North Coast Association of Mental Health Professionals

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Newsletter Fall 2014

Letter from Your President ~ Bonnie M. Carroll, LCSW

Greetings NCAMHP members,

I hope you are all doing well and feeling ready to embrace the coming Fall Season.

At our last Board meeting we discussed the need for volunteers to join the Board of Directors and a few different Committees. The Board would like to recruit 2-3 new Board members, the Education Committee would like 3-4 new members, and our new Outreach Committee wants to have another 3-4 members join them.

The Board is currently made up of 7 active members and at least one of those will be leaving by the end of 2014. The Board now includes Diane Warde, Paula Nedelcoff, Peter Moore, Sarah Haag, Loren Farber, Katherine Salinas, Bonnie Carroll and Caitlin Scofield. Loren Farber is planning to resign at the end of 2014 after providing 5 years of active and dedicated service.

The Education Committee will also be losing Jennifer Finamore, Loren Farber, and Scott Sherman at the end of 2014. They have been very involved in every aspect of the Committee's work, and they will be leaving a huge gap that needs to be filled if we want to continue providing trainings for our membership. Members of the Education Committee are able to determine the types of trainings that NCAMHP provides.

The Outreach Committee, which was just created, is an umbrella committee for fundraising, marketing, health fair representatives, membership, and the Redbook. Ideally this committee would have 6-8 active members who can meet every month or two. At least one member of the Outreach Committee should also serve on the Board of Directors as liaison representative. There are now 4 members in this Committee: Caitlin Scofield, Tom Johnson, Paula Nedelcoff and Melissa Ward. It would be good to recruit at least 4 more NCAMHP members to join them.

Remember that joining the Board or one of the Committees will provide you with an opportunity to meet with other therapists, and enable you to influence the types of benefits that NCAMHP provides. I think these opportunities to connect and work with other therapists is important for those of us in private practice whose professional interactions are often limited to the clients we work with.

Another opportunity to connect with other NCAMHP members will be coming soon in the form of a book club. I can host the first book club at my house after the New Year: maybe in mid January. At the first book club meeting, we'll have a better sense of who wants to join and how it will be structured. I've suggested that interested NCAMHP members can take turns hosting the book club at their house. Whoever hosts the book club gets to choose the book and provide the refreshments. It will be a nice opportunity to meet with each other in an informal and thought provoking setting. I will choose one of these four books to be our first book club book: Hardwiring Happiness by Rick Hanson, Hold Me Tight by Susan Johnson, Learned Optimism by Martin Seligman, Attachment in Psychotherapy by David Wallin. Let me know if you are interested in joining the book club and if you have a preference regarding which book I should choose.

Bonnie M. Carroll, LCSW
NCAMHP Board President
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News From NCAMHP Committees

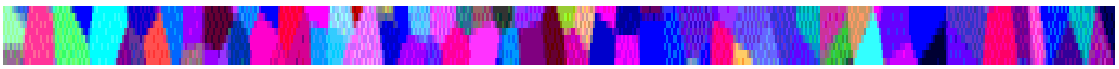
The Education Committee has retained Pamela Harmell, PhD for required Law and Ethics training, scheduled for the Spring Workshop on February 28, 2015. The Education Committee plans to send out a survey regarding possible future trainings. The committee would appreciate member participation in the survey, in order to assist in selecting training options suitable for the training needs and preferences of NCAMHP members.

The Website Committee, Education Committee and Newsletter Committee are seeking new members.

A new Outreach Committee is forming, and may have sub-committees assigned for specific functions such as member recruitment, fundraising and marketing. The Outreach Committee is also seeking members.

Committee Updates

Recent openings on committees have necessitated new committee member installations. If you are interested in joining one of the committees, please contact members of the committees, or note your interest on your NCAMHP membership renewal form.



The NCAMHP Ethical Complaints Process
An interview with Bruce Silvey MFT, Chair of the NCAMHP Ethics Committee
Written By: Emily Siegel LCSW

Why did NCAMHP decide to develop an Ethical Complaint process?
NCAMHP had a couple of complaints that came to us from people who felt there was an ethical violation in their treatment from an NCAMHP member. For various reasons they didn't want to make a BBS (Board of Behavioral Sciences) complaint, civil lawsuit or criminal complaint. However, they didn't want the problem to go unnoticed, or have it happen to somebody else. NCAMHP Board members thought this issue was an important spot to fill for clients like this. They felt they could develop an NCAMHP process that would get a local resolution for both the client and therapist, and perhaps it would help to maintain our NCAMHP list of Clinical Members in Good Standing.

How did the Ethical Complaint process get developed?
We started down the path of researching other clinical professional organizations' complaint procedures by getting copies of those so we didn't re-invent the wheel. Then we made up our own version from those procedures and adjusted our bylaws to accommodate the process we were going to implement. Next we ran it by an experienced mental health ethics lawyer in Sacramento who was connected to the APA (American Psychological Association). He reviewed our documents and said they were pretty good. However, he wondered did we realize how much risk we were putting NCAMHP in because we were following the same punitive model the other groups used. He pointed out that as a much smaller organization, NCAMHP did not have the resources of much bigger organizations that have a lot of money and attorneys already on staff that they could use to defend themselves if they needed to. He pointed out that if we found in favor of a complainant/client that an ethical violation had occurred, and part of the resolution was that they would no longer be a member of NCAMHP, that NCAMHP could be sued for restriction of trade. This information led us to switch directions.

