Clinical Update

California Society for Clinical Social Work

Volume XLV Number 4 December, 2013

INSIDE Update

Happy Thanksgiving to all CSCSW Members!!

Medical Masquerades: When "Psychological" Disorders Are Physical
By Stacy Taylor, LCSW

Matt[1] was 15 years old when his parents went through a high-conflict divorce. Matt became more sullen, and his grades plummeted. His mom, an acquaintance of mine, did what many concerned parents would do: she brought him to a psychotherapist. The psychologist came up with a reasonable explanation: Matt was understandably depressed and angry about his parents' divorce; because he felt powerless, he was attempting to exert control through his acting-out behavior.

Therapy continued for several months, though Matt began manifesting a variety of other symptoms, including headaches. When his headache became severe, his mom took him to the Emergency Room where a concerned physician ordered a brain scan. The diagnosis: a benign, but rapidly growing, brain tumor. Matt had surgery and made a slow, but steady, recovery.

Rachel, age 42, was a happily married woman, with a secure job and a lovely home, although she was plagued by unexplainable bouts of depression. When I saw her for therapy, she presented as animated, although prone to sudden mood shifts. Rachel also was coping with some medical problems, including chronic pain, obesity, and infertility.

During the year I saw Rachel, she was hospitalized five times for severe depression. Her condition became so life-threatening that I made a number of urgent calls to Rachel's psychiatrists, her internist, and hospital social workers to advocate for thorough medical evaluation, including a work-up by an endocrinologist. All of my attempts were dismissed.

Rachel ended up losing her job, marriage, and house. She had to move to another state to be cared for by relatives, and I lost touch with her. To my surprise, three years later, I received a message on my answering machine from Rachel who informed me that she was finally referred to an endocrinologist and was diagnosed with a thyroid condition that contributed to her severe depression, as well as her weight problems and infertility. (Continued on Page 9)

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DISTRICT MEETINGS:

SAN DIEGO DISTRICT MEETING:

The CSCSW SD Region Invite you to their Annual Meet, Greet & Network Event

Host: Ros Goldstein and Committee
Phone: 619-692-4038 #3
When: Thursday, December 5 from 5:30 PM to 7:30 PM
Where: Jewish Family Service 8804 Balboa Avenue San Diego, CA 92123

SAN FERNANDO VALLEY DISTRICT:

Coordinator: Tanya Moradians, PhD, LCSW
Coordinator Phone: 818 783-1881
Coordinator Email: tmoradia@ucla.edu
Date: Sunday, December 8, 2013
Time: 10:00 – 12:00
Presenter: Kim Cookson, PsyD
Topic: **An Introduction to Eye Movement Desensitizing and Reprocessing (EMDR)**
Location: Sherman Oaks Galleria Community Room (Ventura and Sepulveda Blvds.) The Community Room is located on the 1st level by the Cheesecake Factory next to the Paul Mitchell Salon. *Validated Parking*
RSVP: Tanya Moradians – contact info above

Current neurological research has made it increasingly clear that trauma plays a significant role in the development of negative, distressing symptomology. Trauma presents with a wide spectrum of symptoms, from Post Traumatic Stress Disorder to phobias, somatic pain, and intense experiences of anxiety and depression. Eye Movement Desensitizing and Reprocessing (EMDR) is an evidence-based treatment for PTSD. It has also gained a wider acceptance as a powerful treatment for anxiety, depression and a wide range of other complaints. EMDR works to support our natural information processing system, which can become stuck or dysfunctional due to the overwhelming effects of trauma. This talk will introduce you to EMDR. You will learn about how trauma interrupts normal processing, and how EMDR facilitates the reinstatement of normal processing. We will also look at ways that EMDR can enhance the internal resourcing of clients. Through case example, I will describe the general structure of the EMDR protocol, and how it works to facilitate the resolution of a client's negative symptoms following a traumatic event.

Kim Cookson received her doctorate from the California School of Professional Psychology in 2002. Kim Cookson is a licensed psychologist, certified EMDR therapist and a facilitator for the Trauma Resource Institute. She is currently the Trauma Training Director at the Southern California Counseling Center and has brought EMDR training to the Center's advanced interns and supervisors. SCCC now offers EMDR and somatic resiliency skills to sliding scale clients.

This course meets the qualifications for 1.5 hours of continuing education credit for MFTs, LPCCs, and LCSWs as required by the California Board of Behavioral Sciences. Members earn credits at no cost. Credits for non-members are $10.00 per unit. All are welcome to attend at no charge (no CEU certificate). MSW students are especially encouraged to attend.

