



# The San Francisco Psychologist

A publication of the San Francisco Psychological Association; a chapter of the California Psychological Association

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MARCH 2004

## The Homeless Veterans Rehabilitation Program

### Helping the homeless re-establish their lives through integrated, contingency-based treatment.

*Keith W. Harris, Ph.D.*

Until it was bumped from the front page by gay marriage, homelessness was the issue of the day in San Francisco. It remains a serious problem. Despite the efforts of service providers, politicians, and the homeless themselves, far too many people continue to live dangerous and unhealthy lives on the streets. In this article, I will describe a program that has had tremendous success treating homeless veterans over the past 16 years: the Homeless Veterans Rehabilitation Program (HVRP), located at the VA hospital in Menlo Park.

In an average year, between 2.5 and 3.5 million individuals are at least temporarily homeless. Approximately 97% of homeless individuals are male, and roughly 40% are veterans. Homelessness is often accompanied by comorbid disorders, with 45% of homeless individuals exhibiting psychiatric disorders and up to 70% being substance dependent. The state of California has approximately 30,000 homeless individuals at any given time, more than twice the amount of any other state in the country, and between 3,000 and 15,000 (depending on the estimate) live in or around San Francisco. It has been estimated that only 10% of homeless individuals receive treatment in a given year, and current sociopolitical events (e.g., the war in Iraq, unstable economy) will undoubtedly lead to an increase in the number of homeless veterans in the next few years. Homelessness is not



going to go away on its own. In fact, it may get worse before it gets better.

### Case Study

Meet Martin (Martin is not a real person; to preserve confidentiality he is an amalgamation of many residents of HVRP). Mar-

tin is an African-American male in his mid-40's. Like nearly all residents of HVRP, Martin was homeless and addicted to drugs when he entered treatment. His history with drugs is typical of many residents here: He experimented with drugs before entering the military, but it was his experiences on base and in combat that permanently impacted his life. There, he had ready access not only to cigarettes and alcohol, but also to marijuana, heroin, amphetamines, depressants, and hallucinogens. He learned to take drugs not only recreationally, but also to quell his fear, loneliness, sadness, and anger. In time, drugs became his only means of handling negative affect. An 18-year-old recreational drug user when he entered the military, Martin left the military a mid-20's addict with a host of mental health problems, including PTSD, depression, and a more general well of painful negative feelings that he was doing his best to eliminate by whatever means necessary.

Like many others, he barely finished high school, so his only job skills were those he acquired in the

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## The San Francisco Psychologist

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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 [cannonthomas@sbcglobal.net](mailto:cannonthomas@sbcglobal.net) or mailed to the editor at the above address.

**415/681-3063**

# The President's Column

David G. Bullard, Ph.D.

I'd rather learn from one bird how to sing  
Than teach ten thousand stars how not to dance  
—e.e. cummings

At the SFPA December social gathering at the beautiful home of the ever-gracious Sung and Haeju Kim, Paul Watsky and I happily agreed as Past-Presidents to help the organization by serving as consultant and president, respectively, until June, 2004, when President-Elect Patrick O'Reilly will assume the office. Patrick brings to our organization a wealth of experience and talent from working in the public sector at SF General and UCSF. We are lucky to have him. I have invited Patrick to give us a talk on "Undue Influence," about his work with the late Margaret Singer on cults. They studied the Manson family, for example, and it will be a most interesting talk with many ramifications for clinical practice. The talk will be at 8 PM, following 7 PM dinner, on Friday, May 14 at Delancey Street Private Dining. Also, members are invited to join in a social/networking hour at 6:30 PM on Friday, April 2 at Laurel Heights Con-

ference Center, UCSF, to meet old and new friends.