How did the NCAMHP Complaint process end up with a mediation model instead of a punitive model?
A couple of drafts later, we came up with the idea that we are therapists and that we should be trying to do something that was therapeutic for all parties involved. So we began thinking of it as a mediation model where the goal is to help the complainant/client feel resolved, and for the therapist to be able to take whatever responsibility was appropriate. When we sent this new mediation model to the attorney, he was pretty excited. He said he'd never heard of anything like this in U.S., but he thought it was great. So we went ahead and set that model up in order to respond to any complaints that came in.

What are the steps in making an ethical complaint?
When NCAMHP gets a call from a complainant/client, someone from the Ethics Committee calls back and talks to them. An anonymous complaint can be made but nothing will happen with it until the process has been started and the releases signed. We explain the process and tell them we will send them the forms, including releases, to fill out, sign and return to get the process started. So we send them these forms which includes a place for them to describe what happened that they felt was an ethical violation. When the client sends the forms back to the Ethics Committee, the committee sends a letter of introduction about the process, and copies of the complaint form and the release, to the therapist. The therapist then decides if they are going to participate.

If the therapist chooses to not participate, the client is so informed and released to pursue other complaint processes if they wish to do so. If both parties agree to participate in the ethical complaint process, the intent is to do most of the rest of the process in writing, although there could be a face-to-face meeting if all parties think it would be helpful. After receiving the complaint from the ethics committee, the therapist sends back a written response to what the complainant/client wrote about what happened. Then the ethics committee reviews the document and makes recommendations on how to proceed. There could be more written communication between the ethics committee and the therapist until the ethics committee feels there is a response from the therapist that is both accurate and therapeutic. Then that response is forwarded to the client. The committee then works with both parties through written communication to help the client clarify what they need to feel resolved about their complaint.

What are possible outcomes of the ethical complaints process?
Clients tend to want acknowledgement of the problem and that the therapist is taking responsibility with some type of assurance that it won't happen again. For example the therapist might agree to be in therapy to work on this issue with a report from their treating therapist to the ethics committee about progress. Other potential outcomes include: the therapist could agree to supervision, education or other action that the client believes would resolve his/her concerns.

What are the benefits and risks to the therapist of participating in the ethical complaints process?
The benefits are: there could be a local resolution to the problem and an opportunity for the therapist to take responsibility and some corrective action that would be satisfactory to their previous client. There is some recent research in medical professional complaint processes that shows that taking clear responsibility for bad outcomes drastically reduces lawsuits. One group of seven major hospitals reduced their litigation costs significantly by quickly taking full responsibility when there was a bad outcome, along with what the hospital planned to do to make sure it didn't happen again. BBS complaints and civil suits can be very expensive for therapists, and could lead to an inability to get malpractice insurance. An ethics instructor at an NCAMHP training said that lawsuits require 2 things: a bad outcome AND alienation. This NCAMHP mediation model could dramatically reduce alienation and therefore, despite a bad outcome that caused the complaint, significantly reduce lawsuits or board actions.

The risks are: we make it clear to the client that if they start down any other complaint process, such as BBS or civil or criminal action in court, the NCAMHP process closes and that our records are ours. However, we recognize that judges can order things to be disclosed, the same as in other court processes for therapists involving claiming privilege. So there is a risk for the therapist that someone could later use something from the process and go to a board or civil or criminal complaint. So we advise the therapist to consult with an attorney before agreeing to the process.

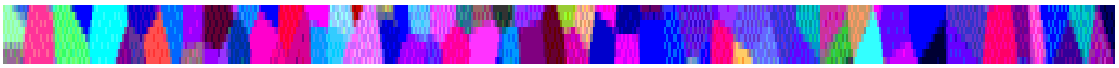
What has happened so far with people making ethical complaints?
NCAMHP has received 6 phone calls asking about filing ethical complaints. These have ranged from violations of confidentiality, unprofessional conduct, sexual boundaries, dual relationships, and one NCAMHP member's concerns about professional conduct of another NCAMHP member. After a positive conversation with an Ethics Committee member explaining the process and the necessary releases, we sent them the forms. So far, no one has ever sent them back.

I don't really know why this has happened, but I speculate that the client wanted to tell someone and be heard. After they told someone and were heard, perhaps they did not want to go further down the process and deal with the emotional stress of confronting their therapist even in writing. It is also possible that telling someone, being heard, and knowing they have the option of making an ethical complaint was enough to resolve the issue for those clients.

How can a therapist inform their clients about the ethical complaint process?
I think it would useful for therapists to put information about the NCAMHP ethical complaint process into their informed consent paperwork at the beginning of therapy. A possible suggestion is: I am a Clinical Member in Good Standing with North Coast Association of Mental Health Professionals (NCAMHP). If there is ever a time during your therapy with me that you feel that you have been harmed in some

way, I hope you will feel free to discuss it with me. If however, you do not feel comfortable discussing it with me, NCAMHP maintains an Ethics Committee you could contact. The contact information can be found at ncamhp.org.

Where do we get the forms for ethical complaints?
Our intention is to get them on the website so that they are accessible to both clients and therapists.



