who retired from The Clinic to private practice in New York after holding the Menninger

post for the last decade.

A search committee, co-chaired by Menninger senior psychologist Jon Allen, PhD, and James Lomax, MD, associate chair of the department, included several members from The Menninger Clinic and the department. The committee reviewed many letters of inquiry and believed that Dr. Oldham was the ideal candidate.

“Dr. Oldham’s reputation is known both nationally and internationally and will draw patients to The Clinic,” Dr. Allen said. “He is experienced in working with complex medical and psychiatric systems, including academic medicine. He is ideally suited for the position because he has the needed clinical expertise on the basis of his extensive experience in similar clinical settings, coupled with a specialization in personality disorders.”

Illustrious career

Dr. Oldham brings a wealth of expertise in psychiatric patient care, research and education. At MUSC he headed ongoing projects ranging from basic neuroscience and brain imaging, to clinical psychopharmacology and the design of clinical service delivery systems.

In his highly distinguished research career, Dr. Oldham is recognized as a world authority on personality disorders. His efforts have focused on clarifying personality disorder diagnosis, prevalence and course across generations and life span.

He has served in numerous leadership and consulting positions for national and international psychiatric organizations. Having received his medical education at Baylor College of Medicine in 1967, Dr. Oldham completed psychiatric training at Columbia University College of Physicians and Surgeons and the New York State Psychiatric Institute. He also completed psychoanalytic training at the Columbia Psychoanalytic Center and holds board certification in psychiatry, psychoanalysis and forensic psychiatry.

He is the recipient of many awards and honors for leadership, teaching and contributions to the field both locally and nationally. He is active nationally as an educator and lecturer, reviewer and editor. Dr. Oldham is author or co-author of over 200 journal articles, books, book chapters and editorials.

Dr. Oldham and his wife, internist Karen Pacella Oldham, MD, have two grown children, Madeleine, the literary manager of Seattle Childrens' Theater, and Michael who is just beginning work on his doctorate in neuroscience.

Dr. Oldham has previously served as chairman of Columbia University's Department of Psychiatry, director of the New York State Psychiatric Institute and chief medical officer of the New York State Office of Mental Health.

In addition to maintaining a private practice for more than 27 years, the breadth of his clinical activities has included a variety of supervisory responsibilities. He was director of Psychiatric Emergency Services, and later, director of Residency Training at Roosevelt Hospital. His advocacy has made him a valued board member of the Alliance for the Mentally Ill, The Project for Psychiatric Outreach to the Homeless and the Mental Illness Foundation.

Getting to know Dr. Oldham

In answer to questions, Dr. Oldham prepared this glimpse of his thoughts

about coming to Menninger:

Q: What experience do you have with Menninger staff and faculty at Baylor College of Medicine?

As a Baylor alum, I have many friends and colleagues here. (Department chair) Stuart Yudofsky is a long-standing friend. We were fellow-students at Baylor and then fellow residents at Columbia, and I succeeded Stuart at Columbia and The New York State Psychiatric Institute, assuming his positions there when he moved to Chicago. One of my medical student roommates at Baylor was Major Bradshaw, and of course I have known and worked with Jim Lomax and Glen Gabbard for many years. One other interesting link is that Dick Munich and I formerly had offices across the hall from each other at The New York Hospital Westchester Division.

Q: What do you believe lies ahead for the future of mental health treatment and research?

In my career there has never been a more exciting time in the field of psychiatry. The bi-directional nature of gene/environment interaction and the stress/vulnerability model of illness are helpful to our understanding of most medical diseases, including brain disorders.

The penetration of the "black box" of the brain by new technology is moving forward at warp speed, with new imaging techniques, molecular neurobiology, genetic microarray networks, transgenic animal models, and many other exciting developments.

Progress from this research becomes quickly relevant in the clinical world, making prevention and wellness promotion much more meaningful, and leading to new treatment approaches and new understanding of existing treatments.

A talk I gave recently was entitled "Psychotherapy: A Biological Treatment," reviewing the persuasive data that brain imaging can show brain changes that accompany psychotherapy and may even allow us

to individually tailor treatment to the individual patient, determined by things like different brain responses in different individuals to pharmacotherapy versus psychotherapy.

