



# The San Francisco Psychologist

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DECEMBER 2004

## Psychotherapy Research: Studying Outcomes and Process

*Constance Milbrath, Ph.D.*

When I was asked to write a piece for the newsletter on my experience of psychotherapy research, I was thrilled to get the opportunity to review the several wonderful research projects of which I was or am currently a part—in large measure because the writing process itself allows one to take the kind of integrated perspective that does not always occur otherwise. One aspect that stood out for me is that my research experiences could be fit rather neatly into a dichotomy often made in the literature between outcome and process research. I will use this as a starting point to discuss first my current experiences as part of Bob Wallerstein's Psychotherapy Research Project II, a group that has been working for twenty years on a measure of structural change in personality, the Scales of Psychological Capacity (SPC). One major function envisioned for the SPC is as a measure of psychoanalytic psychotherapy outcome. My research experiences with Mardi Horowitz' Program on Unconscious and Conscious Mental Processes<sup>1</sup> (PCUMP) falls more squarely into process research. Here the goal was to develop methods and paradigms for studying the influence of unconscious processes on emotions and conscious mental content. The methods developed in this venture led to microanalysis of therapeutic process. These two types of research are complimentary. On the one hand, outcome research allows us to study the benefits of specific psychotherapies, to compare different types of treatments, and even to compare specific treatments for different types of patients. Process research, on the other hand, allows us to study what it is in the treatment process that accounts for its effectiveness as well as to study the process of patient change during treatment.

### Psychotherapy Research Project II (PRPII)

At the time that Bob Wallerstein moved from the Menninger Foundation Clinic to become chief of Psychiatry at Mount Zion, his goal was to follow up on his intensive 30 years of research studying changes that take place as result of psychoanalytic psychotherapy and psychoanalysis. This research addressed factors in the evolving life situation of patients and in the therapeutic process that brings about change. But change beyond symptom reduction was difficult to assess. Sharing a belief common to the psychoanalytic community that effective treatment brings about change that goes beyond outward symptoms, extending to the "structure" of personality itself, Wallerstein recognized that few if any viable measures of personality structure were available.<sup>2</sup> In part, this was the result of a general disagreement among the various psychoanalytic theoretical perspectives as to what constitutes personality structure. But the difficulties of making a distinction between enduring structural change and more surface behavioral changes also posed serious measurement obstacles. The shared assumption of structural change could not be tested, nor goals of psychoanalytic research met, without a valid measure. Wallerstein formed a new research group, PRPII, with Kathy Dewitt, Nate Zilberg, Dianna Hartley, and Saul Rosenberg. The group set the goal of creating a measure of structural change informed by theory but neutral "with respect to the range of differing psychoanalytic metapsychologies." They settled on an indirect approach by proposing to assess the psychological resources an individual has available

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The San Francisco Psychologist is the official publication of the San Francisco Psychological Association, a not-for-profit association of licensed psychologists in the City and County of San Francisco. Our Information and Referral telephone number is 415/681-3063 and our mailing address is SFPA; P.O. Box 590482; San Francisco, California; 94159.

Membership in the SFPA is opened to all licensed psychologists, registered psychological assistants, and students of psychology. Annual fees are \$85 for psychologists and \$15 for affiliate and associate members, including students and psychological assistants. Participation in the Information and Referral Network is \$195 per year. Membership includes four issues of *The San Francisco Psychologist*, legislative representation, and reduced fees for social and professional events. Applications for membership can be obtained by calling the Information and Referral telephone number or the membership chairperson listed above.

Articles for publication are accepted in any of the following categories: feature articles on current clinical practice and research findings up to 2000 words; workshop, book, and movie reviews up to 1000 words; political and economic news relevant to the professional practice of psychology up to 1000 words. Special topics accepted upon approval of the editor. The editor reserves the right to edit all submissions for clarity and length. Articles should be either e-mailed to normanz@lanset.com or mailed Norman Zukowsky; 295 Fell Street, Ste. B; San Francisco, CA 94102. Articles included in the newsletter do not necessarily represent the opinions of the SFPA or of its board.

415/681-3063

# The President's Column

Patrick O'Reilly, Ph.D.

The Board of Directors of the San Francisco Psychological Association is excited about the increased membership of the organization, and increasing membership remains a primary goal for 2005. We have other things in the works, as well. We are planning to do a concerted outreach to Bay Area graduate schools. As I can attest, it is easy for doctoral students to get bogged down in studies and lose sight of the fact that very soon they will be practicing clinicians. We hope to make that transition less daunting by offering formal and informal mentorship to these students. To do this, we are contacting the schools and intend to meet with faculty and students, making both groups aware of the services we offer.

Education is a key component of SFPA and we want to make SFPA more visible in the San Francisco community. The wealth of professional exper-

tise that our members possess is unsurpassed in the Bay Area, and we are setting up a speakers' bureau so that community organizations, religious groups and undergraduate psychology programs will contact us when they need a speaker on a topic specific to a psychological specialty. SFPA is contacting the media for the same reason. It is our hope that they will contact us when preparing a story relevant to psychology.

Finally, the membership of the association is diverse and fascinating and we so seldom see each other! To correct this, we are planning at least four purely social events for 2005. Please join us for these events. Also, please attend our Board meetings. Meetings are held on the third Friday of each month at 6:30 at Hellman Hall at Mount Zion Hospital. We will very much welcome your ideas and assistance.