The Sisters of Perpetual Indulgence
Written By: Emily Siegel, LCSW

Non-profit Agencies in Humboldt County serve many different people. The NCAMHP Newsletter Committee has connected with one local non-profit to learn more about this important area of service in the community. The Sisters of Perpetual Indulgence's, Sister Gaia Person, Mistress of the Purse and Propaganda, answers our questions.

How did The Sisters of Perpetual Indulgence get started?

The Sisters of Perpetual Indulgence started in San Francisco in 1979 as a response to the lack of diversity in the queer community at the time. The Sisters wanted to focus on using guerrilla street theater for issues that affected our community and also the world in general. We started our charitable works with a bingo fundraiser for Cuban refugees in 1980. We operate from a fund raising perspective but also from a spiritual perspective of ministry. We identified our mission in the world to promulgate universal joy and expiate stigmatic guilt. With the AIDS crisis we began doing real direct support work for individuals in our community. We've held onto that value as we've spread now internationally. We currently exist in 10 countries with over 30 chapters in the U.S. The Eureka Sisters started in 2006. We have predominately been focusing on fund raising and supporting other organizations in our community. Individual Sisters have also done work in our other mission areas. More recently we are beginning to focus on community building and organizing.

What populations does the Eureka Sisters of Perpetual Indulgence serve?

We serve the fringe, the people on the fringe of all communities. We work to minister to LGBTQ and other gender and sexual minorities, often times with a focus on people who don't necessarily fit in. We try to include young people, elders, people that are homeless. Sisters believe in harm reduction and have a vision of starting a needle exchange. Our fund raising works to support all of the organizations that are doing amazing work in our community with a focus on organizations that are small and not so well funded.

How do people become involved in the Sisters?

People become involved by volunteering to help out at our events, such as Bingo fundraisers, Bat & Rouge baseball game, picnics and other celebrations or by coming and participating in our public ritual work, such as Trans Day of Remembrance, World AIDS day, Non-Judgment Day and others

To become a Sister it is a 2-year process where you move from volunteer, to an aspirant, to a postulate, to a novice, to a fully professed member. To be a Sister you have to be an event planner and work at all the events, a public figure, to give blessings at the drop of a hat and we spend a lot of time together as a tribe, having dinners and meetings and committee work, coordinating and creating fabulous outfits, and time to build strong bonds so we work well together and taking care of each other so we can best serve our community.

Are there other supports/services that you offer?

We are spiritual dignitaries. We do weddings and funerals. We also meet with people individually to support them and help connect them to resources. Anything you would ask from another person who gives other kinds of spiritual guidance we are willing to do for people.

What kind of people are members of the Sisters?
Members of the Sisters range from gay men to heterosexual women to trans people of all genders, college professors, mental health workers, students-- people from all walks of life who feel the calling.

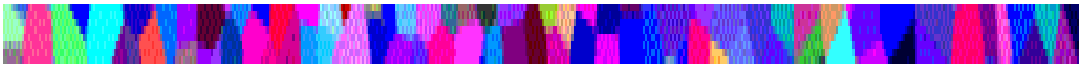
Please share anything else that you would like the mental health professional community to know about the Eureka Sisters of Perpetual Indulgence.

Right now we are working on several projects. We are helping support the creation of an LGBTQ community center. We are also working to help get more training for mental health and physical health professionals to work with trans people in our community. We are going to be putting together a museum show with the Morris Graves Museum to celebrate the life work of Father Oh Mary!, who recently passed away and was our local president for many years. Our next fundraiser is for National Coming Out Day. It is called Cocktober Fest on October 11 at the Siren Song Tavern. It's basically Octoberfest but with chicken humor (about chickens) and dirty jokes. You can find more about that at our website: eurekasisters.org

How do people contact you?

If you have questions or interest in volunteering contact us by email at: info@eurekasisters.org

We also have a hotline: 707-676-ESPI (707-676-3774) with a Sister answering most of the time or calling you back when you leave a message.



The following is an excerpt from:
Attachment Theory vs. Temperament: Treating Attachment Disorder in Adults
By Mary Sykes Wylie & Lynn Turner
To read the entire article or for more free reports, visit
http://www.psychotherapynetworker.org/free-reports © Psychotherapy Networker

Attachment Theory in Action

While some believe that attachment-based therapy sounds an awful lot like a souped-up version of psychodynamic therapy, Daniel Siegel disagrees, arguing that its foundation is in the empirical, neurobiological study of how relationships actually shape neural processes and emotional regulatory capacities throughout life. "You use your sensitivity to the client to engage in contingent communication in a way that can establish new pathways in the person's brain that increase his capacity for self-regulation, "he says. "That means the client learns to tolerate emotions he couldn't handle before." Furthermore, claims Siegel, by helping the client become more capable of self-regulation, the therapist is actually helping him coordinate and balance neural firing patterns and promote greater integration of different areas of the brain— right and left hemisphere, for example.