Neuroscientists have recognized the importance of studying the biology of the unconscious, which wonderfully brings us full circle to Freud's 1895 Project, but with new science to enlighten us about the cellular mechanisms at work in learning and memory, of particular interest to us, since a crucial form of learning and memory is called psychotherapy.

Q: You've been a prolific writer in your career. Which books do you consider to be the best known? Will you continue your writing activities?

I have enjoyed writing and editing through the years. I served as senior editor for the "Annual Review of Psychiatry" series for American Psychiatric Publishing, Inc. (APPI) for many years, and I now serve on the APPI Board of Directors. I am editor-in-chief of the *Journal of Psychiatric Practice*, which I have done for almost 10 years and plan to continue in this role. Recently, with colleagues Andy Skodol and Donna Bender, I edited the *APPI Textbook of Personality Disorders*, which received great reviews in the *American Journal of Psychiatry*, the *New England Journal of Medicine*, and the *Journal of the American Medical Association*—no surprise when you consider the terrific contributing authors to the volume such as Glen Gabbard and Peter Fonagy (both of the Department)! Perhaps my most unique project was writing, with co-author Lois Morris, a book for the general public called *The Personality Self-Portrait*. Published in 1990 and then revised as *The New Personality Self-Portrait*, it continues to do well, referred to by its publisher, Bantam, as a "backlist best-seller."

Q: What interests you outside of psychiatry?

I enjoy reading, art (especially 17th century Dutch and the old masters), long-distance running and opera.

Generous individual gifts fund important research

Donor Betty O'Shaughnessy decided to combat personality disorders through research.

California resident Betty O'Shaughnessy is interested in Menninger's research surrounding borderline personality disorder (BPD), a psychiatric condition that is among the most difficult to treat disorders.

BPD is suffered by two percent of Americans, most of them women.

Ms. O'Shaughnessy knows that just as patience and determination have made her a successful Napa Valley businesswoman, patience and determination are also critical qualities necessary for discovering more effective treatments for mental illness.

Research of this nature is slow and time-consuming and requires significant expertise and great attention to detail, important factors that have influenced her decision to support Menninger BPD research with generous gifts.

Individuals with BPD often need extensive mental health services and account for 20 percent of psychiatric hospitalizations. Some hospitalizations are initiated by self-injury, often the result of significant rates of suicide attempts. Yet, with help, many persons with BPD improve over time and are able to lead productive lives, despite the significant challenges the disorder poses.

BPD is characterized by unstable relationships, an emotional disconnect from friends and loved ones and acquaintances, and a propensity for



Betty O'Shaughnessy

distorted perceptions. BPD's most predictable element is its day-to-day unpredictability. BPD is frequently linked to a host of negative outcomes that include high conflict, divorce, suicide, substance abuse, child abuse, physical, sexual and emotional abuse, eating disorders, estrangement from family members and much more.

Through her foundation, Ms. O'Shaughnessy supports Menninger research efforts designed to better understand BPD and improve treatment. Pairing Menninger's behavioral expertise with the expertise of the Brown Foundation Human Neuroimaging Laboratory at the

Menninger Department of Psychiatry & Behavioral Sciences, Baylor College of Medicine, researchers are exploring the intricate linkage between brain function and behavior. Using functional magnetic resonance imaging (fMRI) technology, researchers can see the brain at work during testing.

Tracking how brains respond to decision-making offers insights that may lead to improving behavioral and pharmaceutical therapies for patients.

Accumulating research data affords Menninger experts the opportunity to segment the information and explore other facets of BPD, as well.

While it remains unclear what discoveries BPD research may make in the years to come, it is quite clear that the help of people like Ms. O'Shaughnessy substantially improves Menninger's understanding of this significant mental illness.

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
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www.MenningerClinic.com
713-333-3320
800-288-3950



Menninger®

Ways of giving

Gifts for the present

The best way to have an immediate impact on Menninger's work is to make a current gift. Every dollar provides either operational support or ongoing endowment income for an institution you believe in. You also have the satisfaction knowing that the Menninger mission is carried out each day because of your generosity.

