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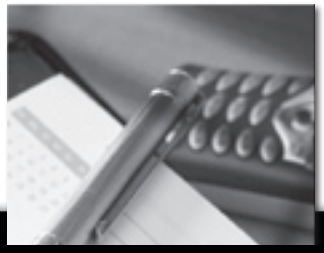
Sleep Disorders: Evaluation, Measurement, and Treatment



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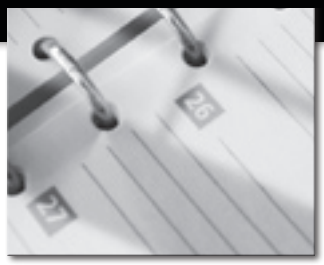

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Enjoying the Ride

Stephen C. Phillips, J.D., Psy.D.

Friends, both in and out of LACPA, have questioned my sanity in taking on the responsibilities attendant to my role as President. At times, such as when my e-mail inbox is brimming with messages that need to be responded to, I share their sentiments. But, by and large, the rewards of the post far outweigh the burdens. LACPA is an amazing organization. (And this from a man who by and large shuns group process.) What is remarkable to me is the dedication of those who actively participate in the life of the organization, the creativity demonstrated by leaders and members alike in generating ideas as to how LACPA can better address the needs of its members, the informed and rational management of organizational resources and risk, and the professionalism and smarts of the leadership, staff, and members in implementing and executing the organizational agenda. It is a wonder to behold.

I recently had lunch with a colleague and fellow Board member who has participated in the leadership of other professional associations. What struck each of us was the pleasant and productive way that LACPA leaders and members work together. I genuinely enjoy my interactions with virtually all of the leadership, our wonderful and highly professional staff, Ms. Patricia Fricker, M.A., and Ms. Carol Torcello, our dedicated members, and the variety of volunteers who populate the little corner of the world that constitutes LACPA. Having served on several other boards, which were sometimes conflictual and often highly political, the LACPA experience is the exception to the rule. This all may sound like a self-serving "puff piece," but it is these factors that led me to take the plunge and accept the nomination to run for President- Elect and to become President of the organization. I would encourage anyone reading this column who wants to make a difference in the local psychological community to give serious consideration to becoming more actively involved in LACPA. Although you will not find things are done perfectly, I feel certain that you will meet wonderful professionals with a real dedication to providing quality services to the membership and to the public.

As part of my duties this year, seven of my LACPA colleagues and I were asked to attend the California Psychological Association's Leadership and Advocacy Conference, which culminated in Leadership and Advocacy Day, a day dedicated to lobbying the state legislature on behalf of mental health consumers and psychologists. Members often express concerns regarding the ability of psychologists and their professional associations to advocate on behalf of our clients/patients and on behalf of our profession. This conference is one concrete way in which your state and local professional associations are working to move a legislative and regulatory agenda forward in order to strengthen the mental health delivery system and psychology as a whole. I would strongly encourage you to consider participating in this annual event in the years to come. Pamela McCrory, Ph.D., LACPA's President-Elect, was graciously invited by CPA to be part of the California delegation to the recent American Psychological Association State Leadership Conference, the analogous conference put on by the APA Practice Directorate to encourage Congress to better consider the concerns of psychologists through active education and lobbying. Both events are a testament to the increasing importance being placed by our professional associations on political action for the betterment of the profession, our standing in the professional community, and the needs and concerns of psychologists.

LACPA leaders have also consistently supported the work of the California Psychological Association's Political Action Committee, commonly known as CPA-PAC. At the April CPA convention, a fundraising luncheon was held to support the work of psychology's statewide entity dedicated to the use of political resources and money to strengthen the role of psychologists, to give voice to our concerns, and to protect the scope of our practice. Through the generosity of individual LACPA members and its leaders, we were able to purchase a table at the luncheon with a donation of approxi-

*See **"President"** continued on page 4*

LACPA CALENDAR OF EVENTS ~2011~

Monday, May 2
Brown Bag Lunch Series
"Developmental Neurobiology of Attachment Dynamics: Clinical Applications"
LACPA Office Conference Room
12:00 p.m. – 1:45 p.m.
Presenter: James S. Graves, Ph.D., Psy.D.
Please see www.lapsych.org for information and registration.

Thursday, May 5
Woodland Hills Book Club Meeting
Office of Ann Schofield, Ph.D.
7:30 p.m. – 9:00 p.m.
RSVP: Ann Schofield, Ph.D.
annschofieldphd@aol.com

LACPA Executive Committee Meeting
LACPA Office Conference Room - 7: 30 p.m.

Friday, May 6
Group Therapy Special Interest Group
LACPA Office Conference Room
10:00 a.m. – 11:30 a.m.
RSVP Evelyn Pechter, Psy.D.
drevelynpechter@earthlink.net

Couple Therapy Special Interest Group
LACPA Office Conference Room
12:00 p.m. – 1:30 p.m,.
RSVP Nancy Gardner, Ph.D.
nangardner@sbcglobal.net

Saturday, May 7
Diversity Committee Multicultural Breakfast
LACPA Office Conference
9:30 a.m. – 11:00 a.m.
RSVP Gitu Bhatia, Psy.D. at gitub@usa.net or Miriam Hamideh, Ph.D. at mhamidehphd@hotmail.com

Santa Clarita Book Club Meeting
Office of Lynne Steinman
10:00 a.m. – 12:00 a.m.
RSVP: Lynne Steinman, Ph.D.
lasteinman@aol.com

Monday, May 9
Mindfulness & Spirituality
Special Interest Group
LACPA Office Conference Room
9:00 a.m. – 10:30 a.m.
RSVP Michelle LeChau, Psy.D.
mlechau@mindful-connection.com

Article deadline for July/August 2011
Los Angeles Psychologist

Tuesday, May 10
Networking Committee
LACPA Office Conference Room
7:30 p.m.
RSVP
Amy Rosett, Ph.D.
dramyrosett@earthlink.net or
818-705-1870

Thursday, May 12
Geropsychology Special Interest Group
LACPA Office Conference Room
12:00 p.m. – 1:30 p.m.
RSVP Annette Swain, Ph.D.
aswain@ucla.edu

Friday, May 13
Pain Management Special Interest Group
LACPA Office Conference Room
10:00 a.m. – 11:30 a.m.
RSVP Shelley Segal, Psy.D.
slsegal@mednet.ucla..edu

Assessment Special Interest Group
LACPA Office Conference Room
12:00 p.m. – 1:30 p.m.
RSVP Jennifer Cassatly, Psy.D.
info@drcassatlyl.com

Thursday, May19
LACPA Board of Directors Meeting
LACPA Office Conference Room
7:30 p.m.

Saturday, May 21
2011 Program Series
"Cognitive Behavioral Treatment of Hoarding"
9:00 a.m. – 12:00 p.m.
LACPA Office Conference Room
Presenter: Gerald Tarlow, Ph.D.
Please see 20 for information and registration or register online at www.lapsych.org

Friday, May 27
Divorce Special Interest Group
LACPA Office Conference Room
10:00 a.m. – 11:30 a.m.
RSVP Diana Mercer, J.D.
Diana1159@aol.com

Monday, May 30
Memorial Day
LACPA office closed

Thursday, June 2
LACPA Executive Committee Meeting
LACPA Office Conference Room
7:30 p.m.

Friday, June 3
Couple Therapy Special Interest Group
LACPA Office Conference Room
12:00 p.m. – 1:30 p.m,.
RSVP Nancy Gardner, Ph.D.
nangardner@sbcglobal.net

Saturday, June 4
2011 Program Series
"Hypnosis, Reframing and Behavioral Activation in Treating Depression"
9:00 a.m. – 4:00 p.m.
The Skirball Cultural Center
Presenter: Michael D. Yapko, Ph.D.
Please see 20 for information and registration or register online at www.lapsych.org

Friday, June 10
Pain Management Special Interest Group
LACPA Office Conference Room
10:00 a.m. – 11:30 a.m.
RSVP Shelley Segal, Psy.D.
slsegal@mednet.ucla..edu

Saturday, June 11
Breakfast with the Board
Location to be announced
10:00 a.m. – 12:00 p.m.
RSVP Karin S. Hart, Psy.D.
talk2drh@aol.com

Monday, June 13
Mindfulness & Spirituality Special Interest Group
LACPA Office Conference Room
9:00 a.m. – 10:30 a.m.
RSVP Michelle LeChau, Psy.D.
mlechau@mindful-connection.com

Thursday, June 16
LACPA Board of Directors Meeting
LACPA Office Conference Room
7:30 p.m.

Monday, June 20
Brown Bag Lunch Series
"Countertransference Responses to Working with Patients with Regressed Mental States"
LACPA Office Conference Room
12:00 p.m. – 1:45 p.m.
Presenter: Daniel Paul, Ph.D.
Please see www.lapsych.org for information and registration.

Thursday, June 23
Assessment Special Interest Group
LACPA Office Conference Room
12:00 p.m. – 1:30 p.m.
RSVP Jennifer Cassatly, Psy.D.
info@drcassatly.com

Friday, June 24
Divorce Special Interest Group
LACPA Office Conference Room
10:00 a.m. – 11:30 a.m.
RSVP Diana Mercer, J.D.
Diana1159@aol.com

For the most up-to-date information, check www.lapsych.org under Events.

"President," *continued from page 3*

mately $2,000. Although LACPA cannot donate monies directly to CPA-PAC, the efforts of the community that constitutes LACPA made this contribution a reality. If, as many members state, political action should be a priority of all psychologists, a contribution to CPA-PAC is one concrete way in which you can continue to strengthen our role in the social dialectic and the political process.