## Steps to Take Now to Save on Taxes in April

Jan Zobel, EA

With the year end in sight, April 15th's tax deadline is bound to follow quickly. Are your records in order, ready to provide you with maximum tax deductions? It's not too late to take action now that will result in April tax savings. Following is a brief summary of the records you'll need in order to claim expenses related to your private practice income.

To deduct car expenses on your tax return, you need to know how many miles you've driven for business during 2004. If you haven't been keeping a log, take some time to recreate your deductible mileage. Use your appointment book as a reminder of the business stops you made and don't forget trips to the office supply store, to your own therapy, or to your consultant. If you went to the same location on a regular basis, find out how many miles it is to get there and back and multiply that figure by the number of times you traveled there.

You'll have additional allowable mileage if you qualify for the office-in-home deduction because you can include as business mileage the trip from home to your first business stop and from your last

business stop back home. In order to qualify for the home office deduction, you must have a space (not necessarily a separate room) that is used exclusively for your business. In addition, if this is not an office in which you meet with clients, it must be the place you do the administrative work for your business. If you qualify for the home office deduction, gather together information about the amounts you paid for mortgage interest or rent, utilities (including garbage), insurance, repairs, etc.

Even if you can't claim a home office, you can deduct telephone expenses. If you have only one phone line in your home, you can't deduct any of the monthly service charges, but you can take the cost of individual long distance business calls. Review your phone bills and circle the deductible calls. If you have a second phone line or a cell phone, you can deduct the monthly charges to the extent that line was used for business.

Equipment and furniture purchases can also provide a tax deduction. You can choose to either

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for adaptive functioning and satisfaction in life through outward manifestations of those resources. These resources were seen as basic, experience-near capacities. The capacities were defined as “low-level constructs” that could be inferred readily from an individual’s behavior, including from feelings and mental states that a person might report in therapy or clinical interviews.

### The Development of the Scales of Psychological Capacities (SPC)<sup>3</sup>

*Content Validity.* It was important to develop a measure that could be useful to any of the major psychoanalytic theoretical perspectives. Drawing on collective psychoanalytic theory, PRPII defined 17 capacities/resources conceptualized as diverging from a zero anchor point of optimal functioning to either a direction of exaggerated or inhibited expression. These included capacities in the areas of self attributions (e.g., self-esteem), self regulation (e.g., affect regulation), and relations with others (e.g., trust). Practical clinical experience told the group that a patient might deviate from optimal expression on any capacity in more than one direction. For example, on the *Hope* scale, a person might unrealistically vacillate between Extreme Optimism and Extreme Pessimism, depending on context and state.

Measure development first requires verification through consultation with experts that the content reflects the domain. One hundred and ten experts, representing the major psychoanalytic perspectives, were asked to rate the scale set as a whole as to its *comprehensiveness*, list any capacities to be added or deleted, and rate each defined capacity as to its *importance*, *clarity* and *vividness*. Sixty-two experts responded; all indicated support for the comprehensiveness of the scales and some suggested modifications in the scales. The result was a set of 36 scales measuring deviation from optimal functioning on the 17 capacities.

*Reliability.* An important next step in measure development is the establishment of reli-

ability. Can different clinicians observing the same person agree on the set of ratings made with the SPC? A manual for use of the SPC was written, and a standardized method to obtain information about each of the capacities was devised in the form of a semi-structured interview. The interview includes a series of questions about functioning for each capacity. These are used to stimulate open-ended disclosure. A preliminary reliability study was conducted on a psychiatric outpatient sample, but the range of functioning was too close to optimal to be useful for establishing reliability. At this point, I joined the group to help conduct the reliability study<sup>4</sup> at Langley Porter Psychiatric Institute, which treated relatively severe psychopathology in addition to the higher functioning neurotic patients. Included in the design of this study was a small battery of self-report and symptom measures, which were used to investigate validity. We trained a group of clinicians to use the SPC and were richly rewarded when our four clinicians observing videotaped interviews of the same individuals agreed to highly acceptable levels on the scale values assigned for patient functioning. Low correlations with patient self-reported symptom measures (e.g., SCL 90) demonstrated that the SPC was not simply measuring symptoms. In contrast, significant and consistent patterns of correlations with other personality measures in the battery, such as the Inventory of Interpersonal Problems and measures of attachment style (a dissertation by Leslie O’Connell) supported the validity of the SPC as a measure of personality. This was great news, but we still needed to know if the SPC actually would be sensitive to changes in personality structure that presumably result from psychoanalytic psychotherapy and psychoanalysis.

*Sensitivity to Change.* The study design was straightforward. We proposed a pre-treatment assessment followed by a post-treatment assessment of a patient population undergoing long term treatment. Assessment on the SPC could be matched with other measures of patient change, including clinical assessments. We had to take account, however, of how ratings on the SPC might change simply as a function of time or

repeated assessment. Known as test-retest reliability, this type of reliability looks at the stability of the measure over repeated assessments. Using a non-patient study sample we demonstrated that, over a 5 month interval, the SPC was very stable. We were now ready to proceed with our final measure development study. And this is where we are currently, soliciting patients at the SFPI and at the San Francisco Jungian Institute. We encourage anyone who wishes to get involved to contact us.

