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We have several committees that you can join!

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NPI REFLECTS

Volume 9: Issue 2 Summer 2019

The Times, They Are A Changin'

By Sonya Thomas, LCSW

Chair of the 2019 NPI Board of Directors

Socrates said, "*The secret of change is to focus all of your energy not on fighting the old, but on building the new".* Following this lead, the NPI Board of Directors voted to make significant changes to Workshop Programming, ones that we hope will ultimately prove advantageous for the organization in the coming years. As Chair of the 2019 NPI Board of Directors, and in the interest of transparency, I would like to share with our members how and why we came to these decisions.

The seeds of change were planted over the past several years as speaker fees have risen and workshop attendance has lagged. However, It was early this year that the Board was placed in the position of facing these realities head on when we received an abrupt cancellation from the confirmed speaker for the Fall 2019 workshop. This left the Fall Workshop Committee scrambling to find a replacement in short order that satisfied several conditions. It should be noted that workshop presenters are typically confirmed 12-18 months in advance of an event, with vetting occurring 6-12 months prior to confirmation. Despite impressive efforts, the committee struggled to locate a speaker who was available on such short notice, in budget, and someone who is both published and has some degree of name recognition, as well as someone who would not re-tread a topic or modality of recent workshop focus. The committee discouraged a strategy of simply finding a local speaker to "fill in" out of concern that such a presenter would likely draw the same number of attendees as the average Spring Workshop, which has historically been well below Fall numbers. The Fall Workshop has traditionally been positioned as the larger workshop, with a speaker who has broader name recognition. Mimicking a second Spring Workshop did not seem prudent. Therefore, the recommendation was made that NPI save the expense and energy of implementing a 2019 Fall Workshop that would likely garner modest attendance and invest that money and energy into the Fall 2020 Workshop.

The Committee went on to scrutinize the data from the last several years as it relates to both the Spring and Fall Workshops. This was an illuminating exercise. It has not been lost on those who have served on the Board over the past several years that the Spring Workshop has been a "barely break even" affair, often drawing attendance far below our average

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NASHVILLE PSYCHOTHERAPY INSTITUTE

What is NPI?

The Nashville Psychotherapy Institute or NPI is a 501(c)(6) non profit, professional organization. Founded in 1985, NPI now boasts 300+ members.

Not a member? Find out more about NPI at www.NashvillePsychotherapyInstitute.org

Inside this issue:

Ice Ice Baby

By Liz Zagatta-Allison, MDiv, LMFT, PhD

Clinicians who have ever had a client or clients involved in infertility treatment know how emotional, exhausting, time consuming, expensive and even physically painful the process can be for individuals desiring to be parents. And in the end, despite the science that increases the possibilities of conception and/or implantation in a womb, a viable pregnancy is never a guaranteed outcome. This essay is a personal story about coming to the end of the infertility process, only to be faced with a new and unexpected dilemma. It is about the questions, considerations, moral challenges and potential decisions that I did anticipate when the ultimate goal was to have my own biological child. While I cannot say that I would have done things differently concerning my choices at each step of the way, I believe it is important that individuals undergoing infertility treatment, as well as their caregivers, be fully informed of the potential decisions they may have to make even after achieving the goal of having a child or children.

My husband, Rob, and I spent four years trying to have a baby. These attempts included timed sexual intercourse for the first year, followed by prescribed infertility treatments including Clomid and Femara (medications), many attempts using intrauterine insemination (IUI), two pregnancies – one ending in miscarriage and the other ending in a medically indicated termination - and finally in vitro fertilization (IVF) with preimplantation genetic diagnosis (PGD) of our embryos. Our IVF process yielded three viable embryos. At this point in time Rob was 49, and I was 38. I wanted more than one child, while Rob was concerned about his age and said he would be content with a single child. We agreed that if we put in two embryos and ended up with twins, our family would be complete. We could avoid trying to have another baby in two to three years. Our doctor was sympathetic to our circumstances and desire and agreed to transfer two embryos. So, we put two embryos in, and they both stuck. Thirty-seven weeks later a very healthy Frances Gardiner and Charlotte Elizabeth were born.