To illustrate how all this works in practice, Siegel describes a case of how attachment-based therapy might work with a dismissing client, one who had had an avoidant attachment as a baby and child to an emotionally unavailable and rejecting parent. Since this person rarely or never experienced an emotionally attuned and predictable relationship with his parent, he had to learn to adapt, psychologically and neurobiologically, to not getting it. As a result, he grew up without much access to—or conscious desire for—emotional awareness or bodily feeling. Because autobiographical memory is mediated primarily through the right hemisphere, such a person often has few or no childhood memories. Typically, as an adult, he's isolated, unaware of the emotional poverty of his life, and disdainful of the idea that he might even want or need more personal connection. In fact, he'd probably never show up in therapy unless his partner—wanting a warmer, less distant relationship—insisted.

In an assessment session, Siegel says he picks up in his own resonating mirror neuron system the client's usual feeling state. "With such a client, I usually feel distant and bored. There's a dull quality to the connection, as if there were no 'we' in the room, just a separate person," he says. "My own immediate experience reflects the client's own impaired access to his right hemisphere—which has direct access to the body and to emotional states. He's just bringing me his dominant left hemisphere, thoughts without feelings, ideas without access to any sense of his own

body." If Siegel were to try too hard to connect with him right- brain to right-brain at this stage—to overdo emotional empathy or try directly to elicit his feelings—therapy would be doomed right out of the gate: "People with avoidant attachment histories are too closed down to have access to experience their right-hemisphere processes," he says. "If someone asks them how they feel or what's going on in their bodies, they will say 'I don't really know what you mean,' or 'I don't know what you're talking about.' They live in the 'Land of the Left,' and if you try to go right-hemisphere to right-hemisphere with them too soon, they become emotion- ally flooded."

Siegel often begins with a left-brain approach, explaining attachment and the brain to these clients. "I explain to them how their relationship with a primary parent helped shape their brains in a way that was highly adaptive to the circumstances they found themselves in. 'You survived, you adapted, you did the best you could, but now, do you want to go on living with half a brain when you can have a whole one?'" Therapy with dismissing people can sound like a slow, tedious trek through (and often detouring around) a seemingly endless, neatly clipped formal garden of Left Brain Land toward the far-off land of Right Hemisphere's lush, untamed forests. Siegel invites the client "to experience a new way of being present inside himself with me, reflect on the process of attachment itself. I talk about how synaptic shadows create constraints on how a person has been, teach him how his own brain regulates itself partly inside himself, partly between the two of us." To help him get a richer right-hemispheric representation of himself—the beginnings of an integrated right- brain/left-brain autobiographical self—Siegel might ask him to consciously become aware of and remember what it was like to walk to his office from the parking lot.

In The Developing Mind, Siegel describes introducing a dismissing client to guided imagery and drawing exercises based on Betty Edwards' book, Drawing on the Right Side of the Brain, through which he gradually became aware of an entire new world of "sensations, intense emotions, visual scenes, thematic struggles, and new perspectives on dilemmas of which the left-sided individual was quite unaware." For example, he experienced the notion that he'd better let his "wilting" marriage "blossom" by buying his wife roses when she didn't expect them—something he'd never done without a logical reason (a birthday or anniversary). "He got the roses simply because it 'felt' right. He couldn't explain it at the time, but he just followed his gut instinct. His right hemisphere took his wife's internal world into account, provided him with a metaphor for her needs, and enabled him to feel her feelings." Although such cut-off clients initially don't welcome this flood of new experiences—according to Siegel, they consider the unaccustomed onset of feeling "weird and useless"— eventually, the payoff can be very rich. A person who's perhaps not really felt much of anything since earliest childhood or even infancy can gradually learn to express and articulate emotion, to experience what it's like to live within a warm, living, breathing body. One client, Siegel reports, exclaimed, "Oh my God, so this is

what it feels like to have warmth in my heart!" Recently, a client told him, "I'm really changing— there is something truly different about me, now."

In contrast to cognitive-behavioral work, much or even most of this therapy is intuitive, played out in "enactments"— what Allan Schore calls emotionally charged moments between therapist and client that are "fundamentally mediated by non-verbal unconscious relational behaviors within the therapeutic alliance." Through these behaviors, therapist and client co-create a coherent story, or a chapter of a story, that helps the client make sense of his own inner turmoil. As Schore puts it, "Enactment is an affectively driven repetition of converging emotional scenarios from the patient's and the analyst's lives. . . . It is his or her chance to relive the past, from an affective standpoint, with a new opportunity for awareness and integration." According to Schore, the most important "enactments occur at the edges of the regulatory boundaries of affect tolerance." In other words, it's when therapy feels worst that it's doing its best work.

What's wrong with This Picture?

It's easy to see why attachment-based therapy appeals to so many therapists. Unlike many clinical approaches, it derives from an apparently robust scientific theory of human development and seems compatible with findings from neuroscience about the way the brain processes emotion. At the same time, it seems to restore not only "deepness" to therapy, but its heart and soul—feelings!—all of which many have felt had gone missing from many years of formulaic, highly technical cognitive and behavioral approaches. Emotion, depth, an awareness of psychobiology, scientific respectability—what's not to like in attachment-based therapy?

Quite a lot, according to some critics. Family therapy pioneer Salvador Minuchin suggests that in focusing so intensely on the early mother–child bond, attachment-based therapy neglects a vast range of important human influences and experiences "The entire family—not just the mother or primary caretaker—including father, siblings, grandparents, often cousins, aunts and uncles, are extremely significant in the experience of the child," says Minuchin. "And yet, when I hear attachment theorists talk, I don't hear anything about these other important figures in a child's life." It's not just the family that vanishes in this kind of therapy, according to Minuchin, "Certainly a stable early environment is important, but focusing so much attention on attachment issues can make compelling social and racial issues simply disappear. It can take us back to the heyday of psychoanalysis and deny the full familial and social reality of children's lives, as well as obscure our understanding of the context in which they grew up."

