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JUNE MEETING

TOPIC:

OPENING UP FOR CLIENTS TO TALK ABOUT SEX

PRESENTER:

Carlos Morales, LMFT

10650 Mountain View Ave. #205
Redlands, CA 92373
951-329-1635
ccmora10@hotmail.com

DATE:

Friday, June 23, 2006

TIME:

8:30 am – 10:30 am

LOCATION:

Loma Linda University
Marriage & Family Therapy Clinic
164 W. Hospitality Lane
San Bernardino, CA 92408
(909) 558-4934

Continuing Education Credits:

2 CEUs

COST:

F R E E for members

INLAND EMPIRE CHAPTER OF CAMFT NEWS

(California Association of Marriage and Family Therapists) JUNE 2006

President's Message

Chapter Members,

These are exciting times for our chapter. Your board of directors have been e-mailing and talking amongst ourselves about expanding our membership and establishing access to our chapter via the web. To this end, we have secured two domains: www.ie-camft.org and www.iec-camft.org. Mr. Patrick Griffiths, our membership chair and web master has devoted much time in securing the two domains and bringing to the board multiple sites established by other CAMFT chapters. We are presently reviewing these sites and collaborating on the development our own website. I hope this news thrills you. Being able to establish our chapter in the Inland Empire as a resource for our community, for those looking for therapists, and as a place for therapists who are interested in supporting our profession and each other, is thrilling.

As a board we anticipate the following projects, first, the development of a membership questionnaire (we are evaluating meeting times, format etc.), this is being spearheaded by Garry Raley, our president-elect and second, a day-long board retreat in July for further strategic planning. I trust that our joint efforts will support, enhance and move our chapter forward positively and professionally.

At our previous chapter meeting, Jan Hackleman, a chapter member and Director of The Family Connection provided us with an informative workshop on Temperament Theory and It's Clinical Implication. Thank You Jan for increasing our knowledge and expanding our clinical skills in this area!. As always, we look forward to your attendance and participation in our chapter meetings. Our next meeting will be held on June 23rd, see you then and bring a friend!

Warm Regards,

Sheri Rambharose
Chapter president.

COMMITTEE POSITIONS

Membership: Patrick Griffiths

CEU Coordinator: Carolyn Dodd

Hospitality: Open

Networking Lunches/Socials: Wendy Hallum

Newsletter Editor: Edward Siahaan

Program Chair: Sheri Rambharose

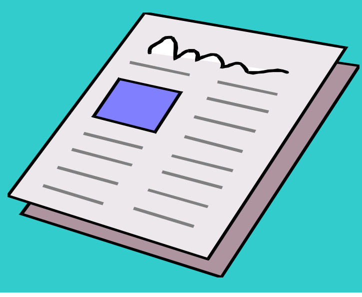
Webmaster: Patrick Griffiths

If you are interested in serving on a committee, please contact Sheri, President.

Get involved! It's fun and your input helps the chapter stay strong.

NEWSLETTER ARTICLES

As a reminder, if you have an article you would like to submit to the newsletter, please e-mail it to the newsletter editor by the last day of the month. The newsletter is e-mailed (unless a hard copy has been requested) to all members by the second Friday of every month.



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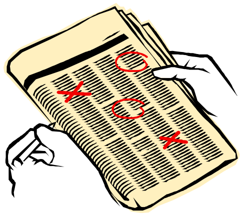

Licensed Mental Health Counselor Needed

A transitional living program run by Lutheran Social Services for homeless women with children is seeking a *Licensed Mental Health Counselor* to work approximately 5 to 7 hours per week to provide one on one counseling to the women and older children. If interested, please contact **Cynthia Carr** or **Sue Lehner** at (951) 656-6020 to discuss the position and set up interview.

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Contact: Garry Raley, MFT

@ (951) 640-5899 or garral@sbcglobal.net

Welcome New Members!

Vernan Bradley
Victoria Carrillo
Molly Miller

Membership Information

Membership to the Inland Empire Chapter of CAMFT requires a membership to CAMFT. There are multiple benefits to belonging to both. For more information on membership benefits or how to join, go to www.camft.org

If you have any questions or concerns, please contact Patrick Griffiths or any of the board members for assistance. Phone numbers are on the first page of the newsletter.