Everything worked out for us. We had two beautiful, healthy babies. Life was chaotic - so chaotic that I barely recall getting the bill for the frozen storage charge for embryo #3. It came before the twins were a month old! I was overwhelmed and just signed the forms and returned the $500 fee for a year's storage of the single embryo. But as the girls grew during their first year of life, our embryo on ice periodically crept into my thoughts. Frances and Charlotte had distinct looks, their own little quirks, and their own emerging personalities and gifts. I started to think about embryo #3 in a way I had not previously – in a way I could not possibly have thought about it before my children existed in the world outside of a petri dish and my womb. What would that baby look like? Our testing had revealed three female embryos, so would *she* look like Frances or Charlotte? Would she act like Frances or Charlotte? What about her personality? This is how my preoccupation with #3 started.

After the girls' first birthday, the bill came again for the frozen storage. I was still overwhelmed with the twins and panicked. I sent off the check for $500 for another year on ice for #3. By the time 2019 dawned, Rob and I kept referring to the "serious conversation" we needed to have about "what to do with the embryo." Being one of three children, I had a resurgence of my original desires to have more than two children, a hope that I grieved over the course of our infertility struggles. My husband, whose initial desire was for one child and who had yet to emerge from "the hardest two years" of his life, balked at the idea of having another child. Our conversations were emotional and intense. We decided to return to the fertility clinic to gather concrete information about our options from our doctor. These were our options. First, transfer the embryo and potentially have another child. Second, donate the embryo to a person or couple in need of embryos. In this case, a person or couple could select our embryo from a profile and it would likely be part of a batch of embryos that could be transferred. The third option was to have the embryo destroyed or "disposed of". While I had been thinking about these options for some time, my husband came out of the meeting more confused. He was adamant about NOT donating the embryo, but now had more consternation about the embryo being destroyed.

Before we left, the doctor suggested that I speak with an infertility counselor, a therapist with a lot of experience supporting folks struggling with infertility and helping others make decisions about frozen embryos. I saw her for a single session. She asked some wonderful questions about my process. I noticed my struggle with language. Was this a baby? Was it my third little girl? Was it an embryo? Was it just a cluster of cells? What did I believe to be the truth about this frozen entity? Other complicated facets of my dilemma: Would I be feeling just as conflicted if I had two, three or even more embryos on ice? I felt strongly that we had ONE pregnancy left in us and trying to have multiples again was totally out of the question. More so, having another child would increase financial stress now and for the next 20-plus years. It would delay our retirement, take resources away from the two children we already had, and require energy that we had yet to regain since the twins were born.

Still, I was excited to once again have the opportunity for a third child. I also harbored the grief of having missed out on the experience of a singleton infant. Caring for my infant twins was chaos. Tandem nursing was a circus, one that required a lot of helping hands and little to no privacy. It was impossible for one baby to have all of my attention. I experienced a lot of guilty feelings, and stress and fatigue made it hard for me to feel connected to my babies at times. Part of me wanted to experience having a single baby. But all that being said, I did NOT feel like my family was incomplete. If there were no more embryos, I would not feel at a loss.

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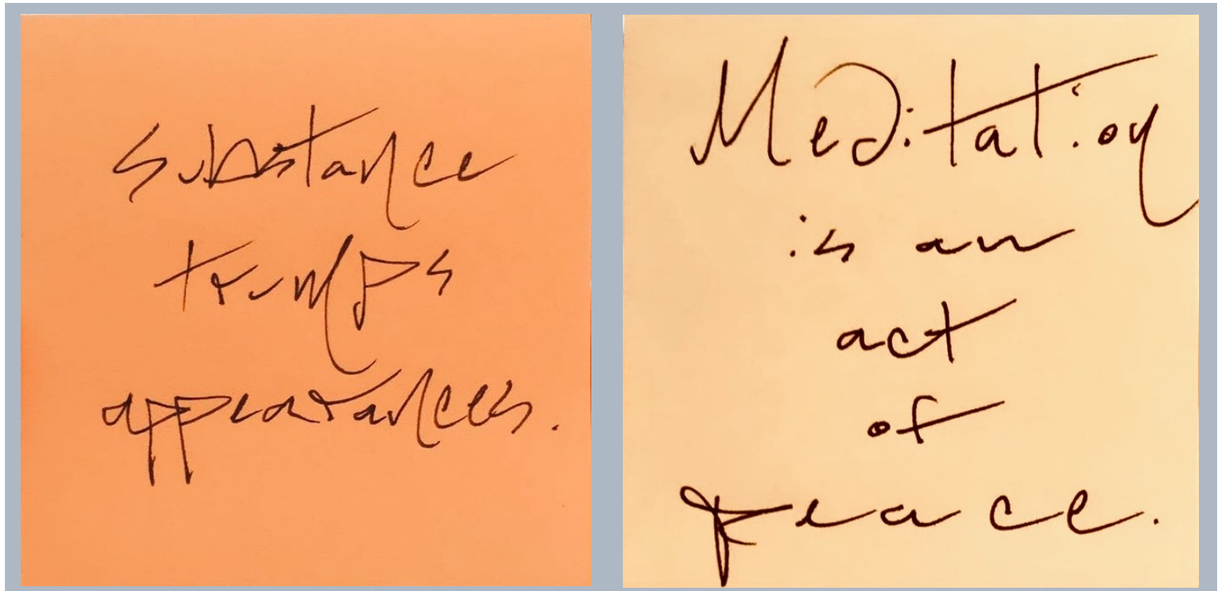