A love of learning and growing brought most of us to the profession of psychology and hopefully continues to enrich us. At the February Board Meeting of the San Francisco Psychological Association, the positive aspects of the various crises this organization faces became more apparent to me. As each person present described his or her efforts to empower our organization in its mission to help our members and the people we serve, I "pendulated" between awe at the tasks yet to be done and gratitude for the intelligence, wisdom, and dedication evident in these members. Susan Chandler, wearing many professional hats for us, as well as having been elected Secretary of the California Psychology Association, is fully engaged in representing us at local, state and federal levels. June Carrin continues with the Herculean (and sometimes midwifean) task of expanding and deepening the impact of the Information and Referral Service. (If you haven't seen it yet, check out the SFPA website at

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## The San Francisco Psychological Association invites community psychologists to join their membership

This newsletter is being sent to ALL San Francisco licensed psychologists, in the hope that we can entice you to join the San Francisco Psychological Association—your local chapter of the California Psychological Association. (You do NOT, by the way, need to be a member of CPA or APA to join.) Here are a few reasons we hope you will consider becoming a part of our organization:

- Become more connected to your colleagues in the psychological community
- Have access to and participate in the Information & Referral (I&R) service
- Receive our quarterly newsletter. As a new member, you are welcome to submit a profile to the newsletter introducing yourself to the community.

- Pay less for continuing education workshops with an SFPA discounted registration
- Receive important legislative updates and professional information, including job opportunities and office rentals, regularly via email
- Help move our profession forward through opportunities for action at the city and state level

If you join by April 15, you are eligible for a discount rate of \$70 for annual membership, so let us hear from you! For more information, call SFPA's Information and Referral number, 415-681-3063.

Applications are available online at [www.SFPA.net](http://www.SFPA.net). Be sure to specify on the application that you are applying at the discount rate.

# Mind and Body in PTSD

## Bridging the Gap between Research and Practice

*Kasey Saltzman, Ph.D.*

Research and clinical worlds are particularly poorly integrated in the field of trauma. It is ironic that even at VA hospitals, home to renowned multimodal inpatient and outpatient PTSD treatment programs as well as epicenters for major PTSD empirical research (i.e., the National Centers for PTSD), there is often little overlap between the work of clinical and research staff.

In some ways, this may represent our field's general tendency to polarize research and applied clinical work. However, even in the area of treatment approaches, there has been conflict. Researchers such as Edna Foa have repeatedly documented that Cognitive Behavioral Therapy (CBT) is the most efficacious treatment for PTSD. This approach involves slow, systematic, repeated review of the traumatic experience, deliberately exposing the client to detailed trauma imagery. This technique, referred to as prolonged exposure (PE), is designed to help the client to reduce emotional, cognitive, and physical reactivity to trauma cues and triggers, and to help gain control and mastery over one's memories and experiences.

Despite the converging evidence that CBT and PE are consistently efficacious in the reduction of PTSD symptomatology, demonstrated by well-designed clinical trials, there is a significant reluctance on the part of many clinicians to unilaterally adopt these standardized protocols or techniques. In many ways, this reluctance appears to be based on discomfort with the admittedly sterile and blunt CBT techniques. Exposure-based treatment is very challenging and sometimes unpleasant to a client, and the actual drop out rate can be quite high. CBT techniques also de-emphasize the unempirical "therapeutic relationship" in treatment. Many clinicians feel this has its own curative power in trauma work, re-establishing a sense of connection and interpersonal relatedness when dissociation, depersonalization, and personal estrangement have occurred. Clearly this can appear to be at odds with a manualized treat-

ment protocol where one of the main selling points is the neutrality and fungibility of the providing clinician.

Some clinicians also believe that research protocol populations are so homogenous and "clean" (i.e., all comorbid disorders are screened out) that they no longer represent an accurate or realistic prototypical PTSD client. In fact, the National Center for PTSD guidelines specifically state that PTSD has a high comorbidity rate, and that "the best treatment results are achieved when both PTSD and the other disorder(s) are treated together rather than one after the other." Another view is that CBT and PE are reductionistic, neglecting to focus on the full impact and meaning of the traumatic experience. Excising certain symptoms in the absence of processing and integrating the totality of the experience appears to some to be unfeeling and cold, not to mention lacking in ecological validity.