FUTURE DISTRICT MEETINGS: *

FRESNO DISTRICT:

Coordinators: Gabriele Case and Anne Petrovich
Coordinator Phone: 559-237-9631
Coordinator E-mail: gh.caselcsw@sbcglobal.net
Date: Saturday, January 25, 2014
Time: 9:30 a.m. to 12 p.m.
Presenter: Herman Barretto, LCSW
Topic: **PTSD Work with Couples**
Credits: 1.5 (1 CE credit per hour of instruction)
Location: Fresno Pacific University
Steinert Campus Center, Pioneer/Johanson Conference Room 103

MID-PENINSULA DISTRICT:

Coordinator: Virginia Frederick LCSW
Coordinator Phone: 650-324-8988
Coordinator Email: ginnyfred@aol.com
Date: Friday, January 17, 2014
Time: 12:20-2:00PM
Presenter: Paul Tang, MD
Topic: **LinkAges: an Innovative, Multigenerational Program that Activates and Engages Community to Support Aging in Place**
Credits: 1.5 (1 CE credit per hour of instruction)
Location: To Be Announced

NAPA SONOMA SOLANO DISTRICT:

Coordinator: Linda Park
Coordinator Phone: 707-321-3147
Coordinator Email: lpark41@sbcglobal.net
Date: Friday, January 17, 2014
Time: 12:00 to 1:30
Presenter: Ali Brinkerhoff, Family Justice Center, Sexual Assault Victim Advocate
Topic: **Victims of Sexual Assault**
Credits: 1.5 (1 CE credit per hour of instruction)
Location: 3554 Round Barn Blvd, Santa Rosa

SACRAMENTO DISTRICT:

Coordinator: Nathan Stuckey, ASW
Coordinator Email: Nstuckey13@gmail.com
Date: Saturday, January 18, 2014
Time: 9:30 am till 12:00 pm
Presenter: Paula Smith, PhD
Topic: **Understanding Adult ADHD**
Credits: 2.0 (1 CE credit per hour of instruction)
Location: Friends Meeting House

*More detailed information will be provided in the January issue of the Clinical Update.

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Presenters include:

- Daniel Siegel, MD
- Allan Schore, PhD
- Drew Pinsky, MD
- Christopher Kennedy Lawford, JD
- Sir Richard Bowlby
- Darcia Narvaez, PhD
- Jennifer McIntosh, PhD
- Stan Tatkin, PsyD, MFT
- Lou Cozolino, PhD
- Judith Schore, PhD
- Margaret Wilkinson
- Alex Katehakis, MFT
- Phillip Bromberg, PhD (*video*)
- Pat Ogden, PhD
- Gay Bradshaw, PhD
- Ruth Lanius, MD, PhD (*video*)

CE credit available for Psychologists, Physicians, Social Workers, MFTs, LCSWs, LPCCs, LEPs, Registered Nurses, and other allied health professionals.

Lifespan Learning Institute is approved by the American Psychological Association to sponsor continuing education for psychologists. Lifespan Learning Institute maintains responsibility for this course and its content. This course offers up to 20 hours of CE credit.

14902-14

Switching Places with My Mother
By Nancy White, LCSW

I spent several weeks living with my mother when she returned home from two months in rehabilitation after her stroke. Her return to herself has been a slow process. She and I settled into a pleasant routine, focused on her continued progress toward independence and better health.

Early in my stay I found my life full of switches with my mom. From the obvious role reversals to the little switches we made daily to help both of us adjust to the profound changes brought on by her serious stroke.

Perhaps the role reversals were the easiest to recognize because of my profession: listening for her during the night, helping her pick out her clothes in the morning, and making sure she ate all her breakfast and took her medications and vitamins as she started her day. I had to remember that it was my job to turn on the coffee pot first thing; both of us needed that cup of joe before anything else. A somewhat amusing switch for me involved the home health nurse's aide who saw Mom several times a week. When she called to alert us that she was coming to help Mom with her bath, my mom would give me a look of total disdain and imposition. "I don't want to do that today," she would tell me and then start to bargain. "Could I take a bath later in the week?" Each time we would talk about her concerns, the pros and cons of doing this now versus later. I cajoled and validated her feelings as much as I could, then found myself gently (but firmly) saying, "Let's do it today. You will feel so good after you take your bath and wash your hair." When the aide arrived my mom would go upstairs and do what was expected. She felt great when she was done. How often in my childhood had I resisted and bargained to stay out of the bathtub! A thousand times at least. She usually prevailed and she was right, of course.