Minuchin also wonders whether the therapist in attachment-based work can become too important as the central, perhaps only, reparative figure in the client's life. "The therapist selects the qualities of affect, cognition, and mood regulation that

the patient needs," he says. "Systemic therapists, on the other hand, don't believe that the therapist should play such a central role, but try to use the person's present relationships—the full range of them—to renegotiate problems arising from past experience." Finally, attachment-based therapy for children or adults, in Minuchin's view, too often seems to implicitly assume that attachment "wounds" are the result of childhood trauma. "These days therapists too often talk as if child therapy is the same thing as 'trauma therapy,'" he says. "But, the danger of focusing so much on trauma is that you develop the view that trauma is somehow the human condition, rather than occasionally a part of it. It is always tempting to make an entire psychotherapy theory from cases of the most extreme pathology."

If Minuchin doesn't think attachment-based therapists fully recognize the role of family and society in the making of the young human being, psychologist and sex therapist David Schnarch suggests that it can keep adult couples stuck in the role of perpetually needy children. Author of the bestselling Passionate Marriage and several other books, and founder of a tough-minded, differentiation-based approach to couples' counseling, Schnarch believes that relationship failure stems not from lack of emotional connection between partners—the focus of attachment-based therapy—but too much of the wrong kind. Partners become enmeshed, lose a sense of self- hood, and depend on positive reinforcement and reassurance from each other because they can't soothe their own anxieties, and then have relationship difficulties when both demand validation from the other but neither will give it. Each partner needs, in effect, to grow up, learn to tolerate anxiety, and take charge of him- or herself before they can fully connect with the other.

Schnarch says that couples come to see him on the brink of divorce, whose own therapists told them not to see him, since they needed to attach before they could differentiate. This is exactly backward, he says. "Adults don't need to go back and attach—that is not the right approach and just reinforces weakness, fragility, and dependency—characteristics of the emotional fusion, connection in the absence of differentiation that is causing the problems in the first place. The solution is not to get them even closer together. Attachment-based therapy plugs together troubled couples only as long as they mutually validate and stroke each other, move in lock step, and keep on doing it. It encourages co-dependency, which will organize functioning, but that doesn't mean it's good." What Schnarch calls "attachment hegemony" is also out of sync with ongoing social and cultural evolution, he argues. "Attachment is an adaptation for when we lived as small, tribal, hunter-gatherer societies, in small, intact clan groups—it was designed by evolution to keep couples together four to eight years, just long enough to get kids born, weaned, and surviving. Now, marriage has fundamentally changed—it's no longer physically necessary for survival. What keeps couples together now long-term is their marital happiness and things like desire, intimacy, and good sex. But genuine intimacy and desire in committed relationships are driven by differentiation—the emergence of the adult human self—which attachment-based therapy doesn't address."

The Emotional Revolution

To an outsider, it might seem as if what therapists do in their offices every day probably looks roughly the same today as it did 15 or 20 years ago, regardless of model, method, or theory. It comprises a quiet, albeit often intense, conversation between two people clearly sharing an intimate, if rule- bound, relationship. Yet, over the last decade and a half or so, the way a large number of therapists think about therapy, what they think happens during therapy, and how they think they should engage in this joint project have changed. From the beginning, psychotherapy has been primarily about using words—a left-brain process—to bring the light of calm reason and insight to the dark chaos of untamed, unconsciously generated emotionality. As the old guy who started it all famously said, "Where id was, there shall ego be."

For many decades, particularly after the so-called "cognitive revolution," the major focus of therapy was helping clients think rationally about their irrational, emotional impulses. Of course, therapists have always realized that emotions, particularly negative emotions, are elemental facts of human life and the reason why people seek out psycho- therapy in the first place. By now, it's common knowledge that the therapeutic relationship is probably more important to clinical success than any particular method or technique. But for many years, because there was so little knowledge about the biology of emotion and feeling—what they were, where they were in the brain, what caused them, how they influenced behavior—they were something of an embarrassment not only to scientists, but to psychologists and therapists who wanted some sort of scientific credibility for their own work.

Besides talking about the inchoate, and largely unconscious processes, of emotions (what neuroscientist Antonio Damasio called "the direct expression of bio-regulation in complex organisms), what else could a scientist or a therapist do with all this messy, mysterious, unpredictable psychobiological inner stuff? You couldn't really get at it directly with any respectable therapy. Only touchy-feely, new-age, "alternative" therapists, trafficking in not-quite-reputable body- based therapies—Reichian work, primal therapy, inner-child work, Rolfing—would even try. To claim genuine scientific credibility, psychological research and therapy had to focus on cognition and behavior.