In the meantime our colleagues from the psychoanalytic communities in Germany and in Sweden have been working on these same issues using the SPC. Dorothea Huber and Gunther Klug in Germany have conducted an impressive series of well-designed studies to examine inter-rater reliability, concurrent validity, and discriminant validity of the SPC and have favorable results showing sensitivity to change from a pre-post treatment study and differential SPC profiles for different DSM-IV diagnostic categories. Marianne Leuzinger-Bohleber with the German Psychoanalytical Association is using the SPC as part of a large, follow-up assessment of patients who have completed psychoanalysis. Eva Sundin in Sweden just published results demonstrating agreement with Blatt’s typology of psychopathology and DSM-III-R diagnoses in a primarily inpatient sample. Recent use of the SPC by John Lundin in his dissertation project suggests further the potential for reliable ratings from individual psychoanalytic sessions.

### The Program on Conscious and Unconscious Mental Process (PCUMP)

Well developed and sensitive outcome assessments become especially important when the goal is to measure what it is in the therapeutic process that brings about change. Research on therapy process has involved a diverse range of approaches, including the early and general focus on patient-therapist communications, the more specific attempts to measure therapeutic interventions, enactment, and therapeutic bond, the study of sig-

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nificant, isolated therapy events as clinically 'meaningful units,' and assessments of level of patient participation. More recent technological advances have allowed for greater integration of these various therapist and patient measures and for the development of increasingly sophisticated methodologies to explore mental processes not possible several decades ago.

Psychoanalytic and psychodynamic theories accept that unconscious mental processes exist and have a profound and lasting influence on conscious life. This assumption, while difficult to test in clinical settings, began to receive renewed attention when experimental paradigms developed earlier in the twentieth century were transformed to answer specific empirical questions. PCUMP emerged during this period of active re-engagement with the concept of the unconscious, at a time when technical advances made measuring unconscious processes all the more possible. The aim of PCUMP was to develop methods and paradigms to study unconscious processes and their effects on emotions and other conscious processes.

### The Theory

The theoretical perspective that piloted PCUMP was developed in the early phase of the program by its director Mardi Horowitz and his colleagues Mary Ewert, Bram Fridhandler, and Charles Stinson. Other influential clinicians consulting with the program, such as Jerome Singer, also had a strong influence on the developing ideas. Horowitz' theoretical stance during the 1980s had moved away from traditional psychodynamic ego-defense mechanism theory toward cognitive control process theory as an explanation of how defensive processes function in instances of trauma and loss. Essential to this convergence of psychodynamic and cognitive theory was the theoretical elaboration of *person schemas*. These hierarchically organized knowledge structures summarize past interpersonal experiences and act as templates against which incoming experiences are measured and restructured for 'goodness-of-fit'

Person schemas can be models of the self, of others significant in one's life, or even of significant relationships (e.g., my spouse and me). These are enduring models established through repeated experiences and slow to change. When life suddenly changes through trauma or loss, a person must revise these models of self, other, and relationships to correspond with the new reality. In some cases, however, a person cannot accept the change and defensively avoids it, maladaptively maintaining the existing relational schemas.

Person schemas have significance for an individual's *state-of-mind*, acting as potential triggers for different states. States-of-mind are not simply moods or emotional tone, but reference a set of behaviors that index a cognitive control process aimed at regulating emotional experience as well as expression. Fear and apprehension, for example, can be experienced and expressed directly in a *well-modulated state*, with noticeable agitation in an *under-modulated state*, or in a deliberately communicative but artificial manner in an *over-modulated state*. Part of an individual's personality is a collection of such potential states-of-mind, with these states shaping an individual's experience of thoughts and memories associated with stressful events.

### Studying the Process of Grief

The theory, applicable to the dynamics of many life changing events, was applied specifically to bereaved individuals in the research done at PCUMP. Manifestations of severe grief reactions in the bereaved include unwanted and intrusive thoughts and avoidance of reminders of the loss. Unbidden intrusions and avoidance are arguably the influence of unconscious processes. It was expected, therefore, that in such cases dynamic changes in several areas of mental process could be observed as the distress evoked by discrepancies between the felt security of formerly adaptive schemas and the new reality threatened to propel a bereaved individual into an undesired state-of-mind. On the one hand, the person might try to deny the event by avoiding any information that related to the trauma or loss. At the same time, there would be the tendency to begin processing the event, with the consequence that intrusive thoughts and

images could intermittently pre-occupy and emotionally overwhelm the person. Such attempts at processing might be triggered internally by contradictions and conflicts that remained unresolved, particularly evident if the loss were traumatic. By studying an intensive psychotherapy of a severe grief reaction, it was hoped that behavioral evidence of attempts to regulate states-of-mind during the therapeutic process of reworking person schemas would be observed.

### Measure Development

It was at this point that I joined PCUMP, with the directive of developing measures that had been already loosely derived from the theory. Working with the team of highly skilled clinicians (at this point also including Steve Reidbord), we set about developing a suite of measures to capture emotionally progressive and defensive processes, states-of-mind, and person schemas. In many instances we worked as well by drawing on a larger network of scholars and scientists, creating task forces around the development of measures and the study of specific areas including *emotions, topics, person schemas* and *defense processes*. The results of this fruitful and highly engaging period are contained in several volumes and a multitude of papers (see references below). Much of the painstaking work described above for the development of the SPC was followed for the development of these measures, with the satisfying result that most could be reliably scored, showed evidence of validity by consistent correlations with other measures, and proved sensitive to patient changes during the course of psychotherapy.