Before closing this column, I want to make sure to acknowledge the remarkable and inestimable contribution to LACPA made by our Executive Administrator, Ms. Patricia Fricker, M.A. Pat, as she is known to most of us, marked her 20th anniversary of employment at LACPA in March of this year. I cannot write enough positive things about her impact on the well-being of the organization, her strengths as an administrator, and her qualities as a human being to do her justice. To know Pat is to respect Pat. My role as President would have been much more difficult without her support and wise counsel.

In summary, here is the takeaway message: in my opinion LACPA continues to enjoy remarkable success in spite of recent marked economic contraction because of the special qualities of its leaders, its staff and, perhaps most of all, its members. I am proud to be part of the LACPA community. ▲

Editor's Corner

John Geirland, Ph.D.

"A good laugh and a long sleep are the best cures in the doctor's book."
- Old Irish Proverb

Psychologists are trained to see sleep disturbances (e.g., insomnia, hypersomnia) as symptoms of psychiatric disorders, such as depression and anxiety. Increasingly, though, sleep deprivation is being recognized as a contributor to these same disorders and others (*Harvard Mental Health*, (2009). Alarmingly, the amount of sleep Americans are getting is steadily decreasing. The norm in the 19th century was nine hours of sleep per night, while a National Sleep Foundation survey in 2005 found that Americans average 6.9 hours per night. That is a loss of more than two hours in a century--and 15 to 25 minute just since 2001. Sleep deprivation has a number of adverse impacts on cognitive performance and health, including hormonal changes that can result in weight gain and obesity (*Newsweek*, 2005). No doubt, sleep deprivation is an under-appreciated factor in mental health, emotional well-being, and performance. I was reminded of this point a year ago when my son was looking for a topic for speech and debate.

My son was a 9th grader at the time and spending an hour each morning riding a school bus to a high school in the West Valley. Not surprisingly, his speech and debate topic was: "Why high school should begin at 9:00 a.m. instead of 8:00 a.m." It turned out that there was a pile of research in support of the proposition that sleep deprivation is common in high school students, with 25% of students in one study reporting excessive daytime sleepiness (Ng, Ng & Chan, 2009). Iowa high school students who took an AP class slept one hour less per night than those who didn't (Jin & Si, 2008). Another study of Chinese students age 13 to 17 found getting less sleep to be associated with higher incidents of AD/HD (Lam & Yang, 2008). Lack of sleep generally has an adverse impact on academic performance (Gais, Lucas & Born, 2006).

One might argue with confidence that high school students are sleep deprived because they stay up too late. True enough, but it is also the case that adolescents experience a phase shift in which melatonin, the substance that controls circadian rhythms, is released 90 minutes later in the night compared to adults and children. Teens go to bed later because they don't get sleepy until later.

Pushing back school start times may well be beneficial. In their book *Nurture Shock*, Po Bronson and Ashley Merryman (2009) describe a high school in Edina, Minnesota, where school administrators moved the start time for school from 7:25 a.m. to 8:30 a.m. Among the top 10% of academic performers in the school, SAT Math scores increased by an average of 56 points and SAT verbal scores a breathtaking 156 points. Happily for my son, the research was on the side of his argument.

Clearly, psychologists working with all populations would benefit from learning more about sleep and sleep disorders, ergo, the theme of this issue of *The Los Angeles Psychologist*. ▲

References used in this column are available upon request from the LACPA office: lacpsych@aol.com.

In This Issue

SLEEP DISORDERS

Important Diagnostic Considerations for the Sleep Savvy Psychologist

Jeffrey Young, Ph.D., CBSM

With growing public awareness of the importance of sleep, many psychologists routinely evaluate patients' sleep quality in diagnostic assessments. A thorough evaluation of sleep difficulties requires an understanding of the differential diagnosis of sleep disorders beyond those traditionally treated by psychologists and an understanding of when a polysomnogram ("sleep study" or "PSG") is required for accurate diagnosis. This article offers a sampling of common diagnostic considerations that confront sleep clinicians. I will discuss diagnostic considerations for three common presenting complaints.

"I can't get to sleep."

Probably the most common sleep complaint a psychologist encounters is difficulty initiating sleep with the most common diagnostic presumption being insomnia, seen as either a primary disorder or a disorder secondary to a psychiatric disturbance such as anxiety or depression. While this presumption is often correct, in some cases the problem is actually a disorder of inappropriately-timed sleep, called circadian rhythm sleep disorders. For example, a patient may find he or she can easily initiate sleep after 2:00 a.m. and sleep solidly until 9:30 a.m. but consistently struggles to fall asleep at 10:00 p.m. (seen as the "proper" time) and rise at 6:00 a.m. for work. In this case, circadian rhythm sleep disorder-delayed type is likely the primary cause of the sleep initiation complaint, if not a strong contributor. This distinction is important because psychological and pharmacological treatments differ considerably (e.g., CBT for insomnia/Hypnotics vs. Light Therapy, Chronotherapy, Melatonin Agonists). Another important consideration in this differential is age. Adolescents and young adults normally have a later biological sleep tendency (delay) which will need to be factored in as a normal phenomenon.

Other considerations involved in the evaluation of "I can't get to sleep" problems are the timing of prescription medications with alerting properties, recreational drug use, late evening exercise or caffeine use, and medical and/or psychiatric conditions that precipitate or maintain the disturbance. Additionally, states of physical discomfort known to interfere with the initiation and maintenance of sleep should be evaluated. For example, Restless Legs Syndrome (RLS) is a disorder of uncomfortable sensations primarily in the lower extremities that is experienced very often as skin crawling, aching, and "pins and needles." The symptoms worsen at rest, are relieved by activity, and, of particular import, follow a circadian rhythm with symptom intensity unfortunately increasing at night. Sleep initiation is interrupted by the uncomfortable sensations in themselves and by the need to move or rub the affected body part to obtain relief. The presence of untreated or undertreated pain is, of course, an important factor to assess in addition to other comfort factors such as bed and bedroom quality (e.g., too firm or soft, too hot or cold, too noisy or even too quiet). A PSG is generally not indicated in the evaluation or diagnosis of either insomnia or circadian rhythm sleep disorder.

"I'm too sleepy during the day."

A common cause of daytime sleepiness is obstructive sleep apnea (OSA). In OSA, the patient's airway becomes partially or completely obstructed during sleep causing a decrease in blood oxygen saturation which triggers the brain to create a brief arousal from sleep so airway patency and normal oxygen levels can be restored. These arousals fragment sleep, making it less restorative without causing full awakenings. The failure to awake fully during these sleep disturbances leaves the patient perplexed as to why he or she can apparently sleep through the night and feel so sleepy the next day. Bed partners can assist in the evaluation process because they often witness the significant snoring and gasps for air characteristic of OSA. Elevated body mass index, large neck size, and an anatomically crowded airway are significant risk factors and should be assessed. OSA requires overnight PSG for diagnosis.

Another common cause of daytime sleepiness stems from simply not getting enough nocturnal sleep. Some patients try to "get by" with less sleep than they need, often in an effort to meet work and social demands. As a result, these patients feel sleepy during the day. In such cases, modestly extending the opportunity for sleep (e.g., going to bed 20 minutes earlier) can significantly improve daytime functioning.

The complaint of excessive daytime sleepiness is also an essential feature of narcolepsy. When narcolepsy is suspected, the psychologist should ask about the presence of cataplexy--a pathognomonic symptom--which manifests as a sudden loss of bilateral

SLEEP DISORDERS

muscle tone typically brought on by an episode of strong positive emotion. Diagnosis of narcolepsy requires a nocturnal PSG plus a daytime nap study called a Multiple Sleep Latency Test ("MSLT"). During these tests, both sleep tendency and abnormalities of REM sleep are evaluated. In narcolepsy, as in all disorders where excessive sleepiness is a complaint, a careful assessment of related risks, such as driving or operating machinery, is essential.

"I do strange things in my sleep."

The term parasomnia refers to a mixed state that emerges out of sleep, in which wakefulness and sleep coexist. This allows for motor and/or verbal behaviors normally suppressed during sleep to be enacted without the full conscious awareness and judgment of the sleeper. During parasomnia events, an individual is not able to make effective and rationale appraisals of the environment or their actions. Sleep talking and sleep starts (a body jerk at sleep onset often associated with the feeling of falling) are common parasomnias that are not necessarily pathological or dangerous.

Other parasomnias, however, merit close attention because of the potential for self or other harm. These include Rapid Eye Movement Sleep Behavior Disorder ("RBD"), sleep walking, and Sleep Related Eating Disorder ("SRED"). In RBD there is the absence of the normal muscle atonia characteristic of REM sleep. This allows for the physical acting out of dreams potentially leading to serious injury from common dream mentation such as running, punching, or kicking. Sleep walking arises out of non-REM sleep (therefore, movements are not related to dream content) but carries similar risks for bodily injury. In SRED there are episodes of involuntary eating and drinking while asleep, which pose a danger as strange combinations of food or non-food items (including toxins) can be ingested, and individuals with SRED may attempt to cook or use sharp kitchen tools while asleep. Parasomnias are diagnosed with a combination of PSG and a detailed sleep history.