But that was then, this is now: for the past 15 years or so, according to Allan Schore and other neuropsychological scientists and therapists, we've been in the throes of an "emotional revolution," which seems to be sweeping all before it. Psychology was dominated by a behavioral model during the '60s and '70s, then by cognitive models in the '80s and '90s, and now, as Schore has put it, "affect and psychobiological processes are taking center stage." Buttressed by the intense, research-driven interdisciplinary study of emotion, psycho- biology, development, and relationship (attachment theory, front and center) are transforming both neuroscience and psychotherapy. "After three decades of the dominance of cognitive approaches,

motivational and emotional processes have come back into the limelight," wrote University of Rochester professor Richard M. Ryan in the March 2007 journal Motivation and Emotion. "Both researchers and practitioners have come to appreciate the limits of exclusively cognitive approaches for understanding the initiation and regulation of human behavior. . . . More practically, cognitive interventions that do not address motivation and emotion are increasingly proving to be short-lived in their efficacy, and limited in the problems to which they can be applied." The emotional revolution, he wrote, is "long overdue."

Today, rather than envisioning human beings in terms of the age-old divide between mind and body, for the first time in history, science appears to be bringing mind, brain, and body together in one whole and complete human organism. It's hardly surprising that therapists should love this revolution since it has the potential to enormously raise the prestige of psychotherapy: the therapist, through the art of a certain specialized form of relationship and attuned connection, isn't just helping people feel better, but deeply changing the physical function and structure of their brains as well. The only possible tiny fly in this sweet-smelling emollient is that it's still unclear whether these psychobiological findings about attachment, emotion, bio-regulation, right and left brain specialization, ad infinitum, can be reliably translated into a more effective therapeutic method. After all, attachment-based therapy remains more an attitude and an orientation to treatment—although a powerfully attractive one. There still isn't a particular model or body of techniques

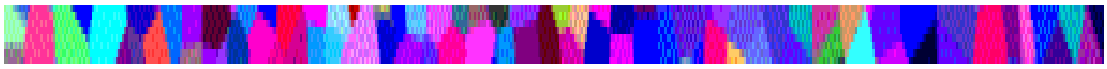
Whether or not attachment-based approaches improve the effectiveness of psychotherapy, they do seem to have already gone a long way to transforming our notions of what constitutes the real McCoy for clinical practitioners. It's a long way from the coolly analytical, talky, left-brain therapeutic ideal of decades past to the far more intuitive, nonverbally adept, emotionally tuned-in therapist envisioned within the emerging attachment-based paradigm. After decades of cognitive and behavioral scientists purposely seeking "to put emotions out of sight and out of mind," says neuroscientist Jaak Panksepp, they're being forced to "relearn that ancient emotional systems have a power that is quite independent of neocortical processes." In our increasingly technological world, therapy seems to be directing our attention to the very core of our primeval being, the "ancient emotional systems" that are the source of love, hatred, rage, desire, compassion, of our unquenchable need for connection with others of our own species.

What really has changed isn't so much the aim of therapy, which has always been, whatever its putative goal, changing, shaping, soothing, controlling, redirecting, harnessing the emotions, even freeing some of them up for more robust expression—that's what "affect regulation" is all about. What's changing is the game of therapy—how it's done. For the first time, mainstream therapists are trying, as it were, to fight fire with fire—to get at that vast, subterranean sea of affect as much or more through nonverbal resonance as through words. Through facial expression,

eye contact, tone of voice, tempo, breathing, the therapist creates a kind of wordless but dense and charged felt presence, which permeates the being of both therapist and client. The therapeutic connection happens, says Schore, through a "relational unconscious" in which "one unconscious mind communicates with another unconscious mind."

It's a paradox, really—the therapist must consciously create the conditions under which his or her unconscious mind takes over and communicates with the unconscious mind of the client. In a way, it sounds almost impossible, or at least mysterious. The fact that the neuroscientists are discovering how and where in the brain these connections happen doesn't make them any less mysterious—outside of our control and awareness, uncanny even. From our very first mother–infant bond, we experience relationships in this same, still mysterious, primarily physical way as did our primitive hominid ancestors. Like them, we look into each other's eyes, we smile and gesture, touch and stroke each other, make soft, friendly sounds, breathe in each other. Through these ancient signs and signals, we come, as they did, to know each other and by knowing each other we come to know ourselves.

Mary Sykes Wylie, PhD, is the senior editor of the Psychotherapy Networker. Lynn Turner, PhD, LCSW, is director of A Center for Relationships. She's written several articles and the chapter "Psychoeducational Approach" in The Encyclopedia of Social Work with Groups.

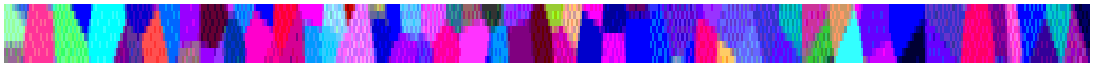


Trainings

The Fall General Membership Meeting was held on September 25, 2014, at the Humboldt Area Foundation; Time: 5:30 pm to 8:30 pm. Speaker: Connie Basch, MD presented on the topic of treating people with chronic pain, titled: Oh What A Pain, Conundrums, Pitfalls and Pearls; 1 CEU was available.

The Fall Workshop will still be held on Saturday, October 11, 2014, at the Humboldt Area Foundation, Time: 9:00 am to 12:30 pm. Topic: Negative Transference and Managing Acting Out Behavior, Presenter: Peter Moore, MFT; 3 CEU's available.