There are a number of ways your gift can be made:

An **outright cash donation** is the easiest and most popular method. You receive an income tax charitable deduction for the full amount you contribute.

An **outright gift of appreciated property**, such as publicly traded securities, real estate or even closely held stock, provides an extra tax benefit if you have owned the asset more than a year. In addition to receiving an income tax deduction for the full fair market value of the asset, you also avoid tax on the capital gain.

Note: The income tax charitable deduction that may be reported in any one year is limited to 50 percent of your adjusted gross income (AGI) for gifts of cash and 30 percent of AGI for gifts of long-term appreciated property. In either case, however, any excess deduction is eligible to be carried forward up to five additional



years, subject to the same percentage limitations each year.

In some instances, it may also make sense to donate other types of assets. Giving a new or existing **life insurance policy** will provide an income tax charitable deduction for the present cash value of the policy and/or the future premiums you pay—*if* Menninger is named as beneficiary *and owner* of the policy. (Simply designating Menninger as beneficiary does not result in an income tax deduction but can offer estate tax benefits. Please refer to the next section, titled **Gifts for the future.**)

Additional possibilities include items of tangible personal property, savings bonds, commercial annuity contracts and funds from IRAs and other qualified retirement plans.

The tax aspects associated with contributing assets such as these will vary depending on your particular circumstances.

Keep in mind that sometimes your gift can be structured as a **bargain sale** in which Menninger actually purchases an asset from you, although for less than its full value. You receive an income tax deduction for the difference and reduce capital gains taxes as well.

A final type of present gift is the **charitable lead trust**, which makes payments to Menninger for a certain number of years and then distributes the principal to your heirs. It can enable you to support Menninger now and significantly reduce gift and estate taxes.

Gifts for the future

A gift that is planned and arranged now but does not become available to Menninger until a future time is known as a **deferred gift**. Two common types are charitable bequests and beneficiary designations. Both allow you to retain assets in case you may need them during your lifetime.

Because they are revocable, bequests and beneficiary designations provide no current income tax deduction, but when distributed to Menninger they will be deductible from your taxable estate. Of course, whether your estate will be subject to estate tax will depend on

the year in which death occurs and the size of your estate.

A **charitable bequest** to Menninger can be as simple as a sentence or two in your will or living trust agreement. Your bequest may specify a certain sum of money:

“I give to Menninger the sum of:
\$ _____.”

You may also leave Menninger a particular asset. Example: “*my shares of XYZ stock*” or “*my collection of ceremonial dresses.*” Another possibility would be a portion of the residue of your estate after other bequests have been paid. Example: “*50 percent of the rest, residue and remainder of my estate.*”

Yet another option is a **contingent bequest**:

“If (*name of a specific person*) does not survive me, or shall die within ninety (90) days from the date of my death, or as a result of a common disaster, then I give to Menninger (*insert here the exact dollar amount, description of property or percentage of residual estate*).”

Note: Even if you already have a will, it can often be revised to include a charitable bequest by means of a document known as a codicil. Similarly, a living trust agreement can usually be amended easily. In any event, be sure to consult with your attorney regarding appropriate documentation of bequests and other estate planning arrangements.

Beneficiary designations may be made with respect to several different assets. Typically, this involves nothing more than completing a standard form obtained from the entity that maintains a particular asset or account on your behalf. On the form, you would identify Menninger as the recipient of all or a portion of whatever may remain at death.

One popular choice is a **payable**

upon death designation with regard to a bank account or **transferable upon death** instructions for brokerage accounts. Many people also designate that some or all of the proceeds of a life insurance policy be paid to a charitable organization such as Menninger.

Finally, you should be aware that from a tax standpoint it is generally better to leave cash, securities and real estate to heirs while designating Menninger as the beneficiary for:

- Funds from IRAs and other qualified retirement plans
- U.S. savings bonds
- Commercial annuity contracts

This is because Menninger is exempt from income taxes that would be owed by your heirs on what they receive from these sources.