### Single Case and Large N Studies

The utility of these measures was tested through the single case study. Two cases of pathological grief reaction were published. In one, our exemplar case, the full suite of measures was applied with astonishing results that detailed the re-schematization process and changes brought about during the year long recorded therapy. For example, we were able to characterize the structure of different states of mind using a combination of our measures, others already in the field (e.g.,

Lorna Benjamin's SASB), and patient physiology (yes, patient and therapist were wired!), and we related these states of mind to topics under discussion. In one study I directed, the re-schematization process was observed through a change in topic sequencing from the first to second half of therapy. The sequence structure in the first half suggested an almost obligatory connection between specific topics in the patient's mind, whereas the structure during the second half showed increased flexibility as the patient moved more freely between topics. In the last years of funding, we turned our attention to testing the theory on a large group of bereaved individuals. In general, results from the two year follow-up study confirmed much of what was demonstrated for the single case studies.

## The Natural Experiment

I have discussed studying the process of patient change, but I would be remiss if I did not also say something about studying what it is in the treatment process that accounts for therapeutic change. I had a rare opportunity to work with Michael Bond and Stephen Cooper on a joint project of assessing 30 brief therapy cases of grief that had been archived at our program. Bond and Cooper had developed a measure of therapist's verbal actions, the Psychodynamic Intervention Rating scale. We used this measure to rate the therapist talk, segmented as small idea units, in the 4th hour of the grief therapies. The correspondingly segmented patient talk was rated with PCUMP developed measures of emotionally progressive and defensive verbalizations. Using sequential analysis to explore the patient therapist interaction, we found that when the therapist made either a transference or a defense interpretation, the patient reliably followed with clinically significant disclosures. Such significant disclosures on the part of the patient were followed in turn with patient defensive verbalizations, suggesting a presumably unconscious control mechanism that kept the patient from being overwhelmed by the disclosure. It is just this sort of process in therapy that ought to lead to positive outcomes for patients. And in fact, we found that defense interpretations

were associated with the best outcomes 5 months post treatment. Transference interpretations did not show an association, but these were infrequent in the hour of these therapies. Support strategies, however, which were not associated with specific types of disclosures during the hour, were also associated with the best outcomes 5 months post treatment. Our results were quite interesting in light of the earlier work done by Wallerstein (see below) which showed a blurring of supportive and expressive techniques in therapies that were ostensibly specifically either expressive or supportive treatments. In addition, Wallerstein found the strongest association between supportive *mechanisms* and positive change regardless of the type of treatment. The supportive *mechanisms* measured by Wallerstein, however, were much more extensive than the supportive therapists' actions measured in our study.

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Constance Milbrath, Ph.D., has been an Assistant Adjunct Professor in the Department of Psychiatry at University of California, San Francisco. She is currently involved in research on adolescent romantic relationships through the Department of Pediatrics. Dr. Milbrath may be contacted at milbrat@itsa.ucsf.edu.

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## Notes

1. The Program on Conscious and Unconscious Mental Processes was funded by the John D. and Catherine T. MacArthur Foundation from 1984-1994.
2. In the last 5 years many new measures have become available. These are enumerated in Dewitt (in press).
3. This research was funded by grants from the Psychoanalytic Research Fund of the American Psychoanalytic Association, the International Psychoanalytic Research Fund and the Windholz Memorial Fund for Psychoanalytic Research of the San Francisco Psychoanalytic Institute.



expense the cost of these items all in the year of purchase (up to \$100,000 of your major purchases can be treated this way) or to depreciate the cost over the IRS' mandated 5 or 7 years.

One thing to keep in mind is that all equipment and business expenses that are charged by December 31st can be deducted on your 2004 tax return, even though you won't be paying the charge card bill until 2005.

Interest you pay on your charge card can also be deducted. If you use one card exclusively for business, those finance charges are 100% deductible. If your card is used for both business and personal expenses, you'll need to prorate the interest you paid.

Another task you can do now in preparation for April 15th is to review your business travel. The cost of transportation, lodging, and meals for conferences and other related

trips is deductible. Meals are only 50% deductible so those amounts should be added up separately. The 50% limitation also applies to your at-home business meals. Be sure that each receipt indicates with whom you were eating and what was discussed.

Adding up the amounts you've paid independent contractors and consultants during 2004 is another year-end project. If you've paid any of them \$600 or more, you'll need to give them a 1099 form by January 31, 2005. This includes your own therapist, if you're planning to deduct your therapy as a business expense. You also need to issue 1099 forms to bookkeepers, client or group consultants, and (surprising to many people) the person to whom you pay rent for your business office. Now's the time to make sure you have the name, address, and social security number of anyone for whom you'll need to issue a 1099 form.

The time you spend looking at your taxes before year end is valuable time spent. Once December 31st has passed, there is only one

way you can reduce your 2004 taxes and that is to contribute to a retirement account. Although some retirement plans must be set up before the end of the year, you have until April 15th to contribute to an IRA, SEP-IRA, SIMPLE, or solo 401(k) account.

There's no better time than now to review the expenses you incurred this year and to make sure you have the records that will provide tax deductions for you on April 15th.