Throughout my stay, I noticed other switches we made daily: With coffee in hand, we switched on the TV news. A residual effect of the stroke caused my mother to have difficulty reading; she couldn't focus on the page or comprehend the material so she relied more on the television for information and being connected to her community. This change was very sad for both of us as she had been an avid reader.
Switching the TV off! We made a pact with each other daily not to watch endless hours of fluff or trauma. We pushed ourselves to find other activities during the day. Most of the time we were successful, but other times we switched it on again in the afternoon to catch Rachel, Katie and Ellen, watching contentedly. No guilt.

Another residual effect of her stroke was that my mother often felt cold. Daily we would fuss over how high the thermostat was to be set. Since it was winter, we dressed her in warm sweaters and I wore what summer clothes I had with me. We switched that thermostat several times a day. At night, she slept like a kitten while I tossed and turned until I snuck downstairs and turned down the heat. She never noticed the difference.

My mother lost a significant amount of weight during this ordeal. She needed endless encouragement to drink fluids and eat, especially high calorie snacks and many small meals each day. So when I made her an ice cream shake, I would make a smaller one for myself. Delicious - plus I secretly saw it as a little reward for her improvement. And it had been years since I last had a chocolate shake! When she weighed herself we would cheer for every ounce she gained. She would then switch the scale over to me. I weighed myself daily as a part of my continual recovery from overeating. I got on that scale praying that my weight stayed the same. We both cheered at that too. Caregiving is so labor intensive, between the worry and the physical exertion, I found I burned the calories as fast as I took them in.

Switching out my jewelry for my Mother's jewelry. Both of us love jewelry and wear it all the time. My mom has always been generous in sharing hers with my sister and me. Almost daily I was looking in Mom's jewelry box and putting on some familiar piece, especially her earrings. This experience also brought back many memories of my mother during our life together with each piece I wore. She let me do this knowing it gave me pleasure.

Our time together was a rich experience. We were both concerned about whether she would continue to improve. We were both thrilled when she made strides especially with walking. I listened and felt a mixture of feelings when she talked about whether she would be able to drive again. We spent countless hours discussing where she will be living in the future and I hoped for her that she could adapt to these changes in her life. I watched to make sure depressive symptoms didn't set in, ready to take action if I saw any decline. Most of all, I was in awe of how the psychological shifts come so naturally to us in times of high stress and profound change.

Nancy White, LCSW is a current CSCSW Board Member and enjoys working with adolescents, families and adults in her private practice in West Sacramento. She is also employed part time with California Department of Corrections and Rehabilitation. Phone (916)335-2150 or email address: NCW007@ATT.net

The AAPCSW
(American Association for Psychoanalysis in Clinical Social Work)
AAPCSW.org
Northern California Chapter:
CE's sponsored by California Society for Clinical Social Work

Co-Chairs: Velia Frost, LCSW & Rita Karuna Cahn, LCSW

Program:	**Lesbian Parenting: Facts and Fantasies**
Presenter:	Janet Linder, PhD, LCSW
Date:	Saturday, January 11, 2014
Time:	10 a.m. to 12:30 p.m.

We are pleased to offer an exciting presentation and rich conversation with Dr. Janet Linder.

Dr. Linder says, "Intentional lesbian parenting is a relatively recent socio-cultural phenomenon. Here in the San Francisco Bay Area we have one of the largest lesbian parenting communities in the country, and in fact, in the world." She will present research findings from her Sanville Institute doctoral dissertation, "Lesbian Non-biological Mothers/Parents During the Transition to Parenthood," and she will share fantasies of lesbian mothers and parents from her interviews and clinical work. Her presentation will address relationship satisfaction, division of labor, gender dynamics, sex, and point to contrasts with opposite sex parenting couples. The transition to parenthood and the role of the non-biological mother/parent will be emphasized. As always, we welcome your observations and countertransference experiences from your own clinical work.

Janet Linder, PhD, LCSW is in private practice in San Francisco and Berkeley for nearly three decades. She is on the faculties of the Women's Therapy Center and The Psychotherapy Institute, Berkeley. She leads a weekly supervision group for new therapists, and specializes in working with trauma, addiction, gender, parenting, and couples. She received her PhD from the Sanville Institute.