For those with further interest in understanding the full spectrum of sleep disorders, I suggest reviewing the *International Classification of Sleep Disorders* 2nd edition (2005). This volume provides detailed criteria for 85 sleep disorders in a familiar format that closely parallels the DSM system. ▲

***Jeffrey Young, Ph.D., CBSM**, is a psychologist in private practice in Encino and specializes in sleep, mood, and anxiety disorders. He is an Assistant Clinical Professor in the Department of Psychiatry at UCLA and teaches a six week course on sleep for UCLA medical students. He is certified in Behavioral Sleep Medicine (CBSM) by the American Academy of Sleep Medicine and is a founding member of the Society of Behavioral Sleep Medicine. Dr. Young would like to thank Jennifer Martin, Ph.D., CBSM, for her thoughtful review of this article.*

References used in this column are available upon request from the LACPA office: lacpsych@aol.com.

SLEEP DISORDERS

The Role of Sleep Labs in Sleep Measurement and Treatment

Jack Johnstone, Ph.D.

Clinicians often hear from clients that they "never" sleep or haven't slept in several nights. The clinician should realize that although clients firmly believe these assertions, it is more likely that they are not accurately self-reporting. We routinely receive reports of "no sleep" where we can document the presence of considerable amounts of slow wave sleep and rapid eye movement sleep (REM). The opposite is also true: We receive reports of good, restful sleep with a maximum sleep depth of Stage II. This variability in self report is an interesting psychological issue and underscores the need for objective measurement and documentation.

Sleep labs do just that by tracking the progression from light sleep to deeper slow wave sleep and REM, documenting the amount of time the client spends in each stage, while also documenting other physiological changes in the patient. In this article I will describe polysomnography (PSG), a method traditionally used to investigate sleep. I will also discuss a form of treatment for sleep disorders involving the use of EEG biofeedback, usually called neurofeedback.

PSG involves overnight recording of EEG to detect depth of sleep, as well as monitoring eye and muscle activity, EKG, blood oxygen saturation, breathing effort and nasal airflow. Musculature is also monitored to detect periodic leg movements and drop out of chin muscle tone with sleep onset. The record is scored for progression of sleep stages, identification of arousals from sleep and their association with significant respiratory or cardiac events. As an indicator of the general medical acceptance of PSG, most insurance companies will pay for the procedure. Many payors require PSG for the first half of the night, and, if apnea is detected, a trial of continuous positive airway pressure (CPAP) is initiated over the remainder of the night. There are also now portable medical devices that can be used in the home to detect sleep apnea.

At our Sleep Center we have collaborated on sleep studies with normal sleepers to evaluate automated methods of scoring depth of sleep. We have studied the BIS™ monitor, a device routinely used to assess depth of anesthesia in surgery, to measure depth of sleep in normal sleepers. The BIS™ monitor utilizes an algorithm called bispectral analysis which automatically measures the coupling of high frequency and low frequency EEG activity from the forehead (for more information see: www.aspectmedical.com). Our study showed good correlation between sleep stage and the BIS index. Interestingly, REM sleep appeared similar to wakefulness in this EEG analysis but concurrent monitoring of EMG allowed for separation of these two stages.

More recently, we have studied the "Zeo" device, now commercially offered as a non-medical consumer product. This is a wireless system that transmits the frontal EEG to a base station that looks like an alarm clock and processes the EEG to determine wakefulness, light sleep, slow wave sleep, or REM. Normal sleepers (n=29) were recorded on two nights in the sleep lab and results of "gold-standard" PSG were compared to automatic sleep staging. The PSG was scored by two expert human sleep technologists, and it was found that the Zeo algorithm showed excellent correspondence with the concordance of the two human scorers. A full manuscript detailing these results has now been submitted for publication.

Given that this is a widely available consumer device, it provides a resource for clinicians, including psychologists, to routinely monitor sleep quality in the client's home. It is possible to use this system to evaluate effects of medication changes or

SLEEP DISORDERS

behavioral changes. Changes in sleep quality associated with clinical changes can now be easily evaluated over multiple nights, and the Zeo Website allows users to track changes over time and review more detailed information about their personal sleep in a way that has not been previously available. More information about the Zeo system can be ordered directly from the manufacturer on-line (www.myzeo.com).

Neurofeedback involves recording EEG, analyzing and extracting specific features of the EEG, and presenting results to the client on a video screen. Neurofeedback can address compliance issues in use of CPAP. In addition, it may be useful in also addressing related clinical components of the sleep disorder such as anxiety and depression, without the use of medications. Clinicians can use neurofeedback to promote physiological arousal while decreasing dosage of psychostimulant medications thereby avoiding side effects such as sleeplessness and weight loss.

Neurofeedback involves training or conditioning of brain electrical activity. If pre-set criteria are met for specific frequencies to be increased or decreased, the client is rewarded. A brief tone is presented, and the client is rewarded by scoring points in a video game. With some practice, individuals can be trained to win the video game and in the process modulate their EEG. Conscious attempts to change the EEG are ineffective. Indeed, conscious attention is not required, nor is it desirable. Conscious awareness of brain activity is not required to perform psychological functions and is not necessary to achieve a beneficial therapeutic effect. This also allows the technique to be used in preverbal children.

Biofeedback has traditionally been used as a relaxation technique. It is clear that the traditional use of EEG biofeedback for relaxation is useful in the treatment of insomnias and in compliance with the CPAP for treating obstructive sleep apnea.

In addition, feedback of brain electrical activity is useful beyond simple relaxation training. Neurofeedback procedures are often used globally to increase arousal or decrease behavioral arousal. In addition, neurofeedback can be targeted to modulate specific brain regions and has been effective in inhibition of left anterior alpha excess in the treatment of major depression. New neurofeedback techniques are currently being used to influence brain connectivity by modulating EEG coherence between regions. (For a discussion of these approaches to neurofeedback, see Johnstone, 2009). Anecdotal evidence suggests possible effectiveness of rewarding very low frequency component of the EEG. Clinicians also have reported success with introduction of very small electromagnetic signals to the scalp according to specific protocols, with many reports of improved sleep quality.

Quantitative EEG analysis is increasingly used in conjunction with neurofeedback to identify brain regions for modulation and in selecting specific frequencies of EEG that are excessive or deficient in an individual compared to normative EEG databases. Quantitative EEG assesses neurophysiologic arousal and regional brain activation directly. Importantly, qEEG may be used to predict effectiveness of clinical interventions and help guide therapy to improved clinical benefit. The predictive ability of qEEG data in guiding clinical intervention with medication, neurofeedback, and transcranial magnetic stimulation has recently been reviewed (Johnstone & Lunt, 2011).

Quality of sleep is a major factor in general health and good psychological functioning. Better awareness and recognition of sleep problems in clinical settings and knowledge of methods for characterizing and treating sleep disorders will assist the clinical psychologist in routine daily practice. ▲

Jack Johnstone, Ph.D., *is the President and CEO of Q-Metrx, Inc. and is responsible for all operations and development at Q-Metrx and the Valley Sleep Center in Burbank, CA. Dr. Johnstone was trained in neuropsychological research and received his Ph.D. from the University of California, San Francisco. He is also an Associate Researcher in the Department of Psychology at UCLA, as well as a consultant to California Clinical Trials in Glendale, CA.*

References used in this column are available upon request from the LACPA office: lacpsych@aol.com.

SLEEP DISORDERS

Obstructive Sleep Apnea: Increasing Treatment Compliance

John Geirland, Ph.D.

Obstructive sleep apnea (OSA) is a serious, even life-threatening, sleep disorder that afflicts about 4% of the population[1]. Overweight and obese individuals are particularly susceptible to the disorder. With OSA, the muscles in the back of the throat relax and obstruct the airway, causing loud snoring or a complete cessation of breathing. Deprived of oxygen, the brain triggers a fight-or-flight response that opens up the airway again, allowing re-oxygenation. In the process the sleeper awakens, though usually not fully, and may do so as often as 60 times an hour. Edward Grandi, Executive Director of the American Sleep Apnea Association, gave me a vivid description of what an apnea feels like: "Somebody is pushing a pillow down on your face, trying to kill you." The consequences of OSA can include high blood pressure, diabetes (hormonal changes reduce the effectiveness of insulin), daytime sleepiness, cognitive deficits (there is a reduction in volume of some neural structures), and depression. The disorder takes a toll on loved ones as well. Grandi recalls meeting a woman at a conference whose husband had OSA. "I don't really get to sleep much at night," she told Grandi. "I spend the night with my hand on my husband's chest, afraid that he's going to stop breathing."

Fortunately, there are treatments for OSA. Surgery is an option, and dental devices have recently been developed that extend the jaw and help open the air way for some individuals, though these treatments are not always fully successful. The gold standard of treatment, however, is the continuous positive airway pressure (CPAP) device. The CPAP is a sophisticated, electronically-controlled air pump that delivers a steady stream of pressured air through a mask or nasal device that is strapped on the user's face. The airflow keeps the airway from collapsing, thus allowing normal sleep. Studies show that the CPAP is highly effective in ameliorating the symptoms of OSA with virtually no side effects (Rosenberg & Doghramji, 2009). Daytime sleepiness goes away. Cognitive functioning returns to pre-morbid levels (Kumar et al., 2008). Many users report that the CPAP has allowed them to have their lives back. Some say they notice colors again. When users are fully compliant, the CPAP can be "life-affirming," as Edward Grandi put it. There is just one problem: reported compliance rates range from 29% to 83% (Rosenberg & Doghramji, 2009). Many OSA sufferers hate the device and refuse to use it.

I was one of them.

Seven years ago I began to wake up gasping for air. This was during a busy and stressful time in my life. My wife and I were busy professionals. Our children were young and had myriad outside activities and play dates that required chauffeuring and creative scheduling. I took gasping for air as a symptom of the stress that filled most of the hours of my day. Exhausted most of the time, I often stretched out on the floor of my office for an impromptu snooze, only to awaken and find myself flipped on my stomach, gulping air.