Artwork by Rob Rickman , LPC/MHSP

(Continued from page 2)

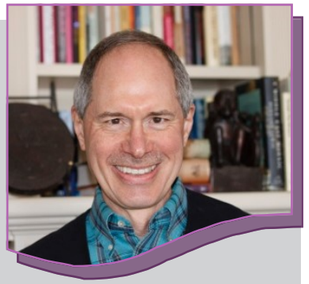
Surprisingly, the biggest challenge for me felt like a moral one. When I considered ending the frozen storage contract, I was overwhelmed with sadness about the end of this potential life that already felt familiar to me as I watched the twins grow and change. I imagined that I would always wonder about that embryo. And someday my girls would learn about our fertility process and (because they are my girls) they would ask if there were more embryos. The decision felt bigger than me and Rob. It felt so weighty. Truthfully, I longed to relinquish the responsibility. I was capable of making a pros and cons list, but it was not helping.

In the course of my counseling session with the infertility counselor, she informed me of two additional options that the infertility clinic neglected to mention. First, doing a *natural cycle frozen embryo transfer (FET)* - forgoing the full hormone replacement portion of the treatment and transferring the embryo at a time in my cycle when I could get pregnant. Or second, considering a *compassionate transfer*, which would mean taking the embryo and putting it in the vagina or uterus at a time when I could not get pregnant. The latter option embodied the symbolism and meaning of returning the embryo(s) to the body and allowing it/them to pass away naturally. The counselor said that this option was very meaningful to some people who were not comfortable with the embryos being “disposed of”. This was information I needed. There were other options. I shared the information with Rob, and we discussed these two additional alternatives.

We decided to do a natural cycle FET, with some progesterone supplementation. I wanted my body to make this decision. I did not want to trick my body into thinking it was ready for another pregnancy. I wanted to lean some on of the body’s wisdom and some on those powers – God, the universe, the wonder of science…all of it - that are outside of my control. I was aware of the statistics (of my chance of getting pregnant given my age, the age of the embryos, the fact the embryos were genetically viable, etc.) and while my chances were slightly better than 50/50, they were close. By the time these thoughts and feelings coalesced, I knew I would have peace with whatever the outcome. Today, as I write this, I am almost 11 weeks pregnant and suffering from daily, all-day morning sickness. The discomfort and fatigue pull me into a place of anxiety and doubt sometimes, but I still have enough perspective to know that we made an informed decision that was in accord with our deepest intuitions about what was right for us. Our baby girl is due January 11th, 2020.

There are well over one million frozen embryos in the US, and this number will continue to grow. Some of you may even have clients now with frozen embryos that they continue to pay storage fees on because they are confused about what decision to make and perhaps are unaware of the various options. After all, a clinic in the business of getting folks pregnant is not going to advertise an option that is an alternative to pregnancy, despite its potential psychological and emotional meaningfulness. I invite your questions and curiosities about our process if it has the potential to provide insight and potential healing.