**********Please note new Location**********

120 Commonwealth Ave., (Between Euclid & Geary) S.F., CA. 94118

Home office of Gabie Berliner, PhD, LCSW

(call for directions) 415-751-3766

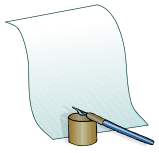
Seating is limited: please RSVP by E-mail to: ritakaruna@mac.com

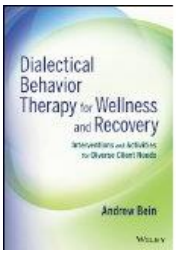
We Would Love for You to Write for This Newsletter:

We welcome your contributions to the newsletter:

- Articles on clinical issues and business aspects of your practice
- Articles on your personal experience regarding some aspect of your work
- Articles from students and new social workers
- Reviews of books, movies, websites and other media that would be relevant to our members
- Tell us about an interesting member

Send your ideas and suggestions for articles and authors to our Editor
Jean Rosenfeld at 916-487-8276 or
Email: jrosenfeld@clinicalsocialworksociety.org





BOOK REVIEW

Dialectical Behavior Therapy for Wellness and Recovery: Interventions and Activities for Diverse Client Needs

by Andrew Bein, Ph.D.

Published by Wiley, October 14, 2013

272 pages

Reviewed by Nancy White, LCSW

I read Dr. Andrew Bein's book on DBT-WR with great interest and enthusiasm. In this work he gives respectful consideration to traumatized clients, their essence and life experiences. The author explains DBT – WR principles in ways that encourage the clinician and client to participate as partners in a trusting, nonjudgmental, safe experience while repairing the psychological wounds caused by continual traumatic reenactments through their lifetime. His thoughtful exploration of recovery reminds us that our clients bring extraordinary strengths and life experience to the healing process.

As a therapist begins to understand the client's unique needs, the author stresses we need to explore the cultural and spiritual attributes that shape the concepts and strategies a client uses and how he or she defines good results. These recommendations have a big impact on chipping away at mental health stigma. His focus on merging DBT principles with wellness and recovery shifts our assessment of the client away from negative, disempowering labels and pathological traits to looking for ego strengths on which to build. Underlying this approach is the belief that the client is able and prepared to learn new skills that are effective.

While Dr. Bein stays true to Dr. Marsha Linehan's original theory structure, he has consolidated the material so it has practical application in diverse clinical settings, i.e., mental health or substance abuse agencies, drop-in clinics and private practice. He has reorganized some key concepts and regrouped them (wise mind and radical acceptance) in ways that are refreshing and new, giving the clinician immediate clarity and a sense of how to teach the material. Early in the treatment the client learns some basic and tangible skills to ground themselves in new constructive attitudes and behaviors; this increases self-confidence and motivation to continue.

The author speaks to the necessity that clinicians working within the DBT-WR framework lead the process and respond to the client within the DBT-WR core concepts. He is generous with examples of how to practically apply the skills. Sensitive to the burnout that can ensue from empathic witnessing of traumatic history, Bein devotes a chapter to therapist self-care, the grounding of the therapist in these principles, and providing tools for holding and supporting the client's progress.

The author revisits the concept of "strong back, soft front," clearly explaining how to be with the client or the group while maintaining boundaries, containers and compassion. I find this concept to be very easy to use as a quick, mindful self check-in during the session. It has the effect of centering the therapist during the process and modeling the intended skills.

Finally, the author has organized the DBT-WR material into fifteen lesson plans. Having done this, it shortens the time investment for all involved. Each lesson has clear directives for learning the skills while assisting the client with attaining the goals of healing. The practical exercises and monitoring tools are well designed and will enhance recovery. Clear, concise, and engaging, I plan to use Dr. Bein's DBT-WR for my next group design.

Nancy White, LCSW enjoys working with adolescents, families and adults in her private practice in West Sacramento. She is also employed part time with The California Department of Corrections and Rehabilitation. Phone (916)335-2150 and email address: NCW007@ATT.net

INSIDE THE INSTITUTE
A Message from Whitney van Nouhuys
PhD Academic Dean

I am sure you have already heard that Jean Sanville, founding dean of our Institute died on November 4th, one month short of her 95th birthday. Originally called The California Institute for Clinical Social Work, the Institute changed its name in 2005 to The Sanville Institute in Jean's honor. The clinical social work profession is much the richer because of this remarkable woman's spirit and dedication, and her passing is a great loss to us all. Read about Jean on our website: on the home page http://sanville.edu/ is the obituary "Jean Sanville: A Life in Dialogue" written by her friend and colleague Joseph Bobrow and her remarks at the time we re-named the Institute are here http://sanville.edu/about/remarks-from-jean-sanville/