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INLAND EMPIRE CHAPTER OF CAMFT NEWS

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Research Briefs

Family Psychiatric History and Schizoaffective Disorder

The relationship between family psychiatric history and risk of developing schizoaffective disorder was examined in a population-based Danish cohort of 2,207,862 persons.

During >30 years of follow-up, 1925 subjects had schizoaffective disorder, while 3721 had bipolar disorder (BPD) and 12,501 had schizophrenia. Having a father, mother, or sibling with schizoaffective disorder, BPD, or schizophrenia was associated with an increased risk of developing schizoaffective disorder (relative risk 2.76). Risk for schizoaffective disorder was similarly increased by having a first-degree relative with the condition. Schizophrenia among relatives also was a risk factor for developing BPD and bipolar disorder among relatives was risk factor schizophrenia.

Schizoaffective disorder may be genetically related to both schizophrenia and BPD.

Source: Lauren TM et al: Family history of psychiatric illness as a risk factor for schizoaaffective disorder: A Danish register-based cohort study. Arch Gen Psychiatry 2005; 62:841-848.

Early Aggressive Behavior and Later Violence in Girls

Early childhood aggressive behavior is associated with later violence. The value of teacher ratings of aggressive behavior (the Teacher Observation of Classroom Adaptation Revised) from grade 1 through 5 in predicting adolescent criminal violence was studied in 845 girls (73.5% black). 6.4% of the subjects had 1 court record for adolescent criminal violence. Logistic regression analysis showed that the risk of adolescent criminal violence was predicted by teacher ratings of aggression most strongly in the 5th grade increasing to 2.5 in the 5th grade. A cutoff in the springs of 5th grade gave the best reduction in both false positives and false negative, and identified 78.4% of girls as being high risk. 9% of high-risk vs. 1% of low risk girls as being high risk. 9% of high-risk vs. 1% of low-risk girls had later records of adolescent criminal violence.

Early childhood aggressive behavior in girls strongly predicts later violent behavior but may not identify high-risk girls early enough.

Source: Petras H et al: The utility of elementary school TOCA-R scores in identifying later criminal court violence among adolescent females. J Am Acad Child Adolescent Psychiatry 2005; 44:790-797.

Major Depressive Episodes Among American Indians

The prevalence of major depressive episodes (MDEs) among American Indians was compared with that reported in the National Comorbidity Survey (NCS) in 1466 members of the Southwest tribe or 1638 members of the Northern Plains tribe. 53.2% and 59.7% of Southwest and 52.6% and 61.2% of NCS men and women, respectively, endorsed depressed mood or anhedonia compared with 34.3% and 42.0% of Northern Plains men and women. Southwest and Northern Plains women were less likely than NCS women to report 5 symptoms (28.8% and 21.6% vs. 38.3%); Southwest and Northern Plains men were less likely than NCS men to report 5 symptoms was required, tribal men and women had depression rates – 30% of those found in the NCS group. The NCS algorithm did not provide superior results in this population than the American Indian Service Utilization, Psychiatric Epidemiology, Risk and Protective Factors Project algorithm.

Rates of MDR for American Indian groups appear lower than the national average.

Source: Beals J et al: Prevalence of major depressive episode in two American Indian reservation populations: Unexpected findings with a structured interview. Am J Psychiatry 2005; 162: 1713-1722.

Characteristics of Suicidal vs. Nonsuicidal Children

Depression and suicidality in youth are linked, but the effect of sex and puberty are unknown. Demographic and clinical characteristics of suicidal behavior were compared in 92 nonsuicidal and 43 suicidal youth (mean age 12.1 years) with diagnosed major depressive disorder. Suicidal youth were older (12.8 vs. 11.8 years; p<.02) than suicidal youths, but there were no significant differences in sex, race, socioeconomic status, or pubertal status. Suicidal youth had more hopelessness (55.8% vs. 26.1%; P = .001) and insomnia (72% vs. 45.6%; P = .001), more severe depression (P = .001), and lower functional status (P = .019) overall. Prepubertal suicidal boys had more severe depression (P = .044) than nonsuicidal boys; depression did not differ between groups among girls. Postpubertal severe girls had more hopelessness (p = .008) and more severe depression (p = .022) than nonsuicidal girls.

The sex and developmental status of depressed, suicidal youth may influence treatment planning.