The Psychiatrist as Psychotherapist: Contemplations on a Species at Risk of Extinction



By Philip Chanin, Ed.D, ABPP, CGP
Board Certified Clinical Psychologist
Assistant Clinical Professor, Department of Psychiatry, Vanderbilt University Medical Center

For Psychiatrists Who Take Insurance, Talk Therapy Doesn't Pay

"Alone with his psychiatrist, the patient confided that his newborn had serious health problems, his distraught wife was screaming at him, and he had started drinking again. With his life and second marriage falling apart, the man said he needed help. But the psychiatrist, Dr. Donald Levin, stopped him and said: 'Hold it. I'm not your therapist. I could adjust your medications, but I don't think that's appropriate.' Like many of the nation's 48,000 psychiatrists, Dr. Levin, in large part because of changes in how much insurance will pay, no longer provides talk therapy…Instead, he prescribes medication, usually after a brief consultation with each patient. So Dr. Levin sent the man away with a referral to a less costly therapist and a personal crisis unexplored and unresolved." ("Talk Doesn't Pay, So Psychiatry Turns Instead to Drug Therapy," by Gardiner Harris, The New York Times, March 5, 2011).

Recently I searched for and found this article, which is as poignant for me today as it was when I first read it eight years ago. It is abundantly clear that Dr. Levin had been trained in and loved doing psychotherapy, and that the choice he has made for financial reasons, to stop doing psychotherapy and do only medication management, has left him feeling often empty. "I had to train myself not to get too interested in their problems," he said, "and not to get side-tracked trying to be a semi-therapist." The article goes on to state, "A 2005 government survey found that just 11 percent of psychiatrists provided talk therapy to all patients - a share that had been falling for years and has most likely fallen more since."

"Now, like many of his peers," the article says, "Dr. Levin treats 1,200 people in mostly 15-minute visits for prescription adjustments that are sometimes months apart. Then, he knew his patients' inner lives better than he knew his wife's; now, he often cannot remember their names. Then, his goal was to help his patients become happy and fulfilled; now, it is just to keep them functional."

Dr. Levin goes on to say that, "the quality of treatment he offers is poorer now then when he was younger. For instance, he was trained to adopt an unhurried analytic calm during treatment sessions. 'But my office is like a bus station now,' he says. 'How can I have an analytic calm?'" The article continues, "the brevity of his appointments—like those of all of his patients—leaves him unfulfilled. 'I miss the mystery and intrigue of psychotherapy,' Dr. Levin states. 'Now I feel like a good Volkswagen mechanic. I'm good at it, but there's not a lot to master in medications.'"

"At first, all of us held steadfast, saying we spent years learning the craft of psychotherapy and weren't relinquishing it because of parsimonious policies by managed care," Dr. Levin laments. "But one by one, we accepted that the craft was no longer economically viable…It took me at least five years to emotionally accept that I was never going back to doing what I did before and what I loved."

The Decline in Psychotherapy Training in Psychiatry

Some statistics bear out the dramatic decline in recent years in most psychiatrists' interest in psychotherapy. The American Academy of Psychotherapists (AAP) is a preeminent national interdisciplinary psychotherapy organization, and it has played a powerful role in my own development as a psychotherapist for the past 27 years. It has 309 members. Only 10 are psychiatrists or other physicians. The Nashville Psychotherapy Institute (NPI) has played a parallel role for me here and has been vital in my building a personal and professional network during this same period of time. NPI has 314 active members. Only 4 are psychiatrists.

Google lists 295 Nashville psychiatrists. The psychiatrists here who are best known to continue to schedule 45-minute sessions for talk therapy are psychoanalysts who have been through their own personal psychoanalysis and have trained for 4 years at the St. Louis Psychoanalytic Institute. These include Doctors Tom Campbell, Anne Bartek, Bill Kenner, Hal Schofield, and Sarah Aylor. Other non-analysts who are known to me to see all their patients for extensive evaluations and for 45-minute follow-up sessions for a combination of talk therapy and medication management include Doctors Mike Reed, Scott West, Casey Arney, John Lambert, Scot McKay, Jack Koch, Daniel Barton, Jill Debona, and Ira Phillips. I am sure there are others not known to me personally, though I think it unlikely that the number would reach the 11% figure (of 295 Nashville psychiatrists) that is mentioned in the above article.