Continuing in the unique educational model Jean Sanville helped establish, students and faculty in the doctoral and certificate programs at the Institute are immersed in their studies. As the fall trimester nears its end, we are preparing for winter convocation in Los Angeles, on Saturday January 25. As always, any of you in the area are invited to attend and CE credit will be awarded. Three students and a faculty member from Smith School for Social Work doctoral program will join us for the weekend, as has become a tradition. This time the program will be on Harry Stack Sullivan. As Joel Kanter (2013) points out in a recent article, there is an obvious link between Sullivan's theory and clinical social work, and yet,

> Given Sullivan's emphasis on the interpersonal world and social work's person-in- environment perspective, the near absence of direct interaction between the Interpersonal School and social work is surprising. In 1940, Sullivan spoke at the Smith College School for Social Work on 'The Social Worker and National Defense,' but there is no other evidence of interaction between Sullivan and social work institutions. (p. 277)

In our convocation program we will look at Sullivan's influence and consider his ideas in historical and cultural context.

We welcome inquiries about our PhD and two-year certificate programs. Information is on our website www.sanville.edu or call 510-848-8420.

The Sanville Institute is a private, non-profit, unaccredited school that is approved by the State of California's Bureau for Private Postsecondary Education (www.bppe.ca.gov). "Approved" means compliance with state standards as set forth in the California Private Postsecondary Education Act of 2009 [California Education Code, Title 3, Division 10, Part 59, Chapter 8, §94897(l)].

Reference

Kanter, J. (2013). Helping, healing, and interpreting: Sullivan, the Interpersonal School, and clinical social work. *Journal of Social Work Practice*, 27, 273-287. doi: 10.1080/02650533.2013.818943

Medical Masquerades: When "Psychological" Disorders Are Physical

(Continued from Page 1)

She was on thyroid medication and doing significantly better.

Matt and Rachel are both dramatic examples of what has been dubbed, Medical Masquerades (MM)[2]. MMs are medical problems that are misdiagnosed by medical and mental health professionals as psychological. While Matt and Rachel's stories are striking, their experiences are not unique.

Some people suffer for years, and even decades, with puzzling symptoms that confound professionals and are resistant to medical and psychological treatment. Many cases are dramatic like Matt and Rachel's, with unnecessary psychiatric hospitalizations or delayed treatment for life-threatening illness. Other situations are much less perilous, though they diminish the quality of life for the person, and propel him or her into an endless and expensive quest for a cure.

According to the book, *Mind or Body,* by Dr. Robert Taylor (no relation to me), all mental health professionals will regularly see clients whose psychological suffering is due to a biological condition[3]. In a study cited in *Mind or Body,* l00 patients admitted to a psychiatric hospital were extensively evaluated for underlying organicity. Half of the patients had biological illnesses that were either causing or exacerbating psychiatric symptoms.

In another study of over 2,000 outpatients, l8% had organic diseases that were causing their psychiatric symptoms. According to Taylor, patients are mistakenly diagnosed for an average of four years, though often longer; some people are never properly diagnosed, or the true cause of their distress is only discovered upon autopsy. Taylor advises professionals to ask ourselves, "What other than the obvious might be the cause of or a contributing factor to the presenting symptoms?"

Why are MMs Missed?

Part of the reason that MMs are so often overlooked is human nature; we tend to hold fast to our belief systems. If physicians treat a woman like Rachel, who is middle aged, overweight and having mood swings, they immediately think of depression.

What complicates matters is that often there is a life issue that convinces professionals that the symptoms are psychiatric. For Matt, it was his parents' divorce, and for Rachel it was infertility. But most people have some type of life stressor. Hence, Taylor counsels therapists not to immediately assume a symptom is psychological.

Taylor had a powerful impact on the mental health realm in the l980's, when he taught classes for psychologists on MMs, and published, *Mind or Body.* The State of California took note of the serious problem, and ordered its psychiatric clinics to run a full battery of medical tests on patients. Unfortunately, the project was never fully funded or implemented.

These days, there are unique reasons why many MMs are dismissed as psychological. These include the advent of managed care, the development of SSRIs, and reliance on medical tests even when clinical symptoms may point to an organicity.