Pamela Harmell, Ph.D. has been retained to provide the required Law and Ethics training on February 28th, 2015, at Humboldt Area Foundation; Time: 9:00 am to 4:30 pm; 7 CEU's available.



Highlights from the Fall General Membership Meeting

At the Fall General Membership Meeting, Connie Basch, MD's presentation on treating people with chronic pain included an overview of pain physiology, pain pharmacology, adjunctive therapies, contraindications of NSAID use, nutritional and herbal supplements, mind/body interventions, and a resource list including authors and websites. More information regarding these topics may be found at her website: connie@fullcirclemed.org. She has also provided a link to the slides that she used during her presentation at our General Membership meeting**.** The slides are posted at: http://fullcirclemed.org/wiki/tiki-index.php?page_ref_id=9. The link is at the bottom of the page. It is titled "NCAMHP Talk PDF Version**"**

Announcements

NCAMHP has a new Listserv. It is intended for communication with the NCAMHP general membership. To be added to the Listserv, please email Sarah Haag, PhD at sarahcatherineh@gmail. NCAMHP encourages members to join the Listserv. It is a way to have questions answered and get clarification on issues common to NCAMHP members. It is a way to connect with the larger group, and gain access to a wider range of answers to your query. It is also a way to share other interesting information such as resources available for clients.

The listserv can be accessed at: ncamhp@groups.electricembers.net
To get started you may wish to access the introduction page at:
http://groups.electricembers.net/lists/help/introduction
Your ID is your subscription email. Here are the guidelines for useage:

Listserv Rules, Etiquette, and Policies

Listserv Etiquette are informal rules and procedures established for users of e-mail and listservs (a.k.a. mailing lists/listserves/list serves) to provide some simple guidelines to make these electronic communication tools more enjoyable and less annoying or bothersome.

Listserv Etiquette
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1. After you have been added to the Listserv list by Sarah Haag, PhD at

sarahcatherineh@gmail.com, you may wish to send an email introducing yourself. Send the message to: ncamhp@groups.electricembers.net for your introduction, you might note your name, professional affiliation, where you live or practice, areas of professional interest, why you joined the list, and any requests or questions you might have.

2. Try to keep your messages concise and to the point.

3. Please sign each of your messages, and include your e-mail address, so that listserv members can communicate any responses directly to you. Most e-mail software includes a signature option that automatically generates this information.

4. If you utilize your e-mail software program that repeats (quotes) the message to which you are responding, please do not repeat any part of the message which is not essential in order to save considerable space (bandwidth) for everyone who receives your message.

5. The purpose of this list is to facilitate communication among members. We encourage you to respond to the topics, questions, and announcements that get posted. If your response is intended or relevant to only one individual (as is often the case) please respond directly to that individual. Do not send responses via the reply-to-all function unless your response is relevant to all subscribers on the NCAMHP listserv.

6. No communication should include any confidential client information.

NCAMHP LISTSERV RULES
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1. Rule 1: Do not use the forum for illegal purposes, including, but not limited to, defamation, violation of intellectual property laws, violation of antitrust or unfair competition laws or violation of criminal laws.

2. Rule 2: Do not use the Forum for commercial purposes. Including communications with the primary of advancing the business or financial interests of any person or entity, or otherwise to promote a financial transaction for the benefit of the author directly or indirectly. Examples of prohibited communications include advertisements for products or services or direct solicitations of listserv members to purchase products or services. [Examples of messages that may be of financial benefit to list serve members but are not prohibited because they do not inure to the financial benefit of the author include news of job listings or position openings, or discussion of professionally-related products or services where the listserv member conveying the information is not in the business of selling the products or services.].

3. Rule 3: Do not use this forum for any communication that could be construed in any way as support for or opposition to any candidate for a federal, state or local public office. The Federal law providing NCAMHP's tax-exempt status forbids the

use of tax-exempt organizations resources or facilities, including this forum, that in any way that would even appear to support or oppose such a political candidate.

4. Rule 4: Postings should establish common courtesy and respect, which excludes personal attacks or criticism.

5. Rule 5: Postings should pertain to mental health and not to issues unrelated to our discipline and practice. Messages exhorting list serve members to advocate for issues that are not on NCAMHP's agenda (e.g., minimum wage, Amnesty International, etc.) are not to be placed on the listserv, regardless of the worthiness of the cause.

6. Rule 6: Communications should be oriented towards increasing the knowledge base of NCAMHP members. The listserve is a forum for sharing information and community building. It is a place where differences of opinion can be voiced however, always with courtesy and respect.

SANCTIONS FOR VIOLATIONS OF THE RULES

NCAMHP does not undertake editorial control of postings (meaning there is no listserv moderator). However, in the event that any inappropriate posting is brought to the attention of the Board of Directors (BOD) listserv administrators, the BOD listserv administrators may take the following action:

1. The BOD listserv administrator(s) will send a warning directly to the violator, with a reminder of the rules, and an explanation of the violation.

2. In the case of a second violation, the administrator(s) will inform the violator of the nature of the infraction, and inform said violator that a third violation will result in suspension from the listserv for six months.