JOIN US

Upcoming Continuing Education Luncheons

Friday, August 9, 2019
"Transliminality: The most Nashville-relevant personality trait you've never heard of," presented by Laura Rosser Kreiselmaier, PhD

Friday, September 13, 2019
"Dissociative Identity Disorder: Learning from the patient," presented by Christina Oliver, MA, LPC/MHSP
Sponsored by Integrative Life Center

Friday, October 11, 2019
"Don't Fix Me; I'm Not Broken: Common mistakes helpers make with Adult ADHD Clients," presented by Terry M. Huff, LCSW
Sponsored by Bridge to Recovery

11:30 am - 1:00 pm
Scarritt Bennett Center
1008 19th Ave. South * Nashville, TN 37212

Program & Registration Information at www.NashvillePsychotherapyInstitute.org
Each lunch presentation is eligible for one CE credit hour

Just Be

By Barbara Sanders, LCSW

Grief envelopes her
Shakes her like a rag doll
With desperate despair,
Knocks the wind out of her
Until she crumples in on herself
Breathless and torn.

Pain and agony
Well up and spill over
Like a flood
Rushing through the
Streets destroying
Everything in its path.

How to express this
Deep anguish and sadness
Instead of holding it,
Just holding it, pushing it
Down, down, down,
Hoping it will wither
Away and bother her
No more?

The feelings start a separate
Life of their own
Taking root deep inside, aching
Her gut, gradually growing
every moment, every year.
Can she touch that planted
Wonder if she tries,
Or is it completely
Invisible to her?

Protected she is
From so many troubling
Feelings when she smiles
And moves about, working
Through her daily struggle. But,
She tries to stay numb, stay numb,
Not brave enough to
Travel down into her inner dwellings
To look upon or touch
Those shut off feelings
Wickedly stored away in the
Vault of her heart.

Tears flow at
Uncertain times
When nothing seems
To call them.
She weeps, she screams
She wails and begs
To keep from experiencing
The torment of these
Old, old feelings.

They didn't seem to hurt so much back then
Because her child self wasn't so aware,
Since she was taught not to express much
Feeling of any sort.

Not to display any excitement nor worry,
Anger nor fear.
Because those made others
Uncomfortable and they
Said "Stop" or "Calm down!"
Or, "You are being too sensitive."
Forcefully, threateningly.
The message: Harbor any untoward
Feelings - even jubilation;
Until she stabbed
Her sister with a pick up stick
After her sister annoyed her
One too many times.

Usually, she plays sweetly
Until she just can't stand
It anymore and she lashes out,
Out of control.
Breaking apart and shattering
Into pieces, afraid she thinks
She will never be able to redesign
Herself, restructure herself
While allowing *all* of her
Feelings and thoughts to
Be known at least
By her.

That breaking apart seems
So scary, but no worse
Than the holding in, holding on,
Holding all of these feelings for
So long that the storm began,
The dam broke
Endangering everyone
Around her.
What happens then?

"Oh, excuse me," as if
She had just belched.
"Oh, pardon me" for
Allowing her shame and
darkness to sprout and
Blossom like kudzu in
Mississippi, stringing all the
Other vines together,
Squelching the life out of
Everything around her
Energetic growth.

But, now.....

She is done with this.
No longer holding,
No longer flooding nor
Slinging her poison
Arrows and swords.
What to do now?

Just be.

P.S. "And, 'know that this entire world is just for you… Accept without further thought of whether you are good or bad and just be responsible to it. This is the spirit you must bring to everything that you do.'
~ I Ching or Book of Changes: A guide to Life's Turning Points (translated by Brian Browne Walker)

For the past 10 years, I have seen Vanderbilt psychiatric residents for psychotherapy and supervision, and for the past 6 years in weekly psychotherapy process groups. Thus, I have witnessed firsthand the degree to which training in psychotherapy is devalued in relation to the amount of training devoted to medication management and biological psychiatry. Residents do not even see their first psychotherapy patient until the beginning of their 3rd and next to last year of residency! Residents are not required to undergo psychotherapy and are given no time out of their busy schedule to do so. Thus, one recent resident who wanted to get psychotherapy spent a month trying to find a Nashville psychotherapist who had Saturday hours.

It was not always like this in Vanderbilt's Department of Psychiatry. For 3 decades, psychoanalyst Volney Gay, Ph.D., was a powerful voice for the training of psychiatric residents in psychodynamic psychotherapy. Other psychoanalysts, such as Doctors Anne Bartek and Tom Cambell, played major roles in providing and advocating for psychotherapy training.