For instance, prior to the development of certain tests and anti-depressants, if a woman presented to her physician as overweight, depressed, lethargic, and with low libido, many doctors would have prescribed thyroid medication. Given that the prior class of anti-depressants -- the tricyclics -- had significant side effects, doctors would have wanted to avoid prescribing them whenever possible. But once the TSH (Thyroid Stimulating Hormone) blood test was developed to evaluate thyroid conditions, it would be very unlikely for a doctor to prescribe thyroid medication unless the patient tested positive on the TSH test. The problem is that many thyroid experts, including a major specialist group, believe that the TSH range is inaccurate, and that half of all sufferers are not diagnosed[4]. Now women presenting with the above symptoms would likely be prescribed a safer anti-depressant, such as an SSRI, not thyroid medication.

Not only has medicine been heavily impacted by reliance on tests and medications, but managed care has created rigid standards physicians must follow. Doctors have less time to carefully evaluate their patients. With overworked physicians rushing to meet their patient quotas, while dealing with insurance issues, many medical problems can be overlooked.

Red Flags for MMs

If physicians so often miss MMs, how can LCSWs correctly diagnosis them? The answer is that we can't, and we reach beyond our scope of practice by trying to do so. However, as psychotherapists we can inform ourselves about the red flags for MMs, and use this information to educate our clients and to make appropriate referrals.

I have culled from several books[5] some signs and symptoms to look for during sessions. While not all clients will, of

course, present with an MM, the following may suggest one and may prompt a referral to a medical professional:

Client appearance: Pay close attention to how each client appears, including his/her gait, size, hair and complexion, and affect. Note anything unusual, including the following: dishevelment, gross errors in dress, excessive drowsiness, movement problems (tremors or rigidity), hair thinning or prematurely grey (could indicate low thyroid), or bulging eyes (which could point to Grave's Disease).

For instance, Gail presented as excessively sleepy during our sessions. A woman in her late 30's, she was also 75 pounds overweight. I urged Gail to have a thorough medical evaluation and to talk to her doctor about possible testing for thyroid problems and/or sleep apnea. She was eventually diagnosed with sleep apnea.

Cognitive impairment: A possible key to a MM could be any cognitive impairment, including memory problems, difficulty with speaking or writing, inattention, errors in judgment, or disorientation.

For example, Adam was a young man who missed our first appointment since he forgot. He did come to our second one, but he spoke concretely and missed subtle social cues. He also presented as easily distracted. I wondered whether Adam had a substance abuse problem, attention deficit disorder, or Asperger Syndrome.

I was startled to find out the real reason for Adam's symptoms: he had had a stroke due to a rare brain infection. In shaky handwriting, he revealed this on my intake form, where I ask about medical conditions and surgeries.

Psychiatric symptoms: Even if clients present with psychiatric symptoms, this doesn't mean that their condition is simply psychiatric. There are numerous medical diseases that mimic psychiatric ones, as well as comorbidity. As with Rachel, mood disorders can be caused or exacerbated by thyroid problems. People diagnosed with attention deficit disorder may have blood sugar fluctuations, for instance, hypoglycemia. Visual hallucinations often point to organicity. Many people with paranoia have an underlying biological problem.

In addition to the above, the following raise the possibility that a client's symptoms may be a Medical Masquerade:

--Sudden onset of symptoms, with no prior history of symptoms, particularly over age 35.

--Age 55 or older.

--No readily identifiable cause.

--Intractable symptoms that persist or get worse despite medical or psychological treatment.

--Coexistence of chronic illness.

--Females going through hormonal changes, such as puberty or peri-menopause (the years prior to a woman's menses stopping. When her period stops for one year, this is called menopause).

--Sexual functioning complaints: In one study of l00 men with impotence who underwent thorough medical evaluation, cited in *Mind or Body,* 70% were found to have a medical problem, for instance, diabetes. Low libido in women and men can often be linked to hormonal imbalances and thyroid problems.

Common MMs

While there are at least a hundred medical illnesses that can mimic a psychiatric condition, I've listed below some of the more common ones. For more information, please consult the books listed in the footnote section.

Endocrine disorders, such as hyperthyroidism or hypothyroidism (that is, high or low thyroid). Thyroid problems have become epidemic, possibly due to environmental contamination. Not only do thyroid problems have the potential to cause psychological symptoms, including depression, hypomania or mania, anxiety, panic attacks, even psychosis, but left untreated, they can lead to high blood pressure, elevated cholesterol, infertility, and osteoporosis.

Seizure disorders can cause cognitive and behavioral problems that may be misdiagnosed as simply psychiatric.