3. In the case of a third violation, the BOD listserv administrator(s) will ask the offending party to unsubscribe from the list voluntarily within ten days. If this action does not occur within the specified time, the NCAMHP BOD reserves the right to remove the violator from the list. After a person has been suspended from the list for six months, the member will be eligible to resubscribe. A re-application for listserv privileges will be made to the NCAMHP BOD. Re-application does not guarantee immediate reinstatement. If reinstated, the prior offenses will be disregarded, and the violation procedure will start again. If not reinstated, the rationale for the decision will be sent to the member.

-- List description: ---

The North Coast Association of Mental Health Professionals is a nonprofit, multidisciplinary organization consisting of psychologists, psychiatrists, marriage and family therapists, licensed clinical social workers, licensed clinical counselors,

licensed educational psychologists, and registered interns of these professions.

To get off this list, you can send any email from your
subscribed address (given above) to:
ncamhp-unsubscribe@groups.electricembers.net

The list homepage: http://groups.electricembers.net/lists/info/ncamhp

General information about mailing lists:
http://groups.electricembers.net/lists/help/introduction

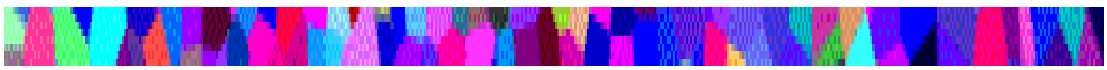
Additional Internet Resources

For becoming a Medi-Cal or Medi-Care provider, contact Beacon at:
http://beaconhs.com. To apply by phone you may contact the California office at:
800 723-8641.

Integrated Primary and Mental Health Care Reconnecting the Brain and Body"
at: http://psychiatry.org/integratedcare
Archived at: http://psychiatry.org/practice/professional-interests/integrated-care-reconnecting-the-brain-and-the-body

A resource for information on acting on Blue Cross claim problems, countering negative online reviews and 12 practice management/billing programs for therapy practices; with links to their websites at:
http://cpapsych.org/displaycommon.cfm?an=18&subarticlenbr=47

Also for more information about ICD-10 codes, see:
http://aparacticecentral.org/update



Advertisements

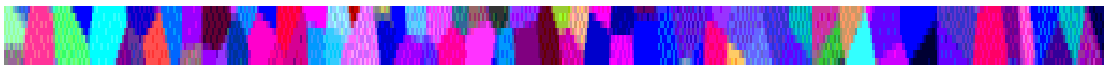
The following advertisements are not endorsed by NCAMHP. As a member, as a member you advertise for free!

Tom Johnson, LMFT, announces the opening of his private practice office in Arcata, providing counseling services to individuals, couples and families. Currently accepting Beacon/Medi-Cal, with pending applications for Anthem Blue Cross, Blue Shield and Humboldt-Del Norte IPA. Background includes 10 years' experience providing therapeutic services in diverse settings, including the foster care system, juvenile hall and schools. Use CBT, psychodynamic, family systems, mindfulness, and forgiveness approaches. 101 South H Street, Suite E, Arcata. Phone: (707) 267-6146

Eric Duff, LCSW is advertising office space available at his office site at 2355 Central Ave., in McKinleyville. He can be reached by phone at: (707) 407-6891, or email: eric6017@suddenlink.net

Eric Duff is also announcing he is starting a support group for men dealing with depression. Interested clients can contact him by phone or email.

Jim Steinberg, mediator:
I invite NCAMHP members to contact me directly at (707)476-0440 for a conversation about my work with separating and divorcing couples. Using the Twin Principles of Transformation Mediation-Empowerment and Recognition, I work with couples in a peaceful process of collaborative problem solving to reach enduring agreements about co-parenting for the best interests of their children and to resolve their concerns about child support, spousal support and division of marital property. Members may also email me at Steinberg@humboldt1.com and visit my website: http://www.steinberg-mediator.com/site/



Job Announcements:

P/T or F/T Clinician to work in state certified Sex Offender Treatment Program. Licensed therapist preferred, but will consider Pre-Licensed DOE. Some training provided. Call Gail Narum at 707 441-8626 ext 1.

Humboldt Open Door Community Health Centers Behavioral Health Team has openings for for Full Time, Part Time, or Contracted LCSW or Psychologist. Must be

licensed and willing to work in fully integrated position in medical setting providing brief interventions, referrals, and time limited individual and group treatments. If you are interested, please apply online at http://www.opendoorhealth.com/opendoor/ or email Lynne Becker, PhD at lbecker@opendoorhealth.com for further details.

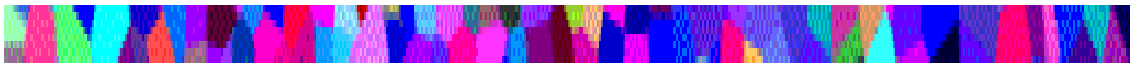
Your Voice is Important!

Contributions are always welcome; anything from a paragraph to a couple of pages would fit well in the newsletter. The deadline for Winter submissions is December 15, 2014. Send your ideas to the newsletter committee: newsletter@ncamhp.org, or Diane Warde, LCSW at wardediane@yahoo.com. Ideas for topics for articles can also be posted on the Listserv. We appreciate your ideas and partcipipation.

Members may advertise and post announcements for office rentals free of charge via the web at any time:

Step 1: Go to www.ncamhp.org
Step 2: Click on Member Login and Login
Step 3: Click on Member Discussion Board
Step 4: Choose "Office Rental"

Please give us feedback: newsletter@ncamhp.org



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