I didn't suspect OSA because I didn't fit the profile of the typical OSA sufferer: I'm tall and lanky, not obese. I don't have a thick, short neck. I don't have high blood pressure. I nonetheless consulted with a sleep doctor who immediately suspected OSA and arranged a sleep study. I was shown to a comfortable, if non-descript, bedroom at a local sleep center, fitted with an EEG skull cap, and wired up. The cables were gathered together in a bundle so that I wouldn't become hopelessly entangled in them. How can I sleep like *this?* I thought. I later estimated that it took me 40 minutes to fall

[1] http://www.sleepapnea.org/info/index.html

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asleep. According to my EEG readings, it actually took me only five minutes to slip into stage 1 sleep.

After four hours, the technician, a polite young man with a calming manner, told me that I had had innumerable apneas. This news took me aback, since I recalled only a couple of semi-conscious moments during the night. At this point I was told I would be titrated for the CPAP. (Titration involves finding the right level of air pressure.) I recall the technician holding a clear plastic mask that made a loud shrill sound. He placed the mask over my nose and mouth and positioned the straps on the back of my head. Five seconds later, wild-eyed and arms flailing, I ripped the mask off my head and hyperventilated, eyes blazing.

How to describe what I felt? In recent years I have read descriptions of what it feels like to be water boarded. Wearing the CPAP for the first time that night felt like being water boarded. I thought I was drowning. I had a full-blown, though very brief, panic attack: racing heart, sweating, feelings of unreality, the conviction that I was dying.

I refused to proceed with the titration of the CPAP. After I calmed down, monitoring continued. The next morning I dressed and went home. Later the doctor confirmed I had severe obstructive sleep apnea on my back, mild to moderate sleep apnea while sleeping on my side. I was told I would clearly benefit from using the CPAP.

I refused to consider it.

A whole year passed. I trained myself to sleep on my side. But I was still tired. I was short tempered. I rationalized big time. Some day they will perfect the surgery for correcting OSA. Some day there will be a medication that will keep the muscles in the back of my throat from closing my airway. Of course, neither of these developments was on the horizon, but the research on the cognitive deficits associated with OSA piled up: anterograde memory loss and measurable reductions in cortical gray matter. That gave me the heebie-jeebies. I scheduled another sleep study. Before I went, I had to prepare myself.

The target behavior I aimed at was being able to tolerate wearing the CPAP for four hours. A pretty daunting goal, considering I had previously managed to keep the device on my face for only *five seconds*. I decided to use a combination of three strategies: (1) cognitive behavior therapy (CBT)/reframing, (2) progressive relaxation techniques, and (3) exposure.

CBT/Reframing. I began by making a list of my automatic thoughts surrounding the wearing of the CPAP, such as: "I'm being water boarded," "My wife won't want to sleep in the same bed," "I won't be sleeping naturally," and "I'll look like Darth Vader." I then did my "homework" and collected evidence. People who wear the CPAP are able to breathe normally. My wife assured me that the *swish* sound of the CPAP was like white noise, unlike my loud snoring (an OSA symptom). Yes, I will need a device to assist in sleeping, but many people need glasses to see properly. People wear glasses in public, but the public won't see me wearing a CPAP. Darth Vader? Guess I'll have to live with that one.

At about this time a CPAP supplier made a passing comment that allowed me to effectively reframe the whole situation. She said she had a client who actually found the CPAP airflow "soothing." It is possible to grow so accustomed to the airflow that it can be soothing, even calming--a radical notion. I took it to heart.

Progressive relaxation techniques. These techniques are familiar to most readers and can be found in Edmund Bourne's *The Anxiety & Phobia Workbook* (Bourne, 2005). I practiced a calming breathing exercise and a visualization exercise that involved imagining I was sitting in a beautiful, shaded garden on a warm day.

Exposure. Ideally, I would have employed an exposure protocol that would begin with wearing the CPAP (shut off) for short periods of time while fully awake and dressed, progressing in stages to the point of tolerating the mask in full operation while supine in bed. Unfortunately, I didn't have access to a CPAP prior to my scheduled follow-up sleep study. I did create an anxiety hierarchy around the use of the device and repeatedly visualized each level (e.g., the technician standing alongside the bed holding the device) until each progressive image no longer provoked distress. As it happened, I got some exposure to the device at the sleep center before being wired up for the night.

Again, I was monitored during the first half of the night and awakened to be titrated with the CPAP. As the technician fitted the mask on my face I felt my heart pound in my ears, and I felt my throat constrict. I focused on my breathing. I visualized the garden. I engaged in positive self-talk. I observed that I could indeed breathe normally. I got past the five second mark and kept going. I calmed down. I closed my eyes. I slept. I kept the mask on.

The efficacy of these strategies has since been demonstrated in a landmark study of CPAP compliance at Royal North Shore hospital in Sydney, Australia (Richards et al., 2007). Individuals diagnosed with OSA participated in a relatively brief CBT intervention (two one-hour sessions) plus treatment as usual (information and mask fitting). At seven days, 88% of CBT group participants wore the CPAP for four hours or more a night, compared to 39% of the control group. In my case, the outcome was similarly striking.

The next morning I woke with a feeling common to many who manage to tolerate the CPAP for the first time. Imagine awakening from the best massage you've ever had in your life. I felt relaxed, alert, refreshed--refreshed in spirit, especially. The morning air smelled especially sweet. In the years since, I have been 100% compliant with the CPAP. And I now find the air flow…soothing.

The American Sleep Apnea Association's Website is: http://www.sleepapnea.org/ ▲

References used in this article are available upon request from the LACPA office: lacpsych@aol.com

SLEEP DISORDERS

You Are Growing Very Sleepy….. Hypnosis and Insomnia

Marc Schoen, Ph.D.

It is a common belief that hypnotherapy for sleep disturbance is driven by the power of suggestion. The clinician gives suggestion to the client to feel tired or sleepy at bedtime. Yet, hypnotherapy can be substantially more than direct suggestions for sleepiness. In its most effective form, hypnosis has the ability to significantly recondition the entire sleep process. It can be used to retrain the client's reaction to negative or intrusive thoughts, early awakenings, stress, and the tendency to resist sleep. In the following paragraphs, I will briefly discuss how hypnosis can be used to recondition the sleep process.

Common concerns expressed by most clients seeking hypnosis for insomnia is that they might be resistant to hypnosis, dislike relinquishing control, or will not be able to sit still or quiet their minds enough to benefit. The apprehensions they hold about hypnosis are commonly the very same dynamics that are operative in impeding their sleep process. This is where hypnosis particularly shines, The process of embracing the trance state is parallel to the welcoming in of the sleep state. Rather than obstructing the hypnosis treatment, these sleep and hypnosis resistances now become part of the treatment rather than outside of it. The goal is not to extinguish these unconscious oppositions but instead to alter the client's reaction to them. In this way, these resistances become sleep enhancing rather than sleep disruptive.

With our culture's growing sense of having to be "on" 24-7, the pressures of remaining alert, attentive, and awake are burgeoning. With this spiraling trend, there is a concomitant pressure to delay or resist fatigue and sleepiness in order to complete our work demands. The unintended consequence is that we are teaching the mind and body to resist its natural rhythms. When it is time to go to bed and switch gears, the mind and body have been trained to resist letting go to the sleepy feeling, a process that I call "sleep resistance." Over time, the process of going to sleep becomes a signal to wake up and is increasingly associated with significant frustration and anticipatory anxiety.

In addition to developing a healthy sleep hygiene routine, hypnosis can be used to restore the client's ability to switch gears from a cerebrally-active mind that resists sleep to one that is receptive to the sleep process. In this case hypnosis is used to influence both the physical and mental experience of going to sleep. By using hypnosis to modify the windup associated with the pre-sleep ritual, the routine is now conditioned to elicit a state of relaxation. The pre-sleep rituals of going to sleep, such as a nightly shower, brushing teeth, television, or climbing into bed are now altered to facilitate a gradual shifting from an alert to a relaxed or sleepy state. Additionally, hypnosis can be helpful in restructuring negative or distracting thoughts; thoughts that are sleep obstructive can be transformed and conditioned to be sleep facilitative. Since it is difficult to quell negative or distracting thoughts, it is possible to imbue them with either a neutral or a soporific effect whenever the client thinks about them.

Pertinent to the issue of intrusive bedtime thoughts is the common misperception that it is imperative to silence conscious thoughts in order for the sleep process to unfold. In actuality, the sleep process unfolds even in the presence of conscious activity. By giving the client practice going in and out of the hypnotic trance while entertaining intrusive thoughts, the client learns to experience consciousness as part of the sleep process rather than outside of it.

The fact that the hypnotic process can mimic the sleep process has particular value in dealing with the early awakening form of insomnia--the condition in which individuals find it difficult to return to sleep after awakening in the middle of the night. To address this condition, hypnosis is used to induce a sleepy relaxed state in the client. While in this relaxed zone, the client is repeatedly awakened from the sleep-like trance, a process that duplicates the early awakenings at night time. Next, by following these interruptions with a subsequent induction into the hypnotic sleep state, the wake ups now become a stimulus for returning to sleep. Thus, rather than the wake ups being associated with protracted periods of non-sleep and frustration, they are now associated with another opportunity to return to sleep.