Source: Barbe RP et al: Clinical differences between suicidal and nonsuicidal depressed children and adolescents. J Clinical Psychiatry 2205; 66:492-498

Alcohol Abuse and the Course of Bipolar Disorder

Alcohol abuse is often seen in patients with bipolar disorder. The effect of the order of onset of alcohol use and bipolar disorders on the course of illness was examined in 144 patients following a first psychiatric hospitalization for mixed or manic bipolar disorder. Subjects were followed for up to 5 years. 84 patients had no history of alcohol-use disorders, 33 had onset of bipolar disorder prior to or concurrent with onset of alcohol-use disorders, and 27 had onset of alcohol-use disorders that preceded onset of bipolar disorders by 1 year. Patients in whom alcohol-use disorders occurred first spent more time in full affective episodes during follow-up and exhibited more rapid cycling. Patients who began using alcohol during follow-up were less likely to recover than those in whom alcohol-use disorder began before hospital admission.

Differences in the order of onset of bipolar and alcohol use disorders affect their courses.

Source: Strakowski S M et al: Effects of co-occurring alcohol abuse on the course of bipolar disorder following a first hospitalization for mania. Arch Gen Psychiatry 2005; 62:851-858.

Obsessive-Compulsive Disorder in Young Patients

Monotherapy is not always effective in patients with obsessive-compulsive disorder (OCD). The characteristics of 94 OCD patients aged 8 to 18 years, all treated with at least serotonin clinical inhibitors (SRIs), were studied in a naturalistic clinical setting (mean follow-up 10 months); 50% received SRIs alone; 50% required adjuvant medications. 46.8% had generalized anxiety disorder, and 26.6% separations anxiety disorder, 17% panic disorder, and 36.2% social Impressions Improvement scale) was 67.0% overall—78.3%, 76.7%, 57.1%, and 14.3% among patients with contaminations, ordering, aggression, and hoarding symptomology, respectively (P = .008). Response rate did not differ significantly with type of pharmacotherapy, the use of concurrent psychotherapy, or the presence of most comorbidities, with the exception of worse rates for bipolar, oppositional defiant, and conduct disorders.

67% of young OCD patients responded to therapy over a mean 10-month follow-up.

Source: Masi G et al: A naturalistic study of referred children and adolescents with obsessive-compulsive disorder. J Am Acad Child Adolescent Psychiatry 2005;44:673-681.

Smoking Cessation Treatment in Veterans with PTSD

Posttraumatic Stress Disorder (PTSD) is associated increased rates of smoking. The effectiveness of a smoking-cessation intervention integrated into ongoing mental health care was compared with that of an intervention delivered separately from mental health care (usual care) in 66 veterans with PTSD, all of whom smoked 10 or more cigarettes daily. Subjects assigned to integrated care were significantly more likely than those assigned to usual care to receive prescriptions for nicotine gum and transdermal nicotine. At 2,4,6 and 9 months, the odds of not smoking were >5 times greater in the integrated-care group (p<.002). Subjects in the integrated-care group were abstinent at more follow-up assessments (52% vs. 25%; p<.02). Scores on the PTSD checklist and the Beck Depression Inventory did not change significantly during higher than those in usual care (p<.04).
Integrating smoking cessation into mental health care is feasible and effective.

Source: Mc Fall M et al: Improving the rates of quitting smoking for veterans with posttraumatic stress disorder. American J Psychiatry 2005; 162:1311-1319.

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INLAND EMPIRE CHAPTER OF CAMFT NEWS

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Suicide Predictors in Patients with Depressive Disorder

Although a few predictors of suicide have been identified, the interactions between predictors are unknown. In an effort to identify predictors of suicide, research data on 785 patients with major depressive disorder, 33 of whom had committed suicide, were retrospectively reviewed >20 years after the initial study. Overall, 27.3% of suicides occurred within 1 year of the study. History of suicide attempts (p=. 018), inpatient status (p=. 05) to commit suicide, while more men than women had committed suicide after the 1st year of entry into a study (p=. 01). After adjustment for age, the suicide tendencies rating no longer was significant. There was a negative correlation between age and suicidal tendencies (p=. 0001), but there were no identified interactions between predictors.

Suicidality seems to be only important predictor of suicide in depressed patients.

Source: Coryell W. Young et al. Clinical predictors of suicide in primary major depressive disorder. J Clinical Psychiatry 2005;66: 412-417.