Organic brain disorders, such as temporal lobe epilepsy or Alzheimer's Disease, can cause personality changes, mood instability, impulse control problems, and anxiety.

Blood sugar disorders: Diabetes and hypoglycemia may cause irritability, anger problems, anxiety, and mood swings that may be misdiagnosed. Hypoglycemia is a common disorder that often evades professionals. It is rare for people to be medically evaluated for hypoglycemia, since testing is expensive and time consuming.

Lyme Disease: a tick-born illness that can remain latent in a person's system for months or even years after exposure.

Brain injuries: Any injury to the brain can cause damage, especially if the person has lost consciousness, even briefly. It can be helpful to ask whether the person has ever had a brain injury or concussion, for instance, through sports.

Brain tumors can cause a plethora of psychiatric symptoms, including mood swings, anxiety, or changes in personality.

While the following aren't diseases per se, they are important to note because they can lead to physical illness.

Foreign travel, particularly recent, can be linked to viruses, bacterial infections, or parasites, all of which may cause symptoms dismissed as psychological.

Specialized diets, such as vegetarian or vegan. Restricted diets can lead to vitamin deficiencies. Vegetarian and vegan diets are very high in carbohydrates that can cause erratic blood sugar throughout the day. Diets high in fish can be toxic for mercury that may produce cognitive and behavioral problems. Poor eating habits, such as skipping meals or eating too much sugar, can also cause psychiatric-like symptoms, including irritability and anger outbursts.

Vitamin deficiencies, particularly Vitamin D, Vitamin B-12, and Folic Acid. Low electrolytes, perhaps from too little or even too much water, can also cause psychiatric-type symptoms.

Chemical exposure: environmental contaminants, such as mold, lead, and various chemicals can cause symptoms.

Caffeine: In our fast-paced world, many people are drinking so many caffeinated drinks, that they can become anxious, hyperactive, and even manic.

Aspartame: a common sugar substitute in most diet drinks that has been linked to psychiatric and medical problems.

Medications, vitamins, and supplements, some of which can produce psychiatric-like symptoms, particularly in combination with each other or with illicit drugs or alcohol.

Peri-menopause: While symptoms of peri-menopause usually begin when a woman is in her 40's, they can start in her 30's or even, in some rare cases, her 20's. Symptoms can include anxiety, mood swings, and/or panic attacks. Infrequently, peri-menopause can cause major psychiatric symptoms, including mania. It is not uncommon for symptoms to be dismissed as merely psychological.

Conclusion

Dr. Robert Taylor estimates that about l0% of all clients in out-patient therapy have an MM that is causing or contributing to psychological symptoms. The numbers are even higher for inpatients as well as certain populations, for instance, the elderly. Taylor states, "Any human service professional actively engaged in seeing clients can expect to see a significant number of organic masquerades over the course of a clinical career."

As LCSWs, we are committed to help alleviate client suffering. One way to do this is to educate ourselves about medical illnesses that can mimic psychiatric ones. At the same time, we are not medical professionals; we need to be cognizant of the limits of our practice and encourage clients to inform themselves. Armed with information, clients may be able to advocate for themselves with the medical establishment and discover the true reason for their distress.

Footnotes

1. While all of the examples cited are true, identifying information has been changed for confidentiality purposes.
2. Along with the term, "Medical Masquerade," other phrases used to denote the same phenomenon include: "Clinical Masquerade," "Organic Masquerade," and "Psychological Masquerade."
3. Taylor, Robert, *Mind or Body,* 1982, NY: McGraw Hill. Updated version of the book was published in 2007 under the title: *Psychological Masquerade.*
4. The American Association of Clinical Endocrinologists issued a press release in January 2003 entitled, "Over 13 Million Americans with Thyroid Disease Remain Undiagnosed." The group stated, "The prevalence of undiagnosed thyroid disease in the United States is shockingly high," and they recommended a narrowing of the TSH range of normal from 0.5 to 5.0 to 0.3 to 3.04. Unfortunately, most doctors and laboratories have not followed these recommendations.
5. Along with Robert Taylor's work, please refer to the following books: Morrison, James, *When Psychological Problems Mask Medical Disorders*, 1997, NY: Guilford Press; Schildkrout, Barbara, *Unmasking Psychological Symptoms,* 2011, NJ: Wiley Press; and *It's Not All In Your Head,* Swedo, Susan and Leonard, Henrietta, 1996, NY: HarperCollins.