Jan Zobel, EA is a Bay Area tax professional (enrolled agent) who, for 25 years, has specialized in working with self-employed people, especially psychotherapists. This article is adapted from the new edition of her book *Minding Her Own Business: The Self-Employed Woman's Essential Guide to Taxes and Financial Records*. Jan's seminar "Basic Tax and Recordkeeping Information for Self-Employed People" is being offered January 16th in San Francisco and February 19th in Oakland. For more information, call Jan at 510-482-1015 or go to [www.JanZtax.com](http://www.JanZtax.com)



## Private Practice and the Need to Involuntarily Assess or Hospitalize

Patrick O'Reilly, Ph.D.

There is always the possibility that a private practice psychologist may find it necessary to have a client hospitalized against her or his wishes. The legal basis for initiating an involuntary commitment to a hospital is covered in Section 5150 et seq. of the California Welfare and Institutions Code. The language of the law can be found on line on page 36 of a pdf file at: [http://www.psych-board.ca.gov/laws\\_regs/law\\_summary.pdf](http://www.psych-board.ca.gov/laws_regs/law_summary.pdf).

Clients should be made aware that a 5150 is an "exception to confidentiality" by noting it in the Consent to Services which the client signs at the onset of treatment. The private practice psychologist should prepare for the possibility that a 5150 may be needed. First, the psychologist should know whom to call. The San Francisco Police Department, Mobile Crisis, and many psychologists and psychiatrists with hospital privileges have the legal right to sign an involuntary hospitalization

order. If the client is in a crisis that represents immediate danger or grave disability, then the San Francisco Police should be contacted. If the situation does not warrant assistance from the police, then Mobile Crisis (415/355-8300) will usually respond in a timely manner to a request for 5150 assistance. Besides responding to calls from psychotherapists, Mobile Crisis also takes calls from family members and concerned citizens. Mobile Crisis will do an onsite competency evaluation and, if necessary, transport the client to a hospital for a more detailed evaluation.

Many psychologists and psychiatrists have hospital privileges which allow them to sign involuntary hospitalization orders. It is recommended that private practice psychologists make prior arrangements to collaborate with colleagues who have hospitalization privileges in the event that a 5150 is necessary.

In summary, a 5150 is an involuntary

assessment and treatment modality that sometimes becomes a necessary action for a licensed psychologist. Utilized at the appropriate time, it may avert a tragedy for a patient and put the patient back on the path to recovery. One should be prepared for this responsibility, having phone numbers convenient for the San Francisco Police Department, Mobile Crisis and colleagues with hospital privileges. For more information about the 5150, you may email Dr. Charles Faltz, the California Psychological Association's Director of Professional Affairs at [cpadpa@pacbell.net](mailto:cpadpa@pacbell.net).

Patrick O'Reilly is president of the San Francisco Psychological Association. He is a clinical psychologist with the UCSF Forensic Project. His clients are mentally ill criminal offenders. The opinions expressed in this article are his own and do not represent an official position of the San Francisco Psychological Association.

## New Development in Tarasoff Liability

### Ewing v. Goldstein

The California Supreme Court, by deciding not to review a lower court decision, has created a new source of liability for California psychologists.

The decision arose from a lawsuit against David Goldstein, Ph.D., a licensed MFT. In 2001, Dr. Goldstein's patient, a former police officer whom he had been treating for four years, became depressed over the fact that his former girlfriend had a new boyfriend, Keith Ewing. In June, two days after a session, Dr. Goldstein had a phone contact with the patient that raised sufficient concern that he asked the patient's permission to speak to his father, which the patient granted. That evening, after the patient spoke to his parents of his depression and his thoughts of causing harm to the new boyfriend, the patient's father called Dr. Goldstein, who made arrangements for the patient to be admitted to a nearby inpatient psychiatry unit.

The next day, the inpatient psychiatrist told the patient's father that he was planning to discharge the patient that same day. Alarmed, the father called Dr. Goldstein, who contacted the psychiatrist and urged him to re-consider. The psychiatrist stated that because the patient was not suicidal, he was going to follow through on the plan to discharge him that day. The following day, the patient murdered Keith Ewing and killed himself.

Ewing's parents filed lawsuits against both the psychiatrist and Dr. Goldstein. However, their suit against Dr. Goldstein was dismissed under the protection of Civil Code 43.92, because the only specific indication that he had had of the patient's dangerousness came through the father's report, not directly from the patient. The Ewings appealed this dismissal to the Second District Court of Appeals, in Los Angeles.

The appeals court agreed that their lawsuit against Dr. Goldstein should not have been dismissed. They reasoned that the Legislature

did not intend to shield a therapist from suit in such a situation because, for the sake of public safety, it would want a therapist to consider a communication "from a family member to the patient's therapist, made for the purpose of advancing the patient's therapy" in deciding whether a Tarasoff warning is needed.

Because the California Supreme Court has declined to review this decision, legal authorities have stated that the Ewing v. Goldstein decision is now law in California. That is, a therapist may now be held liable for failing to make a Tarasoff warning based on a communication from a patient's family member.