Gifts that give back

Some gifts actually **return the favor** by combining a charitable gift with life payments for you and/or other beneficiaries you designate. These attractive plans can help you make a substantial gift for the eventual benefit of Menninger while still providing for your personal financial needs. They offer significant tax advantages and, depending on the asset contributed, may even *increase* your cash flow.

A **charitable gift annuity** is the oldest, simplest and most popular life payment gift. In exchange for a contribution of cash, marketable securities or certain other assets, you and/or another beneficiary receive a specified life annuity that is contractually guaranteed.

Rates depend on the ages of the beneficiaries but frequently provide greater cash flow than fixed payment investments. Part of your contribution is tax deductible in the year the gift is made and a portion of the annuity will be tax free. If appreciated property is contributed, tax on the gain is reduced.

A **charitable remainder trust** is a planned giving arrangement in which property is irrevocably transferred to a trustee under a trust agreement. Income (and, in some cases, principal) from the trust is paid to you and/or other beneficiaries for life or a term of years. Menninger then receives the remaining trust assets.

Such trusts offer great flexibility in meeting individual income and estate planning needs. The trust payout rate may be a fixed amount or a percentage of the trust assets as revalued annually. At the time of the transfer, you receive a tax deduction for the actuarially determined present value of the remainder interest.

A **gift of real estate with retained life interest** “gives back” in a somewhat different way. You may donate a personal residence (not necessarily your *principal* residence) or a farm to Menninger, but retain the right to occupy or use it for the balance of your life. You receive an income tax deduction for the present value of the remainder interest and avoid any potential tax on capital gain.

For more information, please contact:

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Glance around

Distinguished addictions researcher joins Menninger

Prominent substance abuse researcher and clinician Thomas Kosten, MD, has founded the Division of Substance Abuse Research in the Menninger Department of Psychiatry & Behavioral Sciences at Baylor College of Medicine (BCM). He brings to BCM and Houston's Michael E. DeBakey VA Medical Center more than \$3.6 million in federal research funding for clinical and basic science studies.

While at Yale University School of Medicine and the West Haven and Connecticut VA Medical Centers, Dr. Kosten's contributions included a cocaine vaccine immunotherapy for hallucinogens, drug treatments for cocaine and opioid dependence.

His recent neuroimaging research includes using functional magnetic resonance imaging (fMRI) to predict pharmacotherapy outcome. He said that a vaccine capable of speeding detoxification from cocaine will soon be available at Menninger.

Mentalizing handbook published for treaters

The Handbook of Mentalization-Based Treatment, edited by Menninger senior psychologist Jon Allen, PhD, and Peter Fonagy, PhD, director of the Child & Family Program, brings together an international group of experts to clarify the concept of mentalization, review



Allen



Bleiberg



Fonagy



Gabbard

current research and knowledge, and explore its diverse applications to treating persons with mental illness.

Mentalizing, the central focus of Menninger research, is crucial to interpersonal relationships as well as self-awareness and self-regulation, and all psychotherapeutic approaches depend on mentalizing capacity. Contributors relate mentalization-focused treatment to established treatments such as psychoanalysis, cognitive-behavioral therapy and dialectical behavior therapy.

Published by Wiley, *The Handbook of Mentalization-Based Treatment* is a valuable resource for mental health practitioners from a variety of

professional disciplines, including psychotherapists, psychologists, psychiatrists, counselors and nurses. It will also be of interest to academics engaged in research in the field of mentalization and attachment. More about ordering the book can be found at MenningerClinic.com under Resources.

Pulitzer-winning author presents Menninger lecture at convocation

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 *N.Y. Times* correspondent in Jerusalem. He also wrote *A Country of Strangers: Blacks and Whites in America* and was invited to participate in President Clinton's first town meeting on race relations.

Menninger globetrotters advocating for mentalizing

Menninger staff members along with international counterparts attended back-to-back conferences in Budapest, Hungary, and London this summer, and New Zealand this fall. George

Gergely, PhD, a developmental psychologist in Budapest, organized the Budapest conference. He has been a major collaborator in the Menninger Child & Family Program since its inception in 1995. More than 250 attended the conference at the Hungarian Academy of Sciences, which was presented with simultaneous translation from English to Hungarian. Jon Allen, PhD, and Efrain Bleiberg, MD, participated from The Clinic.