I also find it helpful to record a hypnosis CD for clients to listen to at bedtime. This CD is comprised of those suggestions that have been facilitative in inducing a hypnotic sleep state in my meetings with the client. This CD has several goals. First, it helps the client disengage from an active cerebral mind and physical state to a frequency that is more conducive to sleep. Second, the CD serves as a transitional object, extending the hypnosis interventions to the client's sleep process outside of our sessions. Third, as the CD is continually paired with falling asleep, the hypnotic CD over time becomes a stimulus for precipitating sleep. Finally, once the client develops this conditioned response to the CD, it can now be employed as a sleep aid to assist the early awakening client to return to sleep.

Since a number of clients start the treatment with a heavy reliance on sleep medications, hypnosis can be a valuable tool in altering their physical and psychological dependence on

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these medications. Therapy sessions can be used to give clients experience in developing relaxation or sleep without medications. This can boost their confidence in their own inner resources while lessening their psychological reliance on external solutions such as medication. Further, hypnosis can also influence the client's physical dependency on sleep medications. In this case, hypnotic suggestions are aimed at affecting how the client reacts to the sleep medications. In this scenario, suggestions are given so that the act of taking less of a medication is now experienced as taking more of the medication. Gradually, this procedure can be utilized to reduce the amount of the medication required by the client. Finally, the power of the sleep medications can be conditioned and transferred to the sleep CD, which allows the sleep CD to exert more power over the sleep process.

For most individuals, reconditioning the sleep pattern can happen in as little as three meetings, while five to seven meetings are more typical. In those cases where there is a previous trauma related to sleep or a heavy dependency on multiple sleep medications, more extensive treatment may be necessary. Additionally, hypnotic interventions tend to work better for more acute insomnia episodes as opposed to chronic insomnia that emanates from childhood or early adulthood.

In summary, since so few visits are necessary to determine whether hypnotic interventions can be a productive intervention for insomnia, hypnosis is worth considering where more traditional forms of intervention have not been fruitful. In those cases in which it is strongly evident that the insomnia is a function of negative conditioning, hypnotic interventions may be of particular value due to their powerful reconditioning properties. ▲

Marc Schoen, Ph.D., *is an Assistant Clinical Professor of Medicine at UCLA's Geffen School of Medicine, where he teaches hypnosis and health psychology and conducts research in the field of mind-body medicine. On staff at Cedars-Sinai Medical Center, he teaches hypnosis to the psychology and psychiatry residents and fellows and was the founder and Director of the Psychoimmune (Mind-Body) Program, one of the first of its kind in the country. Dr. Schoen is also a prolific author of research papers, articles, and books related to hypnosis, stress, addictions, and inflammation.*

OFF-THEME

Traumatic Brain Injury in Adults: Sometimes a Bump Isn't Just a Bump

Deborah Buckwalter, Ph.D.

Several years ago "Dan" came to my clinical practice through a colleague who was relocating. The psychologist informed me that Dan had been injured in a heavy- equipment accident the previous year. He required surgeries on both upper and lower extremities; he continued to deal with chronic pain and physical limitations. Not surprisingly, Dan was having difficulty adjusting. Both his personal life and work life were profoundly affected.

When we met, Dan described the problems he was having. Many were typical of his PTSD primary diagnosis including nightmares and insomnia, intrusive thoughts about the accident, fearfulness, irritability, and outbursts of anger. He also complained of problems with concentration, staying engaged in conversations, losing his keys and wallet, and forgetting important conversations with his wife. Their warm and engaging relationship had become strained and distant. At work he was having problems following instructions and completing mechanical tasks he had been doing more than a decade.

Dan went on to describe the terrible accident that changed his life when the brakes failed on the huge crane he was driving down a steep, winding road. He recalled, "I was picking up speed and trying everything I knew to stop. When nothing worked, I figured I had two choices--to go sailing off the edge or turn the huge rig into the hill." He opted for the latter. When I asked what happened next**,** he paused and said, "I can't recall exactly.

Defining Traumatic Brain Injury

According to the Centers for Disease Control and Prevention, a traumatic brain injury (TBI) is caused by a bump, blow, or jolt to the head or by a penetrating head injury that disrupts the normal functioning of the brain (Centers for Disease Control and Prevention, 2003). Not all blows or jolts to the head result in TBIs. The **"**severity" of a brain injury is generally defined according to changes in mental status or consciousness at the time of the injury. Thus a **"**mild" traumatic brain injury (MTBI) constitutes a brief change in mental status or consciousness at the time of the injury, while a **"**severe" traumatic brain injury involves an extended period of unconsciousness or amnesia after the injury (Faul, Wald & Coronado, 2010). In actuality, these terms may be misleading when considering the functional impact of brain trauma. "Mild" does not fully characterize the variety and severity of symptoms experienced by tens of thousands of individuals who sustain brain injuries. The following is a partial list of TBI symptoms: headaches; concentration difficulties; impulsivity; decision-making difficulties; memory problems; subtle changes in reading, writing, spelling, and math; fatigue; apathy; depressed mood; sleep changes like insomnia and hypersomnia; behavioral changes; onset or exacerbation of a psychiatric disorder; onset or exacerbation of substance abuse; hypersensitivity to sensory stimuli; dizziness; imbalance; organizational difficulties; perspective-taking difficulty; relationship difficulties; decreased "other-mindedness;" slowed thinking, speaking, and acting; irritability; anger management problems; and decreased productivity.

Disagreement about the definition of TBI, inconsistency in factors utilized in data collection, as well as a lack of awareness and education among first and subsequent responders to injuries, has made the epidemiology of TBI difficult to define reliably and consistently. To further complicate matters, Newton's Third Law of Motion: "For every action, there is an equal and opposite reaction" works for physics, but not for TBIs where a significant blow to the head may cause little or no apparent sequelae, and conversely where seemingly little force may cause substantial affective, behavioral, and cognitive symptomatology.

For example, "Sarah" was the sole survivor of a plane crash; she was unconscious nearly two weeks. Her rehabilitation for orthopedic injuries was substantial. Yet a neuropsychological evaluation completed three months after her crash revealed relatively intact cognitive functioning on nearly all measures.

On the other hand, "Allen" was an accomplished, well-educated schoolteacher who tripped on a tuft of grass and hit his forehead. He recalled feeling dazed, but he did not lose consciousness. He interpreted his symptoms over the next few weeks as "burnout" from his job. He took time off, initiated psychotherapy with complaints of depressed mood and irritability, and saw his physician for a check-up. Upon returning to the classroom, his cognitive deficits became more apparent. Skills essential to teaching and managing a classroom were compromised. Like many patients with mild traumatic brain injury, affective and behavioral changes were perceived before cognitive changes.

Neuropsychological Evaluation Process

When a patient is referred for neuropsychological evaluation, the overall process integrates information obtained from comprehensive interviews**;** reviews of medical, academic, and/or legal documents; and findings from cognitive, mood, and behavioral tests and measures. In structured interviews, neuropsychologists take into consideration the onset, frequency, duration, and intensity of physical, cognitive, social/interpersonal, behavioral, and spiritual difficulties. In an effort to tease out premorbid factors that may contribute to the person's current neuropsychological profile, a thorough history is taken. It includes developmental factors like illnesses and injuries (particularly those with the potential to affect brain functioning), as well as psychiatric factors, and psychosocial factors like education and occupation, substance use, toxic exposure, and legal involvement. Whenever possible, information is also obtained from a family member or other close observer of the patient's behavior before and after an injury.

Following a comprehensive interview, a battery of tests is administered, designed to measure abilities within a number of functional domains of the brain. Neuropsychologists have access to literally hundreds of different tests and thus the ability to vary the battery according to the referral question and specific complaints. A basic battery includes measures of intellectual functioning, language, visuoperception and visuoconstruction, various aspects of verbal and nonverbal memory, academic functioning, motor skills, and executive functioning--often considered the higher-level command and control abilities of the brain. Additionally, given the relationship between neuroaffective functioning and cognition, mood is assessed and personality factors are considered. Finally, neuropsychological assessment takes behavioral functioning into consideration by using self-report and observer-report of an individual's behavioral tendencies.

The statistics associated with TBI are sobering. For a good overview, I would direct you to *http://www.cdc.gov/TraumaticBrainInjury/statistics.html*. There is no "typical profile" of individuals who have experienced a brain injury. There are generally twice as many males as females and relatively higher rates of injury among 15- to 25-year-olds, geriatric adults, veterans returning from active duty, and substance abusers. The three most common mechanisms of traumatic brain injury in the United States are motor vehicle accidents, falls, and firearm wounds.

Survivors of TBI are particularly at risk for developing psychiatric disorders including major depression, generalized anxiety disorder, and post-traumatic stress disorder (Rogers & Reed, 2007). It's fortunate that Dan got good psychological care for the affective sequelae of his injury, and that PTSD was an accurate diagnosis. It's unfortunate that Dan's traumatic brain injury went undiagnosed for over a year. Once areas of neuropsychological compromise were identified, adjunctive treatment incorporated strategies to bolster memory, attention, and concentration, and to assist him in better management of his mood and behavior.

As clinicians, we work with individuals who present with adjustment, mood, anxiety, relationship, and behavioral difficulties. It is worth considering if there is any history of brain injury that may contribute to our patients' maladjustments. ▲

Deborah Buckwalter, Ph.D., *is a clinical psychologist with specialization in neuropsychology in private practice in Pasadena. In addition to a robust general practice, she provides psychological/neuropsychological assessment and treatment for individuals with brain and bodily injury and illness.*

References used in this column are available upon request from the LACPA office: lacpsych@aol.com.