Length of Family Therapy for Adolescent Anorexia Nervosa

The efficacy of family therapy for 6 months vs. 12 month was compared among 86 adolescents with anorexia nervosa randomized to these interventions and evaluated at 6 and 12 months. The 2 groups were similar on all the primary efficacy outcomes, body mass index (BMI) and eating disorder examination (EDE) score. There also was no difference between groups for secondary outcomes-general psychopathology, severity of obssesionality and compulsiveness, global problem of interpersonal functioning, and family functioning. Outcome of long-term treatment was better only on the EDE eating-concerns and the Child Behavior Checklist Internalizing subscales. Analysis by subgroup found that long-term therapy had a greater effect on BMI for patients with greater obsessional-compulsive problems and on global EDE in those with nonintact families. Family therapy for 6 months seems as effective as 12 months in adolescent with anorexia nervosa.

The longer therapy may benefit those from non-intact families or with more severe obsessionality-compulsiveness.

Source: Lockk J. et al: A comparison of short and long term family therapy for adolescent anorexia nervosa. J Am Acad Child Adolescent Psychiatry 2005; 44: 632-639.

Fear Conditioning in Psychopaths

Psychopaths lack the ability to anticipate punishment and impending harm. Activity in the neuronal structures involved in fear conditioning was examined in 10 emotionally detached psychopaths with criminal records and 10 healthy controls. Neuroimaging with functional MRI was performed in al subjects during aversive differential delay conditioning. Psychopaths had no differential response in emotional valence ratings. In controls, fear conditioning resulted in activation in the amygdale, orbitofrontal cortex and anterior cingulated. While sustained activation of the left amygdale was seen in controls throughout the acquisition phase, only a small activation in the right amygdale was seen in psychopaths. Activation was lacking in the orbitofrontal cortex and the anterior and middle insula of the psychopath group, and deficient in the secondary somatosensory cortex.

An inability to emotionally relate biologically significant and neutral events may be a core feature of psychopathy.

Source: Birbaumer, N et al: Deficient fear conditioning in psychopathy: A functional magnetic resonance imaging study. Arch Gen Psychiatry 2006; 62:799-805.

We Welcome your Articles!

Do you have an article to share? If so,
Please contact our Association Chapter Officers and submit on or before the 25th of each month.
We Thank You

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INLAND EMPIRE CHAPTER OF CAMFT NEWS

(California Association of Marriage and Family Therapists) JUNE 2006

Child Abuse can Cause Schizophrenia

by Psych Central News Editor

- June 13, 2006

University of Manchester researcher Paul Hammersley is to tell two international conferences, in London and Madrid on 14 June 2006, that child abuse can cause schizophrenia.

The groundbreaking and highly contentious theory, co-presented by New Zealand clinical psychologist Dr John Read, has been described as "an earthquake" that will radically change the psychiatric profession.

"In their review of the 33,648 studies conducted into the causes of \schizophrenia between 1961 and 2000, they found that less than 1% was spent on examining the impact of parental care"

Clinical psychologist and writer Dr Oliver James commented: "The psychiatric establishment is about to experience an earthquake that will shake its intellectual foundations [and] may trigger a landslide."

Mr Hammersley, Programme Director for the COPE (Collaboration of Psychosocial Education) Initiative at the School of Nursing Midwifery and Social Work, said: "We are not returning to the 1960s and making the mistake of blaming families, but professionals have to realize that child abuse was a reality for large numbers of adult sufferers of psychosis."

He added: "We work very closely in collaboration with the Hearing Voices Network, that is with the people who hear voices in their head. The experience of hearing voices is consistently associated with childhood trauma regardless of diagnosis or genetic pedigree."

Dr Read said: "I hope we soon see a more balanced and evidence-based approach to schizophrenia and people using mental health services being asked what has happened to them and being given help instead of stigmatizing labels and mood-altering drugs."

Hammersley and Read argue that two-thirds of people diagnosed as schizophrenic have suffered physical or sexual abuse and thus it is shown to be a major, if not the major, cause of the illness. With a proven connection between the symptoms of post-traumatic stress disorder and schizophrenia, they say, many schizophrenic symptoms are actually caused by trauma.

Their evidence includes 40 studies, which revealed childhood or adulthood sexual or physical abuse in the history of the majority of psychiatric patients and a review of 13 studies of schizophrenics found abuse rates from a low of 51% to a high of 97%. Psychiatric patients who report abuse are much more likely to experience hallucinations – flashbacks which have become part of the schizophrenic experience and hallucinations or voices that bully them as their abuser did thus causing paranoia and a mistrust of people close to them.