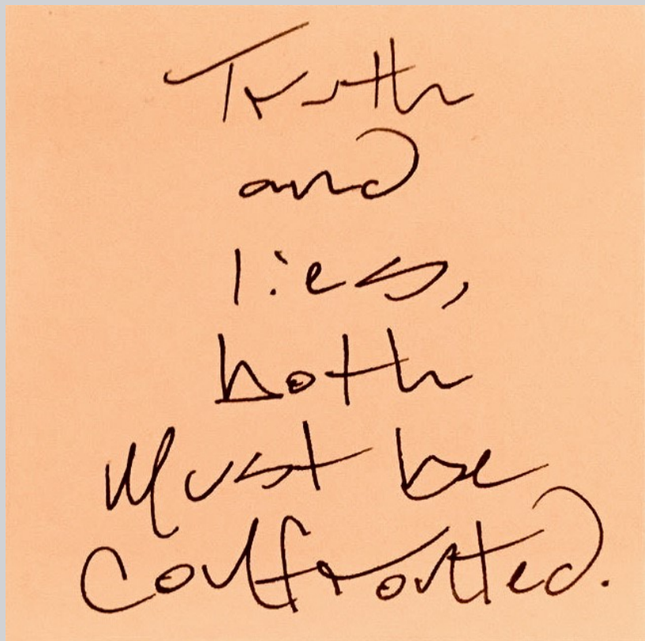
Psychiatrist Dr. Mike Reed, who trained in the Department 30 years ago, wrote to me this week: "I was lucky enough to have had as my mentors Marc Hollender, Pietro Castelnuovo-Tedesco, James Nash, and most importantly, Volney Gay. I felt well trained in psychotherapy and focused on getting as much training as I could during my years at Vanderbilt. But, I think the average graduating resident now may have had much less exposure and probably is inadequately trained. Or perhaps it's a lack of interest, which is hard to comprehend. Maybe though the current emerging flock of psychiatrists think of providing psychotherapy as 'old school.'"

Even in the past, however, personal psychotherapy was not required of the residents. Instead, most underwent euphemistically defined "self-awareness" sessions for 6 months with Dr. Campbell or another member of the resident or volunteer faculty. The "self-awareness" program dried up about 3-4 years ago when Dr. Gay's contract with the Department ended. Last year, Doctors Campbell and Bartek taught their last psychotherapy class to the residents. Dr. Gay also retired from Vanderbilt last year and Dr. Bartek gave up her role in promoting psychotherapy in the Department.

No one has stepped into the void that their departure has created in the training of Vanderbilt psychiatric residents in psychodynamic psychotherapy. These days, most of the psychotherapy training in the Department focuses on CBT and DBT rather than psychodynamic psychotherapy. 3rd and 4th year residents carry a caseload of 5 or so patients with one psychotherapy supervisor. The Department does support a 1-hour weekly process group where residents can together air their professional and personal challenges. But most current psychiatric residents have minimal interest in practicing psychotherapy once they graduate. Most plan careers in such areas as inpatient or geriatric or forensic psychiatry. They are very well trained for these endeavors, but unfortunately not as psychotherapists.

As a Nashville psychoanalyst wrote to me recently, "Big Pharma and the insurance companies have gutted
psychiatry at this point. As an analyst, I feel at times like a Buddhist monk in his saffron robes, with my bowl,
asking for rice, working for lower fees, or being restricted to seeing only the financially privileged."

The above cited article about Dr. Levin includes a profile of one of his former colleagues, Dr. Louisa Lance, who, "practices the old style of psychiatry from an office next to her house…She sees new patients for 90 minutes and schedules follow-up appointments for 45 minutes. Everyone gets talk therapy. Cutting ties with insurers was frightening, since it meant relying solely on word-of-mouth, rather than referrals within insurers' networks," Dr. Lance stated, "but she cannot imagine seeing patients for just 15 minutes. She charges $200 for most
appointments and treats fewer patients in a week than Dr. Levin treats in a day. 'Medication is important,' she said, 'but it's the relationship that gets people better.'"