LACPA WORKING FOR YOU

Special Interest Groups

Special Interest Group (SIG) meetings are open to all LACPA members and announcements of meetings are posted on the LACPA listserv and Website. Contact facilitators or the SIG coordinator, Pamela McCrory, Ph.D., for more information:

Addictive Behaviors
Ilene Bell, Ph.D.
323-464-3823
ibell@ca.rr.com

Assessment
Jennifer D. Cassatly, Psy.D.
310-339-0416
info@drjcassastly.com

Child and Adolescent
Eileen Escarce, Ph.D., MSN
310-913-5441
eileen@uclacommons.com

Cognitive Behavioral Therapy
Jenny Yip, Psy.D.
310-268-1888
dryip@renewedfreedomcenter.com

Couple Therapy
Nancy Gardner, Ph.D.
805-496-3475
nangardner@sbcglobal.net

Divorce
Diana Mercer, J.D.
310-301-2100
diana1159@aol.com

Early Career Psychologists
Halle Aten, Ph.D.
310-339-2546
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Geropsychology
Annette Swain, Ph.D., ABPP
818-385-0913
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Group Therapy
Evelyn Pechter, Psy.D.
310-622-5741
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LGBTQ *Lesbian, Gay, Bisexual, Transgender, Queer/Questioning*
Bonnie Jacobs, Ph.D.
323-655-4056
drbajacobs@yahoo.com

Mindfulness and Spirituality
Michelle LeChau, Psy.D.
310-487-6636
mlechau@mindful-connection.com

Pain Management
Shelley L. Segal, Psy.D.
818-784-1055
slsegal@mednet.ucla.edu

Sexuality and Sex Therapy
Beth Leedham, Ph.D.
818-254-5554
bethleedham@hotmail.com

Coordinator
Pamela McCrory, Ph.D.
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2012 BBL Program: An Opportunity to Share your Knowledge

Carla Elia, Ph.D.

It is not too soon to learn about the 2012 Brown Bag program--one of LACPA's most popular member benefits! I'm excited to announce that in response to suggestions from LACPA members, the Brown Bag presentations will be expanding to both lunch and evening hours! The series is now renamed Brown Bag Lectures; a more appropriate name and yet retaining the same initials of BBL.

BBL is an excellent opportunity to present your area of research or clinical specialty. Presenters are encouraged to use PowerPoint or handouts. Since 1.5 free CE credits are offered, all proposals must conform to APA requirements as clearly explained in the application. For further information and a copy of the application, including a sample application to help you complete it correctly, please contact DrCarlaElia@yahoo.com. The application deadline is **June 30, 2011**. Don't delay! Take advantage of this LACPA member benefit to educate your peers about your area of expertise. You will also gain valuable experience in speaking in a professional and friendly setting. ▲

Attention LACPA Members!

Remember that one of your membership benefits is free, brief consultations regarding (non-emergency) ethical concerns, provided by LACPA Ethics Committee members. Call the LACPA office at 818- 905-0410 to contact the committee member on-call (Monday-Friday, 9:00 a.m.-4:00 p.m.). ▲

LACPA WORKING FOR YOU

The New Networking Committee

Amy Rosett, Ph.D.

Recently the LACPA Board of Directors voted to make a change: the Practice Development Network Committee (PDN) is now being restructured and renamed the Networking Committee. Its mission includes providing both professional and social networking opportunities. I truly appreciate that our 2011 President Stephen Phillips, J.D., Psy.D., asked me to be the chairperson.

The professional part of the committee's activities will basically function as PDN did: helping members learn effective networking and marketing techniques, providing valuable private practice information, and forming small groups to have more meaningful networking opportunities. I plan to hold meetings in various locations in our huge county. Also, I'm going to try different meeting times since many members have daytime jobs during the week. For example, the next professional networking meeting will be at the LACPA Office on Tuesday, May 10 at 7:30 p.m. To loosely paraphrase President Lincoln, we can only please some of the people, some of the time. I also plan to have presentations about various networking topics; feel free to make suggestions to help our meetings be relevant and valuable to LACPA members.

The social part of the Networking Committee includes our four existing clubs: Book, Film, Hiking, and Parenting. A fifth club, Running, is under consideration. Maybe you are the person with an idea for our sixth club? Speaking of our clubs, I deeply thank Ryan Janis, Psy.D., for leading the Hiking Club over the past four years. He began when he was a 4th year graduate student and now is licensed with a practice in Beverly Hills. During the time he achieved these professional steps, he led hikes every few months for LACPA members. I know that the club will continue to be in great hands as he passes the baton, or should I say walking stick (not that either of them use one) to Andrea Ackerman, Ph.D. She is an avid hiker, including surviving the Grand Canyon.

In addition to the clubs, most social events that are not part of the Membership Committee's activities will be sponsored by the Networking Committee. This could include some no-host relaxing activities that don't have to be related to psychology at all--restaurants, art, music, places in nature, or adventures. Has anyone tried any of the scavenger hunts in Hollywood, Downtown, or Santa Monica; if so, would you recommend them to others? How about the "food tours" of different neighborhoods? Someone already recommended an Oscar viewing party. The possibilities are endless; undertaking some of them about four to six times a year is realistic.

There is a lot of flexibility about how our networking opportunities will grow. Whatever ends up happening, it will be a great opportunity to meet colleagues, share ideas, learn how to market your career, help one another professionally, and have some fun. Most communication about the Networking Committee will be on our listserv (so please sign up if you haven't already) and our Website. Please contact me with your recommendations, comments, and questions at dramyrosett@earthlink.net or 818-705-1870. I look forward to meeting you at both the professional and social networking events. ▲

Classifieds...

Office Space

Beverly Hills: Prime location on Beverly Drive. Window office in two-story building. Full-time availability, unfurnished. Building is open on Saturdays. Street parking available for patients. $600 per month. Contact: Howard at (310) 277-7477 or hbw1@sbcglobal.net.

Beverly Hills: New psychotherapy offices, prime location on Wilshire and Doheny, upgraded sound proofing, full-time and part-time, terrific views, lots of parking. Call Rami Sadeghi (310) 273-7000, drsadeghi@drsadeghi.com or Jeff Blume (310) 273-1372, nowhour@aol.com.

Brentwood: Beautiful offices available P/T in prestigious Brentwood Plaza building with views of the city, mountains, and San Vicente Blvd. Psychotherapy suite, separate exit, great parking. Full or half days only. Call Natalie (310) 472-2329

Brentwood: Competitive Pricing / Rent Incentives. Location! Location! Location! San Vicente. Parking in exceptionally maintained medical high-rise. Exquisitely furnished. Comfortable, cozy. F/T, P/T. It's a must see! (310) 207-4200.

Brand Blvd. in Glendale: A soundproof unit with a call light system, fully furnished, freeway access, parking garage available and a floor to ceiling window view of Brand Blvd. (818) 913-7301.

Downtown Los Angeles. Newly Remodeled suite of offices available for sublease in historic building. Four furnished offices approximately 200 square feet each at affordable prices for sublease in established psychiatric setting. Full, P/T or Hourly. Contact stephenkramermd@gmail.com or (213) 623-1301.

Santa Monica: Office space available in UCLA Medical Building. Desirable location next to hospital at 1245 16th Street. Two tastefully furnished offices - one large with windows, one smaller, inner. Pleasant waiting room, call light, WiFi/copy machine/refrigerator included. Available part-time or full-time. Contact Adriana at (310) 828-1113.

Santa Monica: 7th Street south of Wilshire, psychotherapy suite, large windowed office, shared waiting room opens to courtyard. Kitchenette, call light, private and public bathrooms. Contact Jeanette (310) 471-1420 or email Jeanetteclavin@yahoo.com

Sherman Oaks: Extra large room, great building right off 101. Lit parking, handicap accessible, waiting room, call light. Kitchen and office machines available. Other professionals provide a warm atmosphere. Available Wednesdays after 3 PM, all day Friday and Saturday. B. Mathis (818) 386-9028.

Sherman Oaks: Part-time contemporary and antique style offices, available by day, half day, hour. Ron Reiter, Ph.D. (310) 273-3060.

West Los Angeles: Light window office in therapy suite with kitchen, bathroom, copier, separate entrance/exit. Beautiful building. Great parking. Barrington and Olympic. Contact Raphael at (310) 570-1919 or RGunnerPhD@aol.com

Three Offices Woodley/Ventura: F/T 10th floor, light, 12X19, stunning view, very comfortable space. Storage, excellent sound proofing, separate exit, signal light system, break room, great location with shops and restaurant on all corners. Available mid-May. P/T 2 brand new offices 11th floor. Light, large (13X18), gorgeous views. Lots of storage, signal light system, separate exit, break room. Large interior office, 14X15, designed to see kids, groups, as well as adults. Saturday/Sunday all day, Monday AM's til 12:00 noon and after 6:00 PM. Great storage, Excellent sound proofing. Available mid-May. Contact Sue (818) 905-8568 or smandelphd@gmail.com.

Mixed Groups

All advertising for mental health services must include the practitioner's license number.

Two Growth-Oriented Psychodynamic Therapy Groups: For men and women dealing with relationship and life issues meet on Tuesday and Thursday in Brentwood. Call Ken Unmacht, Psy.D. (MFC16673), (310) 207-1246.

Interpersonal Process Groups - Beverly Hills: For clients with relational issues (e.g., intimacy, trust, assertiveness). Members learn to express their feelings, witness the impact their behaviors on others, and receive support. Cara Gardenswartz, Ph.D. (PSY18399), (800) 306-2773. www.CaraGardenswartz.com

Special Groups

All advertising for mental health services must include the practitioner's license number.