They admit not all schizophrenics suffered trauma and not all abused people develop the illness, but believe less traumatic childhood maltreatment, rather than actual abuse, may be an important difference. In their review of the 33,648 studies conducted into the causes of schizophrenia between 1961 and 2000, they found that less than 1% was spent on examining the impact of parental care. Still, they say, there have been enough studies to suggest negative or confusing early care may be an important addition to abuse as a cause.

Genes may still have a role to play but other evidence Hammersley and Read cite shows that genes alone do not cause the illness. A recent study compared 56 adoptees born to schizophrenic mothers with 96 adoptees whose biological parents did not have the illness. The families were observed extensively when the children were small and all the adoptees were assessed for psychiatric illness in adulthood. It was found that if there was a high genetic risk and it was combined with mystifying care during upbringing, the likelihood of developing schizophrenia was greater - genes alone did not cause the illness. In addition a recent review revealed that, apart from for Alzheimer's, not a single gene has been shown to play a critical role in any mental illness, while sociological studies show that schizophrenia poor people are several times more likely than the rich to suffer schizophrenia and urban life increases the risk.

Finally, they argue, if patients believe their illness is an unchangeable genetic destiny and that it is a physical problem requiring a physical solution, they will readily accept a drug prescribed to them when in fact they require other therapy. Worse, those who buy the genetic fairytale are less likely to recover, and that parents who do so are less supportive of their offspring. They recommend that all patients be asked in detail about whether they have been abused, anti-psychotic drugs no longer be doled out automatically and psychological therapies offered more often.

Hammersley and Read will propose the motion 'Tears on my pillow, voices in my head: This house believes child abuse is a cause of schizophrenia' at a public debate at the Institute of Psychiatry in London on 14 June 2006. They will also be speaking at 15th ISPS Symposium for the Psychotherapy of Schizophrenia and other Psychoses in Madrid on the same day.

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The University of Manchester is the largest higher education institution in the country with almost 36 000 students. Its Faculty of Medical & Human Sciences (www.mhs.manchester.ac.uk) is one of the largest faculties of clinical and health sciences in Europe, with a research income of over £37 million. The School of Nursing, Midwifery and Social Work enjoy national and international research acclaim, attracts considerable funding and publishes extensively in internationally renowned journals. It has three research groups which comprise a number of project and theme-based teams – acute care and rehabilitation, primary health care and mental health.

The University of Auckland is New Zealand's pre-eminent research-led University. Established in 1883, it has grown into an international centre of learning and academic excellence and is New Zealand's largest university. The Department of Psychology has teaching and research interests in social psychology, cognitive neuroscience, child development, learning, industrial/organisational psychology, speech language therapy/speech science, clinical, health psychology, and psychological and developmental disabilities.

"We ought not to look back unless it is to derive useful lessons from past errors and for the purpose of profiting by dear bought experience....."

George Washington

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INLAND EMPIRE CHAPTER OF CAMFT NEWS

(California Association of Marriage and Family Therapists) JUNE 2006

Half of Americans Who Need Mental Health Treatment Do Not Receive It

by Psych Central News Editor
June 9, 2006

Millions of Americans have found out the hard way that employer-provided health plans offer far more limited mental health benefits than for physical illnesses.
"This lack of parity is leading to a national mental health crisis and is costing far more than providing proper coverage," says Pamela Greenberg, chair of the Coalition for Fairness in Mental Illness Coverage.

"Lack of true mental health parity, coupled with ignorance and social stigma about mental illness, means that our nation faces a mental health crisis that will continue to skyrocket with crippling effects for many Americans, their families, communities and their employers," Greenberg stresses.
One woman who can attest to this reality is Gail Griffith, the mother of one of the estimated 57 million Americans who suffer from a mental health disorder. In 2001, Griffith's teenage son suffered severe depression and attempted suicide. The mental health treatment he required proved to be very costly, despite the fact that his family had insurance.