Artwork by Rob Rickman , LPC/MHSP

(Times...continued from page 1)

monthly luncheon numbers. This has prompted the Executive Leadership to question along the way whether or not the Spring Workshop was a worthwhile endeavor to continue to pursue. After a closer inspection of all the numbers including attendance, sponsorships, speaker fees, venue costs, revenues earned and losses incurred, hours spent by the Executive Coordinator, etc., the following observations and recommendations for future workshop programming were made:

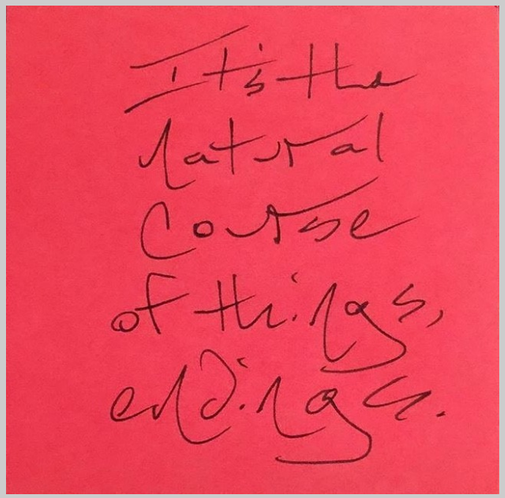
- Fall Workshops Attendance ranges from 50 - 72.
- Generally, the Fall Workshops have featured an out-of-town speaker who is authored/published and prominent in their field.
- Spring Workshop Attendance: 34 – 36. This participation is less than most monthly NPI luncheons.
- Resources expended by Committee's and/or the Board are equal for both the Fall and Spring Workshops.
- The Executive Coordinator is the primary implementer. Her investment of hours is extensive and nearly the same for each of the workshops.

Based on the above, the recommendation was made to discontinue the Spring workshop beginning in 2020, and move to one Annual "Jules Seeman" Workshop to take place in the Fall, with Jennie Adams being made Honorary of the bi-annual NPI Connections Retreat which will take place in the Spring of even numbered years. The Board approved this recommendation at the May 2019 Board Meeting. In approving this change, we took into account the anticipated benefits on one Annual Workshop, which include:

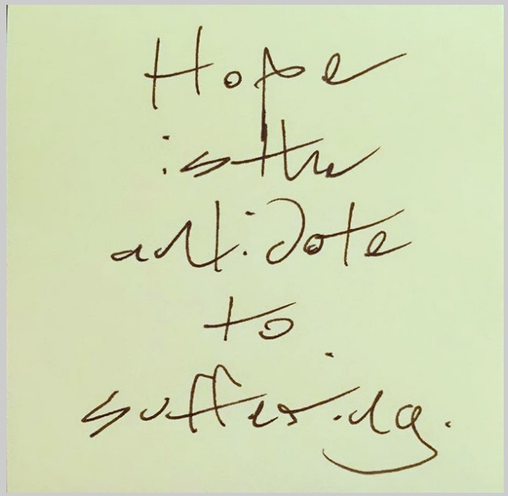
- Combined Fixed Expenses: Executive Coordinator Labor Hours, Marketing (Brochure & Postage), Venue Costs, CEU's, etc.
- More flexibility to pay higher fees for top tier talent.
- Increased focus of BOD/Committees may inspire more consistent participation/attendance.
- More prominent presenters are likely to attract more Non-NPI Clinicians from Nashville and Middle Tennessee.
- Developing collaborations with other entities that can underwrite a portion of the speaker fees will allow for increased speaker budgets (much like the Wellness 66 event in the Fall of 2018).
- Higher attendance facilitates sponsorship sales.
- One versus two workshop events avoids sponsorship burnout.

The Board recognizes that some members of our community will likely meet this change with a degree of skepticism and disappointment. We, too, are saddened and wish that circumstances were different. At the same time, we are also hopeful and excited about the possibilities this change portends. I will close with a quote by another Greek philosopher, Heraclitus: *"There is nothing permanent except change."*

Recognizing this, we look forward to seeing you at future NPI events!



Artwork by Rob Rickman , LPC/MHSP



Artwork by Rob Rickman , LPC/MHSP

CALL FOR NOMINATIONS

NOW ACCEPTING NOMINATIONS FOR THE NPI BOARD OF DIRECTORS

The NPI Nominating Committee is currently accepting nominations for Board membership. Board members serve a three-year term that would begin January 2020, except for the student member which is a one-year term. We are accepting applications for three board positions and one student member. Visit the NPI Website at **www.NashvillePsychotherapyInstitute.org** to learn more about **The Role of The Board Member** and to access **The Application for Board Membership**. You can apply yourself, or nominate a colleague. Please note that ALL individuals interested in serving on the board must complete an online profile, even if you have completed an application before.

All nominations must be received by July 20th.

If you would like to nominate someone else, please let them know, and forward their name to Angela Hart, Chair of the NPI Nominating Committee at anghart29@gmail.com.