Both Budapest and London attracted packed conferences and reflected a great deal of enthusiasm. In London the editor of the United Kingdom cognitive therapy journal, *Clinical Psychology and Psychotherapy*, requested papers from the conference for a special issue. The proceedings also will be published in Hungarian in book form.

Mentalizing can serve as a conceptual bridge between psychodynamic psychotherapy and cognitive therapy. Notably, Thröstur Björgvinsson, PhD, and John Hart, LCPC, respectively the director of and a therapist with the Menninger Obsessive-Compulsive Disorders Program, charted this new direction in a chapter, "Cognitive Therapy Promotes Mentalizing," that was published in *The Handbook of Mentalization-Based Treatment* (see previous note) edited by Drs. Allen and Fonagy. Furthering the international effort, Drs. Fonagy, Allen and Anthony Bateman, MD, FRCPSYCH, presented on mentalizing and mentalization-based treatment in a conference, "Minds in the Making," in Christchurch, New Zealand, in early September.

Staff, collaborators present at Yale Child Study Center

Five Menninger professionals presented at the Yale Child Study Center in March during a two-day conference on mentalizing that brought together clinicians and investigators from the Anna Freud Centre in London and the Menninger

Department of Psychiatry & Behavioral Sciences, Baylor College of Medicine. Both Yale and the Freud Centre are significant research collaborators with Menninger. In inaugurating the conference, Peter Fonagy, PhD, director of the Child & Family Program and Freud Professor at University College London, 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."

Other Menninger-trained professionals who presented include: Jon Allen, PhD, Toby Haslam-Hopwood, PhD, Glen Gabbard, MD, and Efrain Bleiberg, MD.

Menninger nurses advance in training and in honors

Menninger nurses have excelled in recent months, receiving advanced degrees, awards and certificates. These achievements fit into the ongoing efforts towards creating a framework for The Menninger Clinic to receive the Texas Nurse Friendly Award and recognition from the Magnet program.

The Magnet Recognition Program® was developed by the American Nurses Credentialing Center to recognize healthcare organizations that provide excellence in nursing care. The multi-year Magnet preparation process will result in Menninger becoming the second free-standing psychiatric hospital to attain this status.

The program also provides a vehicle for disseminating successful practices and strategies among nursing systems.

The Magnet Recognition Program® provides consumers with the ultimate benchmark to measure the quality of nursing care they can expect to receive. Recent achievements in nursing include:

□ Compas charge nurses Alison Beebe, RNS, CARN, and Reyna Bouchard-Kilp, RN, CARN, completed training as certified addiction

registered nurses;

□ Joyce Hamilton, RN, staff nurse, Professionals in Crisis, completed her master's in business administration degree at the University of Phoenix;

□ Durf Wood, RN, The Clinic's infection control nurse, received a certificate and a plaque as this year's recipient of the Nursing Excellence Award for Outstanding Continuous Patient Care from The Menninger Clinic.

Nursing director contributes chapter to important text

Jane Mahoney, DSN, CNS-P/MH, BC, Menninger director of nursing practice and research, co-authored a book chapter published in October. The chapter, "Populations Affected by Mental Illness," appears in *Community/Public Health Nursing: Promoting the Health of Populations (4th Ed)*. Edited by M. Nies and M. McEwen, the book is published by Saunders/Elsevier.

Other staff advances, some of which are supported by The Clinic's tuition assistance program, include:

□ Shelly Forbes, unit coordinator on Hope, received a master's of education degree in counseling from Texas Southern University;

□ Nicolas Valadez, BS, manager of Housekeeping, received a bachelor of science degree in business management from The University of Phoenix;

□ Natalie Wilhite, LPC, an admissions coordinator, passed the licensed professional counselor exam;

□ Mike Rios, LCDC, addictions counselor on ATP, passed the oral and written licensed chemical dependency counselor exams;

□ Martha McCrory, CPRP, director of Rehabilitation Services, passed the certified psychiatric rehabilitation practitioner exam;

□ Debbie Janis, manager of clinical support services, received her master's of science in health administration degree from Houston Baptist University.

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