Stacy Taylor, LCSW, is a psychotherapist in private practice in Berkeley. While she sees clients for most presenting problems, she specializes in anxiety disorders, as well as chronic pain and illness. She is the author of the book, *Living Well with a Hidden Disability,* published in 1999 by New Harbinger Publications. To contact Stacy, you can email her stacytaylortherapy@gmail.com. Her website is: stacytaylortherapy.com

Remembering
Jean Sanville (1918-2013)

Jean Sanville passed away peacefully on, Monday morning, Nov. 4th at 2:37 AM. Jean was a member and past president of California Society for Clinical Social Work, one small facet of her impact on clinical social work. Below are two tributes to Jean from our members.

I was so so very sad to learn of Jean's final days and death from her niece. We all mourn her loss, our beloved and highly esteemed founder and first dean of the Sanville Institute, formerly the California Institute for Clinical Social Work, as well as her vast overall contributions to our field. Jean was a true scholar and an original thinker, who published many papers and important books. The educational principles she espoused, indeed her vision for advanced clinical education, are followed today, as they were set in motion by Jean. Jean's values and ethos inform us and guide us. She and I had a very special relationship from the time we worked together during the original process of forming the Sanville Institute. Our collegial and personal bonds were deep and we remained in close contact throughout all these years. I treasured Jean and feel very fortunate to have known her and worked with her for so many years. Nothing will be the same without her!

~ *Samoan Barish*
CSCSW Member

My time with Jean was always treasured, as was being with her recently on Saturday afternoon. She passed on, just yesterday morning, Monday Nov. 4th at 2:37 AM. I took some poems with me to read to her at her bedside since we often shared reading poems to each other. She was calm; peaceful; and seemed ready to move on. Jean showed me a number of pathways, including this one: moving on and into the great mystery. I sense that she went 'gently into the night.' I remain grateful for her kind & loving ways. Just wanted to share…

~ *Karen Redding*
CSCSW Member

Dear friends and colleagues, The Los Angeles Institute and Society for Psychoanalytic Studies is graciously hosting a Memorial in Jean's honor and memory. We are hoping that you will not only attend, but be willing to say a few words, given you and your (professional/personal) relationship to her. Please let me know so that I may inform Terry McBride who will be facilitating this Service. I remain warmly appreciative, Karen Redding, Kredding@mac.com

The Los Angeles Institute and
Society for Psychoanalytic Studies
cordially invites you to a memorial service honoring
Jean B. Sanville, Ph.D.
Friday, December 6, 2013
2:00 p.m.
New Center for Psychoanalysis
2014 Sawtelle Boulevard
Los Angeles, California 90025

CSCSW Advertising Rates & Deadlines:

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Classifieds

∞∞∞∞∞∞∞∞∞∞∞∞∞∞∞∞∞∞ PAID INTERNSHIP – SANTA ROSA, CA ∞∞∞∞∞∞∞∞∞∞∞∞∞∞∞∞∞∞

INTERNSHIP at Chrysalis Community Counseling Services, a diverse, dynamic feminist counseling agency that provides sliding scale psychotherapy for individuals, couples and families. MA and previous experience required. $8.00/client hour, weekly individual and group supervision, great support and community. Send resume and cover letter by 1/24/14 to Chrysalis, 1821 4th St, Santa Rosa, CA 95404. FMI call 545-1670 x208.

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Professional Office Building in Cupertino has a spacious window office, approximately 377 gross square feet, available for rent. Adjacent is a smaller window office, approximately 170 gross square feet, also available for rent. The rental amount includes receptionist service, use of conference rooms, utilities, phone equipment, and use of the kitchen. If interested, please reply to torreventure@gmail.com

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There are two offices - one large, one small - available @ 4420 N. First Street, located centrally and with easy access to bus. The buildings are multi-use, currently housing professionals like therapists, dentists, a CPA, and a couple of agencies. For therapists looking for office space, please call Gabriele Case @ (559)224-2495.

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1st e-blast $30; Each additional e-blast - $15
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Have you been struggling with the new Noridian billing system for MediCal?

Through many telephone conversation with Noridian, Dr. Cheryl Jern, Petaluma - has gained some valuable information, gathered contacts, is keeping a list of complaints and is interested in hearing from others who have had difficulty. If you would like to discuss your situation with her, and get some guidance on how to proceed with your own billings, please email her at drcjern@sonic.net or give her a call at 707 762 9398. She looks forward to helping our members master this new billing system.

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