Clinician Survivors of Client Suicide Support Group (W. Los Angeles). Peer support is one of the most effective ways to recover from this tragic experience. Lauren Wecker, Psy.D. (PSY23365) drlaurenwecker@gmail.com (310) 383-1505

Social Skills Group for Adult Asperger's and high functioning autism now forming in West L.A. For more information, please contact Dr. Esther Hess (PSY16090) at (310) 652-7581 or by e-mail Drhess@centerforthedevelopingmind.com.

Migraine Sufferer's: A support/process group now forming for all people who suffer from varies forms of headaches. All ages; day/evening. Free consult. W.L.A. Pasadena. (310) 470-2626. Randi Riffkind, Ph.D (PSY 10571)

10-week program for separating and divorcing individuals, provides education, tools in a supportive group environment to heal the pain of divorce. Great adjunct to individual therapy. Santa Monica. Dr. Andra Brosh (PSY22901), (888) 456-7056. www.divorcedetox.com.

Mixed Group for Eating Disorders: Excellent on-going pyschodynamic group for binge eaters, bulimics, anorexics, age twenty-five plus. Wed. evenings. Good addition for people already in individual therapy. Janet K. Smith, Ph.D. (PSY12167) Westside. www.weighty-issues.com.

Therapy Group for Therapists & Grad Students: Psychoanalytic/interpersonal. For grad students, pre- and post-licensed therapists. Tuesdays, 7–8:30 PM. Led by Psychoanalyst and Certified Group Psychotherapist Karen Shore, Ph.D., CGP (PSY18745), (310) 917-3320. Santa Monica-Brentwood area.

Anxiety, Depression, Eating Disorders: On-going psychodynamic psychotherapy groups. Santa Monica. Dr. Sheila Forman, JD, PHD, CGP (PSY15265). Free consultation. (310) 828-8004.

Dream Appreciation Group: Explore dreams through an intimate group experience. This group meets occasionally on a Saturday morning, 9:15 – 11:30 AM. Call for information. Karen Shore, Ph.D., CGP (PSY18745). (310) 917-3320. Santa Monica-Brentwood area.

Adult Individuals with Social Anxiety: Jayson Mystkowski, Ph.D. (PSY20077) is running a weekly therapy group. If interested, please contact (310) 858-3831 at the Cognitive Behavior Associates in Beverly Hills.

Parents of Children with Special Needs. A supportive environment to share the joys and challenges of raising a unique child. Tuesday nights. Studio City. Call Debra Brause, Psy.D. (PSY21242), (310) 470-4156.

Attachment-Based Parenting Groups Forming: Pregnant Moms: This is a profoundly transformative time physically and emotionally. This group focuses on the experience of pregnancy, preparation for birth, motherhood, and building support networks. Infant and Toddler Groups: The format is psychoeducational informed by cutting-edge infant research with discussion, education, structured play, music, movement and more. "Dad's Turn" is the first Sunday of each month. Confidential and supportive. Contact Sue Mandel, Ph.D., MFT (MFT22333) at (818) 905-8568 or smandelphd@gmail.com.

Women's Groups

All advertising for mental health services must include the practitioner's license number.

Groups for Women Sexually Abused in Childhood: Psychodynamic, limited to five patients. Specialist for 25+ years. Work collaboratively. Mariann Hybels Miller, Ph.D. (PSY8418), Santa Monica (310) 397-6106.

Women in Transition: A support/process group now forming for women going through life changes and decisions. All ages; day/time TBD; free consult. W.L.A., Brentwood, S.M. (310) 979-7473. Sandy Plone, Ph.D. (PSY8882)

Men's Groups

All advertising for mental health services must include the practitioner's license number.

Studio City Men's Group: Now forming, evening TBD. Men and Relationship: ongoing, WLA Wednesday evenings. Support/psychotherapy groups. (310) 948-3301. Larry Starr-Karlin, JD, MFT (MFC44427).

Consultation/ Study Groups

All advertising for mental health services must include the practitioner's license number.

Case consultation from a contemporary psychodynamic and integrative perspective. Discuss your cases in a warm supportive atmosphere. Ken Waldman, Ph.D. (PSY16335), (310) 473-1505.

EMDR Certification Consultation Groups forming in Westwood and Pasadena. Third Friday (Pasadena) and fourth Friday (Westwood) of the month, 10 AM - 12 noon. Rachel Howard, Psy.D. (PSY16829), (310) 281-1882, rachelhowardpsyd@hotmail.com.

Case Consultation Group from a contemporary psychodynamic perspective. Starting weekly in Brentwood for licensed therapists. Will offer the opportunity to discuss cases while learning more about contemporary psychoanalytic ideas. Carol Mayhew, Ph.D. (PSY8950), (310) 207-9902.

Consultation Group: For licensed psychologists and other therapists who want to discuss their cases utilizing contemporary psychoanalytic perspectives. Meets 1:00-2:30 PM the last Friday of every month. Contact Ken Unmacht, Psy.D. (MFC16673), (310) 207-1246.

Couple and Sex Therapy Consultation: Dr. Berta Davis (PSY7683) is a certified sex therapist, diplomat, clinical supervisor and provider of CEs by AASECT. For further information contact her at (818) 784-3959.

Consultation/Supervision in Emotionally Focused Couples Therapy: For licensed therapists who have taken the Four-Day Externship in EFT. Hours would count toward your certification in EFT. Karen Shore, Ph.D. (PSY18745). Certified in EFT; Supervisor-in-Training. Santa Monica. (310) 917-3320.

Miscellaneous

Collections Solutions: Caring, compassionate, confidential collector for your collection needs. For an appointment, questions, consultation, contact: Liz at (310) 393-3141

The LACPA Hiking Club at Eagle Rock in Topanga State Park

(Back Row, Left to Right) Ken Waldman, Bruce Hirsch, Ryan Janis, Michael Bowdren, Carl Shubs, Mara Thorsen, Hillary Wright, Jackie Meltz, Andrea Ackerman

(Front Row, Left to Right) Paula Bruce, Tara Ford, Amber Walser, Catherine Auman, Elizabeth Suzuki

Welcome New Members

FULL MEMBERS
Alexa Altman, Ph.D.
Tammy Brandt, Psy.D.
Lyanthie Conyersharrisberg, Ph.D.
Elisabeth Crim, Ph.D.
Milena Dun, Ph.D.
Melissa Gondek, Ph.D.
Carrie King, Ph.D.
Allegra Klacsmann, Ph.D.
Holly Knight, Psy.D.
Nina Nguy, Psy.D.
Susan Park, Ph.D.
Rebekkah Roberts, Psy.D.
Jennifer Schwartz, Psy.D.
Gregory Travis, Ph.D.

AFFILIATE MEMBERS
Vanessa Nellis, Esq.
Kira Stein, M.D.

OUT-OF-COUNTY/STATE
Maritza Baez, Psy.D.
Phyllis Larkin, Psy.D.

STUDENT MEMBERS
Garbiella Azzam
Melissa Bagwell
Gary Berghoudian
Lynn Blanchette
Jenna Blume
Yasmin Bolourian
Fernando Cabiles
Yuning Cheng
Brad Conn
Shari Giti
Esther Granados
Kacy Heggan
Myra Irani
Allissa Johnson
Ahoo Karimian
Patricia Mejia
Margaret Moe
Lauren Paolino
Lili Sanchez
Sarah Schewitz
Brittany Sovran
Carol Swann
Hong To
Robert Vazzana
Megan Wagner
Tracy Wheeler
Ryan Witherspoon
Rebecca Wriedt
Garret Wyner
Ester Yesayan
Sterling Zielinski

LACPA'S 2011 CONTINUING EDUCATION SERIES REGISTRATION FORM

May 21, 2011
Gerald Tarlow, Ph.D., will present *Cognitive-Behavioral Treatment of Hoarding*. Dr. Tarlow will discuss the assessment, diagnosis, and treatment of hoarding as well as its relationship to OCD. Discussion about the involvement of family members, friends, and other professionals will also be included. Held at the LACPA office, 9:00 a.m. – 12:00 p.m., 3 CEs.

June 4, 2011
Michael D. Yapko, Ph.D., will speak on *Hypnosis, Reframing and Behavioral Activation in Treating Depression*. Depression has proven to be highly treatable with directive, active, and experiential interventions like hypnosis, which absorbs clients in new ways of thinking about and relating to their own internal experience. Dr. Yapko will also discuss integrating hypnosis with empirically-validated treatments for depression to catalyze effective treatment. A clinical demonstration of hypnosis with a depressed man also suffering PTSD will be presented and discussed.
Held at The Skirball Cultural Center, 9:00 a.m. – 4:00 p.m., 6.0 CEs. Includes lunch.

September 10, 2011
Psychopharmacology Update for Psychologists presented by **John Preston, Psy.D., ABPP.** Dr. Preston will address suicidality in children and teens treated with antidepressants, childhood onset of bipolar disorder, new diagnostic criteria and medications for bipolar spectrum disorders, treatment guidelines for ADHD and major depression, experimental treatments for PTSD, and new studies on over-the-counter products such as St. John's Wort, Omega-3 fatty acids, and SAM-e. Dr. Preston will also speak to recent studies addressing the combination of pharmacology and psychotherapy and the role of psychotropic drugs in protecting and healing the brain. Held at Argosy University LA Campus, 12:00 p.m. – 4:00 p.m., 4.0 CEs

November 12, 2011
LACPA will present **Gary M. Yontef, Ph.D., ABPP**, who will speak on *Dialogue and Technique: The Relational Gestalt Therapy Approach*. Dr. Yontef will present Relational Gestalt Therapy as a paradigm shift that enables the integration of deep engagement with patients through a dialogic, relational, intersubjective search for understanding and the use of focused techniques aimed at helping patients understand themselves and their own internal processes. Held at Argosy University LA Campus, 9:00 a.m. – 12:00 p.m., 3.0 CEs

We cannot accept phone registration. You may access online registration for all programs on the home page at www.lapsych.org.