"Our family was fortunate enough to have the financial resources to sustain my son's mental health crisis — and it still required a titanic lift from everyone involved. But the sad reality is that there are millions of families whose insurance won't cover their children's psychiatric care," remarks Griffith, whose memoir Will's Choice examines how she coped with her son's depression and confronted a health care system fraught with economic inequalities.
Unfortunately, Griffith's story is not unique. For many families, treatment and coverage costs for depression and other mental health disorders are simply too high. The President's New Freedom Commission on Mental Health reports half of Americans who need mental health treatment do not receive it.

However, the costs of untreated mental health and substance abuse disorders to American businesses, governments and families are even higher. These costs have grown to $113 billion annually. A 2003 study found that depression alone cost the economy $83 billion a year including absenteeism and lost productivity at work and treatment costs. Untreated mental health needs can also lead to unemployment, costly emergency room care and hospitalization.

Opponents of mental health parity have claimed that parity would be too costly. However, these claims are not supported. Recent studies, including a report in The New England Journal of Medicine commissioned by the U.S. Department of Health and Human Services, show clearly that parity can improve health coverage without increasing overall health care costs.

Ten years ago, Congress approved legislation requiring annual and lifetime dollar limits for mental health coverage to be the same as for other health coverage. However, the Government Accountability Office found that 87% of employers that comply with the law have reduced other aspects of their mental health coverage, such as day and visit limits.Today's health plans routinely provide coverage for mental health that is far more limited than coverage for physical illnesses. Some patients now face lifetime coverage limits of the number of treatment sessions they can receive — regardless of their medical needs. But insurance sets no comparable benefit limits on needed treatment for any other illness.
"A comprehensive parity law is more than a decade overdue. We need to end insurance discrimination against people with mental health problems," emphasizes Greenberg.
Source: ***PR Newswire***

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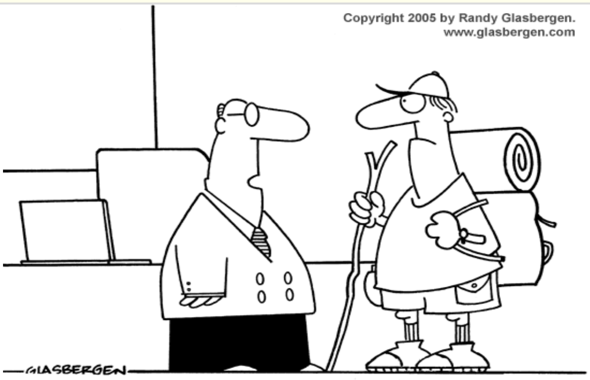
When planning for a year, plant corn. When planning for a decade, plant trees. When planning for life, train and educate people.

Married couples tell each other a thousand things without speech.

- Chinese Proverbs

The Ligher Side of Life…..

"We can contain health insurance costs if you're willing to let your coworkers diagnose you with information they find on the Internet."



"They say I'm out of touch with my employees, but something tells me you're not a happy camper."

"We used to hold hands to be romantic. Now we do it to keep each other from touching the credit cards."

"I hate to see children lose respect for their parents, so this year we're doing 'Bring Someone Else's Child To Work Day'."

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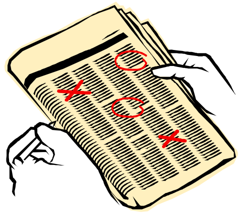

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Presents:
Psychodrama Seminar
June 10th 10:00am to 4:00pm
University United Methodist Church Wesley Lounge 940 E. Colton Redlands
Call (909) 798-2765 for this and other seminars in psychodrama

INLAND EMPIRE CHAPTER OF CAMFT NEWS

(California Association of Marriage and Family Therapists) JUNE 2006

MEMBERSHIP APPLICATION

Name and Degree____

Address____

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Telephone Number ( )____________________Fax Number ( )____________________

E-Mail Address____

Business Name__________________________Business Telephone Number ( )______________

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_____Clinical (Licensed)…………………………………………………………….$40
_____Prelicensed (Trainee, Intern, Social Worker Associate………………………………….$25
_____Associate (Licensed in a related mental health field)..…….……………..………………….$40
_____Affiliate Practitioner in another field (e.g., RN, Attorney)………………….…………..$40

CAMFT Member #____
Must be a member of CAMFT to join the local chapter, unless Affiliate member)
Dues are paid annually in April. MAKE CHECKS PAYABLE TO IEC-CAMFT

Inland Empire Chapter of CAMFT
(California Assoc. of Marriage & Family Therapists)
9708 SVL Box
Victorville, CA 92392