Unfortunately, this raises ambiguities that will take time (and perhaps more court cases) to resolve. The decision does not, for example, relieve us of the legal responsibility to use clinical judgment in assessing the seriousness of a patient threat before issuing a Tarasoff warning. That is, we can still be sued for unwarranted breach of confidentiality if we issue a warning without a clinically reasonable basis. In fact, the decision may give us the additional task of determining whether the communication has been made "for the purpose of advancing the patient's therapy." This puts us in the difficult legal (not to mention clinical) situation of needing to assess the reliability and motivation of a family member's communication without inappropriately violating the patient's confidentiality.

Many therapists, including myself, accept communications from third parties, but tell these third parties (1) that they cannot reveal whether they are providing services to the patient and (2) that their policy is to share such communications with a patient, both to preserve the necessary openness of the therapy relationship and to pursue the safety issues raised by the communication. In some situations this raises problems, of course, such as when the third party is afraid of retaliation. However, it often works smoothly; and, when it does, it helps to preserve the viability of therapy while still bringing in potentially critical information. It also, of course, allows the therapist to assess dangerousness based on direct

information from the patient, which is arguably much better information than reports from third parties. (Notably, the only apparent obstacle to this approach in the Ewing v. Goldstein case was that Dr. Goldstein did not speak to his patient in the two days between the father's report and the murder-suicide.)

The November 30, 2004 issue of CPA's Progress Notes carried a statement from CPA's attorney on the import of the decision, and the California Psychologist is also likely to include legal recommendations in the near future. These are the best sources of legal advice in the wake of this decision. (Another great reason to join CPA, if you're not currently a member . . .).

Because of the increased liability and the probable undermining of effective psychotherapy represented by this appellate decision, several organizations sent letters to the California Supreme Court vigorously requesting that they review it. These organizations included SFPA, the Alameda County Psychological Association, and CPA (working with the legal staff of APA). CPA has indicated that the available recourse now is to seek legislation overturning the decision. If you favor this effort, you should contact Susan Chandler, Ph.D., SFPA's representative to the CPA Board and current CPA Secretary, at or (415) 551-0061. If you contact her, please indicate whether or not you are a CPA member.

## Patriot Act Update

As readers may recall, Michael Donner, Ph.D. and I, in separate articles in the July, 2004 San Francisco Psychologist, reported that the USA Patriot Act apparently allows the FBI to seek court orders forcing therapists to turn over their records on patients who are under FBI investigation while keeping all this disclosure secret from the patient. We argued that such a situation would force the therapist to harm the patient, in violation of the APA Ethics Code, and that these subpoena powers constitute another in a long line of

*continued on page 11*

The last few months have brought notable progress at CPA, as a number of efforts at the state and federal level have come to fruition. It is nice to be able to report mostly good news in this issue! In addition, the recent CPA election and staff hires have provided leadership that, with your support, will make it possible in the future for us to continue to protect and advance the causes that are important to us.

The Board certified results of the recent CPA election on October 16, naming Dr. Gilbert Newman to the office of President-Elect. Dr. Newman has had a distinguished career in the Bay Area, acting as Director of Clinical Training at the Wright Institute and 2003 President of the Alameda County Psychological Association. In addition, he has served the CPA as chair of the Political Action Committee and as Federal Advocacy Coordinator. Dr. Newman brings to his office a strong commitment to advancing initiatives central to the mission of the organization. In particular, he has pledged to work to protect privileges currently held by psychologists (e.g., the renewal of our current licensing law) and to expand the role of psychologists in our state. Dr. Newman has joined with the majority of CPA's leadership in identifying prescription privileges as an area where progress is particularly important in the next two years, taking advantage of the momentum established by the approval of prescription privileges for psychologists in other states.

CPA also has been fortunate to bring on board Jo Linder-Crow, Ph.D., as Executive Director, effective January 1, 2005. Dr. Linder-Crow brings more than 20 years of senior executive experience in educational and non-profit organizations to her new position as the Executive Director of the largest state psychological association in the United States. Since 2002 Dr. Linder-Crow has served as the Executive Director of The Glendon Association, a non-profit organization in Santa Barbara, California that conducts research and provides education and training for mental

health professionals. From 1995 to 2002 she was the Associate Executive Director for Education and the Director for Continuing Professional Education at the American Psychological Association (APA) in Washington, DC. In these capacities, she represented the APA on issues related to lifelong learning initiatives in psychology.

Among legislative efforts at the federal level that have been important to CPA, the signing into law by the President of the Mentally Ill Offender Treatment and Crime Reduction Act represents a milestone in protection of an individual's rights to appropriate mental health care. The law will improve access to mental health services for adult and juvenile non-violent offenders. "This law places critical resources where they are needed most, on the front lines," says Russ Newman, Ph.D., J.D., APA's executive director for professional practice. "It will improve collaboration among the criminal justice, juvenile justice, mental health and substance abuse treatment systems. It will ensure that both adult and juvenile non-violent offenders with mental health disorders are identified properly and receive the treatment they need from the point of arrest to re-entry into the community, [so that they] are not simply recycled into the system."

At the state level, CPA's legislative efforts have also led to substantial progress over the last few months. One important success was the defeat of State Bill 1853, a bill that would have added diagnosis to the professional role of clinical social workers in our state. The bill was sponsored by The California Society for Clinical Social Work, on the grounds that LCSWs receive sufficient training to make accurate diagnoses. Our research had showed that the curriculum offered by the accredited Social Work Master's Programs did not contain key classes in psychopathology, biological bases of behavior, neuropsychology, assessment, tests and measurements, or psychodiagnosis, all of which we felt were integral to maintaining reasonable standards for the effective identification of mental disorders.