Name (as on license)_____ Degree_____

Business Address _____

City/State _____ Zip _____

Phone (_____) _____ CA Professional License # _____

Email Address _____

PLEASE CIRCLE YOUR APPROPRIATE CATEGORY AND THE APPLICABLE FEES:

PLEASE CIRCLE YOUR APPROPRIATE MEMBERSHIP CATEGORY AND THE APPLICABLE FEES.	**LACPA Member**	**LACPA Student Member**	**Non-Member**	**Student Non-Member (Proof of Student Status Required)**
5/21/11 Hoarding (3.0 hrs.) Gerald Tarlow, Ph.D.	$70	$35	$100	$45
6/4/11 Hypnosis (6.0 hrs.) Michael D. Yapko, Ph.D. **Lunch is included.**	$165	$95	$225	$115
9/10/11 Psychopharmacology (4.0 hrs.) John Preston, Psy.D.	$95	$50	$135	$60
11/12/11 Gestalt Therapy (3.0 hrs.) Gary Yontef, Ph.D.	$70	$35	$100	$45

Los Angeles County Psychological Association, 17277 Ventura Boulevard, Suite 202, Encino, California 91316
818-905-0410 Fax 818-906-3845 lacpsych@aol.com www.lapsych.org

PLEASE MAKE CHECK PAYABLE TO LACPA OR COMPLETE THE CREDIT CARD INFORMATION BELOW. *(No American Express)*

Visa/Mastercard No. _____ Expiration Date: _____

3 security numbers on back of card _____ Name as it appears on credit card: _____

Now required to process: This credit card bill is mailed to this street number _____ city _____ zip code _____

CALL FOR POSTERS

LOS ANGELES COUNTY PSYCHOLOGICAL ASSOCIATION
TWENTY-THIRD ANNUAL CONVENTION
RADISSON HOTEL CULVER CITY
SATURDAY, OCTOBER 22, 2011

2011 Convention Featured Speaker – Kay Redfield Jamison, Ph.D.

"Bipolar Disorder: Clinical and Personal Perspectives"

LACPA invites poster proposals from its student and early career (within seven years of receipt of doctorate) members. Proposals on any research or theoretical topic related to the field of psychology will be considered. The LACPA Foundation will generously award $200, $100, and $50 for the three best posters presented at Convention.

What is a poster?

A poster is an excellent way to summarize your research project, describe a single case study, or present a conceptual model or innovative intervention in psychotherapy.

What does a poster look like?

Key information (brief paragraphs, bulleted outlines, diagrams, tables, graphs) is posted on a project display board, typically in large print to make it easier to read. Posters can be printed on a single large sheet of paper or on separate sheets of paper. They are mounted on a project display board, approximately 36" high x 48"wide. Kinko's, or other similar businesses, can usually print posters from a PowerPoint file for a reasonable cost.

What does the presenter do at Convention?

Presenters will stand by their posters at the specified time to answer questions and engage in a dialogue with other professionals who are interested in the content. Presenters often provide handout summaries to interested Convention attendees.

How do I submit a poster proposal?

1. To submit a post proposal you must be a current student or early career (within seven years of receipt of doctorate) member. If needed, download a membership application from www.lapsych.org . Only one poster proposal per applicant.

2. Online submission of proposals is encouraged. Go to www.lapsych.org to submit the application. Then email your title and abstract (100 word max.) to lacpsych@aol.com. Abstract should be at least 12 point and double spaced. Submissions which do not follow the application format and/or are missing information will not be considered.

3. If you prefer to mail in your application, please send four - 8 1/2" X 11" copies of the completed application, title, and abstract (100 word max.). Abstract should be at least 12 point and double spaced. Mail submission to LACPA CONVENTION POSTER SESSION, 17277 Ventura Blvd., #202, Encino, CA 91316.

4. All submissions must be postmarked or emailed no later than **Friday, June 10, 2011**. Submissions received after that date will not be considered.

Please call the LACPA office at (818) 905-0410 if any clarification is needed. Applicants will be notified in late June whether the submission has been accepted. Rules for the Poster Session will accompany acceptance letters.

LACPA Poster Session Application

Twenty-Third Annual LACPA Convention
Saturday, October 22, 2011

ABSTRACTS MUST BE POSTMARKED OR EMAILED NO LATER THAN
FRIDAY, JUNE 10, 2011

ABSTRACT AND TITLE PAGES MUST ACCOMPANY THIS APPLICATION
(DO NOT FOLD)

PLEASE TYPE OR PRINT THE FOLLOWING INFORMATION

Name _____
(First Name) (Middle Initial) (Last Name) (Degree)

Address _____

_____

Telephone _____ Fax _____

Email Address _____

Affiliation
(University/Center) _____

If graduate student:
Name of University advisor for this research _____
(Name) (Degree)

If Early Career Psychologist (ECP):
Name of University and date of doctorate _____
(Name) (Date)

Additional Authors: (If more space is needed, please list on a separate sheet.)

Name _____
(First Name) (Middle Initial) (Last Name) (Degree)

Address _____

_____

Telephone _____ Fax _____

Name _____
(First Name) (Middle Initial) (Last Name) (Degree)

Address _____

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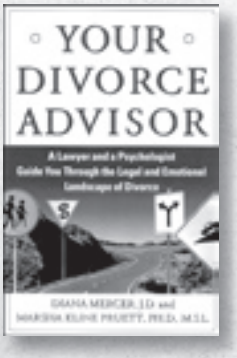
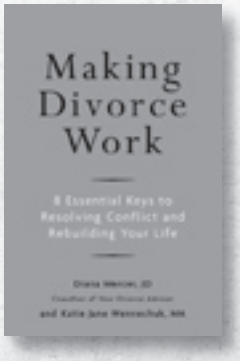
LACPA CONVENTION POSTER SESSION
17277 Ventura Blvd., #202
Encino, CA 91316

PeaceTalks.
mediation services for family law

Peace Talks Mediation Services' goal is to take everything that people hate about the family law system and do the opposite. Our mission is to create peace in the world, one family at a time.

Books by Diana Mercer





Peace Talks' mediation team of attorneys and therapists offer a constructive, forward-thinking and peaceful ending to relationships.

Marriages may end, but families endure.

Our services include all aspects of family law mediation: divorce, custody, parenting plans, financial settlements, premarital agreements.

Mediation orientations are private, confidential and free of charge. For more information, resources, and divorce planning tools, visit **www.peace-talks.com.**

Diana Mercer, Attorney-Mediator
mediator@peace-talks.com / 310.301.2100

WWW.PEACE-TALKS.COM

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ADVERTISING OPTIONS WITH LACPA

DISPLAY ADS - W X H.....MEMBER/NON-MEMBER

Full Page – 7½ x 9½ ..... $400/$494
Half Page – 7½x 4¾..... $250/$314
Quarter Page – 3¾ x 4¾ ..... $130/$163
Eighth Page – 3¾ x 2½..... $85/$104

All display ads must be submitted via e-mail (lacpsych@aol.com), we require a black and white PDF file; select the features that will embed all the fonts and images into the file. Export the file in high resolution (at least 266 dots per inch).

CLASSIFIED COLUMN ADS:

Member: $1.00 Per word .....Min. charge $25
Non-Member: $1.20 Per word .....Min. charge $35

Specials to LACPA Members only:
BUSINESS CARD AD – 3½ x 2 .....$50/issue or $250/6 issues with payment in advance

GROUP THERAPY ADS

All advertising for mental health services must include the practitioner's license number.

One 30 word Group Therapy Ad per issue free; $10 for any part of any additional 10 word increment.
Additional Group Therapy Ad(s): $10 for 30 words; $10 for any part of any additional 10 word increment.

ADVERTISING DEADLINES FOR *THE LOS ANGELES PSYCHOLOGIST*

- ADS - Deadlines have been established for submitting all ads for publication in *The Los Angeles Psychologist* by noon on the date listed. Advertising CANNOT be taken by telephone.

Jan/Feb Issue .....December 1
Mar/Apr Issue ..... February 1
May/June Issue..... April 1
July/Aug Issue.....June 1
Sept/Oct Issue ..... August 1
Nov/Dec Issue..... October 1

Receive a 15% discount on display advertising only when you advertise in six consecutive issues. Total payment must be received in advance.

Classified Advertising on LACPA's Website www.lapsych.org
(We are unable to accept display advertising for the Website at this time.)
LACPA's website is updated every Friday (Monday, if holiday falls on Friday).

Website Only
(Ad listed on Website for four weeks, beginning with the date of upload)
Member: $1.50 per word .....Minimum charge $35
Non-Member: $1.80 per word.....Minimum charge $45

Combination Website and *The Los Angeles Psychologist*
(Ad listed on Website for eight weeks, beginning with the date of upload and in the next upcoming *Los Angeles Psychologist*)
Member: $2.00 per word .....Minimum charge $45
Non-Member: $2.40 word.....Minimum charge $55

Please submit all ads to the LACPA office via email lacpsych@aol.com

- Credit cards (Visa or Mastercard only) not accepted under $35.
- Enclose your check made payable to LACPA with a copy of your ad and send to 17277 Ventura Blvd., Suite 202, Encino, CA 91316

NOTE: LACPA does not endorse any of the products, programs or services advertised in *The Los Angeles Psychologist* or in articles submitted.