One of many other state legislative issues in which CPA was recently involved was the pulling of State Bill 730 from hearing before the Assembly Judiciary Committee. The bill would have allowed custodial parents to relocate with their children without legal constraint. Under the provisions of the bill, a child's best interests would not have been considered by the courts when determining child custody arrangements. CPA was active in opposing this bill, citing the vast psychological research indicating the importance of children's interests being taken into consideration in these cases.

CPA's efforts often are directed at enforcement of existing laws — an important focus, given that there is often a gap between the role the state has assigned to psychologists legally and the actual constraints put on our profession in practice. One such case in the last few months involved the omission of psychologists as Independent Medical Reviewers (IMRs) in California's Workers Compensation system under proposed state regulations. When CPA learned of that omission, advocacy staff quickly researched the issue and determined that staff in the Division of Workers' Compensation in the Department of Industrial Relations was not well informed about the relevant law. The CPA governmental affairs staff sent a strongly worded letter of comment, which argued that the underlying statute required that psychologists be eligible to be IMRs. The result was the successful establishment of psychologists as IMRs in California's revamped Workers Compensation system.

Recent successes do bring into focus the impact that the CPA can have in our professional mission to see adequate mental health care provided to the citizens of our state. Part of that mission is to ensure that the training we have received as psychologists is understood and legally protected by those who make decisions about how mental health care is provided. In the dynamics of an evolving

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Norman Zukowsky, Ph.D.

## Upsizing the Private Practice Bottom Line

Review of *Essentials of Private Practice: Streamlining Costs, Procedures, and Policies for Less Stress* by Holly A. Hunt (W. W. Norton, New York, NY, 2004)

Somehow, in my peregrinations through life, I neglected to pick up an MBA. I had other interests, which eventually led to a doctoral degree in psychology. It did not occur to me to consider my lack of a graduate business education a deficit until I made the leap to private practice. Like many of my peers, I was a bit taken aback to discover I had to market myself. Wasn't that, I had mused, what one did to introduce a new brand of soft drink? But we clinicians are nothing if not flexible, pragmatic, and eager to learn (always looking to provide a good model for our patients). I learned that marketing (MBA lingo) is all the things we do to bring in the patients who in turn generate gross receipts (accounting jargon).

Receipts are not the same as income, however. Drat. Income equals receipts minus disbursements or costs. So while having an adequate number of patients is an absolute necessity for a successful practice, it can be undercut if expenses are high. And income can be maximized at any number of patients by keeping expenses low. There are a number of books, tapes, and, according to my mailbox, an unending stream of consultants and seminar givers eager to teach the private practitioner how to get more patients and thereby increase receipts. But the expenses part of the equation appears to be a relatively neglected subject. That has been corrected.

Holly Hunt is a psychologist in private practice in Southern California, and she has written a highly informative and useful guide to the nuts and bolts of private practice, with an eye to keeping costs low and procedures efficient, thereby maximizing income. The text is clear, an easy read, and the information concise and to the point, much as if a colleague were sharing his or her experience. Cautionary vignettes and stories illustrative of happy solutions add

to the conversational tone of a friendly mentor giving pointers.

The content is comprehensive, covering everything from how to estimate expenses before opening a practice—a business plan—to the details of cancellation policy and how to talk on the phone to insurance providers. The work is most useful therefore to someone just beginning or, even better, just thinking of going into private practice. I wish I had had this book then; it should be handed out with diplomas. For example, the discussion of the relative advantages and pitfalls of individual practice and group practice was impressively thorough. But it is so full of hints and information that I imagine almost any practitioner will find food for thought and enough useful ideas to justify a reading. For instance, I did not know that one could negotiate better rates with communications service providers when one renews; I'm going to try it. I found the discussion of the plethora of options in communications devices and services useful as well. And the author persuaded me to reconsider the advantages of requiring the fee at the beginning of sessions rather than at the end.

The work is well organized, and especially useful are the frequent sidebar boxes that list essential issues with recommended solutions. A number of checklists and sample forms at the end add to its value as practical workbook. I thought the sections on potential insurance billing problems and phone policies—an entire chapter on each—were particularly good in laying out and simplifying difficult topics, thinking through complex alternatives, and making sensible recommendations.

As a psychologist, the author understands the importance to the practitioner of not just monetary costs but also psychological costs, how one can lead to the other, and the fre-

quent difficulty in separating the two and making wise tradeoffs. Much of the discussion is oriented toward reducing psychological costs—saving time, lowering stress, and simplifying life in the fast lane of private practice. Importantly, one has the sense of listening to an experienced clinician who is always sensitive to the fact that, in our line of work, every self-interested business decision has clinical and sometimes ethical implications. When her advice regarding cutting costs or streamlining procedures overlaps with therapeutic concerns, she addresses them directly, often with sound advice, and with the priorities we hold dear as professionals. She is sympathetic to gray areas of practice and decision-making, and to the personal preferences of individual psychologists.

I would have liked to have seen more on setting fees and also more on taxes, but taxes for the self-employed professional requires its own book, I think. Also, email and websites are not considered, nor are the non-therapy but for-money activities that many clinicians pursue. But those are quibbles in the context of this book's overall usefulness. It provides ample, practical, on-target information delivered with a friendly attitude. And, speaking of keeping costs low, it's a good value at a list price of under twenty dollars. A book that walks its talk. Maybe they could use that for marketing.

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Norman Zukowsky, Ph.D., is a psychologist in private practice in the Hayes Valley/ Civic Center area of San Francisco. He also is the 2005 editor of *The San Francisco Psychologist*.



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## Letter to the Editor

To the Editor:

I generally agree with the article on evidence-based treatment published in the September issue of *The San Francisco Psychologist* but wonder whether many may balk at the arduous task of administering patient questionnaires? Short of that procedure, I believe that introspection, review of clinical notes, and less formal client feedback may also assist quality control.

Introspection and analysis can at least partially reveal what induced a client to leave therapy before resolving the initial, presenting issues. Research shows that the therapeutic alliance is crucial to healing (see [www.talkingcure.com](http://www.talkingcure.com)). I ask myself, and if possible, the client, about what may have breached that alliance or prevented it from consolidating and even whether the client perceived a breach. I also consider what theory or treatment approach might help me better understand someone like the client in order to fill my educational gaps.

I also review my countertransference to see whether the client's presentation may have elicited blinders to other possibilities, or whether my preconceptions may have interfered with holding unconditional positive regard. Then there are such mundane concerns as whether I was tired or preoccupied during some sessions.

Another common dilemma is focusing too little or much on client goals versus an ongoing appraisal of hypothetical unconscious issues. How does one strike this balance? Also, is there a hidden effect of believing strongly in a manualized treatment or theory? I'm reminded of Milton Erickson's mastery of telling healing stories. What if presenting a healing framework that specifies procedures and explains many client experiences is in itself soothing and more of a relational element than a confirmation of the theory behind the story? Research at the above source shows that clients benefit more from the relationship in general than from different theoretical approaches, with the exception, of course, of specific conditions that benefit more from specific techniques.

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Gary Seeman, Ph.D., is a psychologist in private practice in the Financial District of San Francisco and in Corte Madera. For more information, visit his web site: [www.drgaryseeman.com](http://www.drgaryseeman.com).



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## California Psychological Association

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profession and a changing society, our continued vigilance is greatly needed. As always, this work can only continue with your support and involvement! If you are interested, more information is available at [www.calpsychlink.org](http://www.calpsychlink.org).

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### REFERRALS AND GROUPS

THE FOLLOWING GROUPS are led by Art Raisman, Ph.D., Licensed Psychologist (PSY7795); Assistant Clinical Professor, Psychiatry Dept., UCSF; Past President, Northern California Group Psychotherapy Society, 415/453-4271:

1. THERAPY GROUP FOR THERAPISTS - Open to mental health professionals and trainees. Mornings, San Francisco and San Rafael.
2. ADULT PSYCHOTHERAPY GROUPS - Long-term, psychodynamic, for men and women. Evenings, San Francisco.

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### Ethics and Issues

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regrettable intrusions on the privacy of psychotherapy.

Legal sources have provided further clarity about this situation. They indicate that FISA, as amended by the USA Patriot Act, does indeed permit secret subpoenas of therapists records (though not of oral testimony). Therapists would be prohibited from revealing the subpoena or subsequent disclosures to the patient, but they should be permitted to consult attorneys. These sources are not aware of whether any such subpoenas have actually been issued. It is possible that the federal psychotherapist-patient privilege would trump such subpoenas, if the therapist forced the issue by asserting the privilege on the patient's behalf.

The legal team in the APA Practice Directorate has concluded that the best strategy for

opposing this intrusion is to work with Congress as bills come forward to renew the Patriot Act, which, unless it is renewed, will expire at the end of 2005. However, they have expressed interest in intervening in an individual legal case challenging the law, if a practitioner is actually adversely affected by application of the statute. They urge psychologists to contact them if they become aware of any practitioner whose records are seized as a result of this Act (email [abowman@apa.org](mailto:abowman@apa.org) or call 202/336-5886).

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Bram Fridhandler, Ph.D., is Ethics Chair of the San Francisco Psychological Association and is in private practice in Pacific Heights. His law and ethics workshop is available in home study format by calling 415/409-9800 or going to [www.fridhand.net](http://www.fridhand.net). The opinions and interpretations presented in this column are his own and do not represent an official position of the San Francisco Psychological Association.

# Submitting Articles and Advertisements to *The San Francisco Psychologist*

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Half Page (4 <sup>3</sup> / <sub>4</sub> " x 7 <sup>1</sup> / <sub>2</sub> " )	\$90	\$110
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## ARTICLE SUBMISSIONS

Please let us know if there is a contribution that you would like to make to the newsletter this year. It is after all the expertise, creativity, and knowledge of our membership that will make

the bulletin as interesting and useful as it can be! We welcome a range of submissions, including letters to the editor, announcements, opinion pieces, research findings, book and movie reviews, reports on conferences attended, as well as articles about topics of professional interest. We do reserve the right only to accept articles deemed to be of particular interest to our members, so please do contact the editor as you are developing your ideas.

If you would like to submit an article, place an advertisement, or just have comments or ideas to share, please Norman Zukowsky at [normanz@lanset.com](mailto:normanz@lanset.com) or 415/885-2470.

### Publication Schedule and Deadlines for 2005

March issue	February 21
June issue	May 24
September issue	August 24
December issue	November 23

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