This challenge to integrate PTSD and trauma research and practice has recently become especially evident around the issue of mind and body relationships in the disorder. In many ways, part of what makes PTSD such a multifaceted and complex disorder is the broad spectrum of symptom presentations. As in other Axis I diagnoses, traumatization can result in both cognitive dysfunction (intrusive recollections, sense of foreshortened future, difficulty concentrating, avoidance of thoughts, feelings and conversations about the trauma), as well as emotional dysfunction (irritability or anger, restricted range of affect, feeling estranged from others, decreased interest in formerly pleasurable activities). Increasingly, both researchers and clinicians are focusing on a third component of PTSD presentation, namely physiological dysfunction (physiological reactivity, hypervigilance, exaggerated startle response, flashbacks).

Many clinicians have been focusing more on the role of the body in the treatment of trauma. Borrowing from the work and theory of bodyworkers or somatic therapists, psy-

chotherapists are re-evaluating the role of the body, especially with regards to traumatic memories. One of the major proponents of mind-body integration in trauma is Babette Rothschild, who believes in somatic memory, or the encoding of physical memory in the body that must be released in order to improve functioning. Similarly, Peter Levine has hypothesized in his theory of somatic experiencing, that trauma response is interrupted and put on hold, resulting in an incomplete response that cycles over and over in hyperarousal, never culminating in physiological release and processing. Therapy, in his estimation, must include breaking out of this loop by means of utilizing body exercises to increase sense of physical efficacy and safety. Pioneering body oriented therapist Pad Ogden has also developed sensorimotor psychotherapy, specifically designed to utilize bodywork techniques to treat victims of trauma.

There has also been an explosion of physiological and neuroanatomical research on PTSD, with numerous studies detailing dysfunction or frank alterations in the brain in the context of trauma and PTSD. Rachel Yehuda has detailed significant alterations in the plasma levels of cortisol in traumatized persons. She has found that cortisol, a diurnally fluctuating hormone that typically increases in reaction to stress, has a paradoxical decrease in persons with PTSD. Neuroimaging experts such as Scott Rauch, Lisa Shin, Michael DeBellis and Douglas Bremner have also documented in PTSD significant brain alternations, both structurally and functionally. Roger Pitman and Scott Orr have also conducted pioneering work on physiology of PTSD response.

While both researchers and clinicians are increasingly focusing on the role of the body in PTSD, there appears to be particularly acrimony about the nature and meaning of this role. For example, one area of particular controversy has been Emotional Desen-

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The California Psychological Association is holding their annual convention, *Change: The Power of Psychology*, at the Hilton Mission Bay Resort in San Diego, March 25–28. More information can be found online, at [www.calpsychlink.org](http://www.calpsychlink.org). I encourage all of you to take a look at the website for complete information about the wide range of workshops that will be available during the convention.

One event occurring at the convention is likely to be of interest even to those who will not be able to attend. Working as chair of a task force for Division I of the CPA, our own Ethics Chair Bram Fridhandler, Ph.D., has recently completed a project intended to provide all of us with practical guidance on ethical and legal matters. Psychologists do not have legal training but encounter many situations calling for legal and ethical knowledge. Current sources of guidance are often conflicting, confusing, or outdated. Moreover, conventional recommendations are often directed at risk management, with less consideration of clinical issues and practicality. In order to address these needs, the task force has revised an existing set of documents known as the Expertise Series.

In producing this set of revisions, the task force attempted to generate concise, clear, authoritative documents on issues of concern to all psychologists. They reviewed pertinent statements of the standard of care, in order to help members avoid legal and regulatory risk and to promote safe, effective care of the public. In so doing, however, they sought to avoid “raising the bar.” That is, they avoided standards that require more time, effort, or intrusiveness than is genuinely necessary for reasonable risk management and effective, ethical care.

At the convention, the seven documents this task force has produced will be summarized and questions from the audience will be answered. If you are unable to attend, you are strongly encouraged to contact CPA in order to receive a copy of these important

materials. They are available to all Division I members without charge and to other CPA members for a small fee.

On the legislative front, CPA has been particularly active in recent months. I have included an invitation on this page asking for your involvement in our legislative efforts at this particularly important time. One recent bill represents just an example of the challenges our Legislative Team is currently facing. The bill, introduced by Assemblyman Alan Nakanishi, is an unprecedented attack on California psychologists’ scope of practice. Specifically, the bill would nullify psychologists’ authority to diagnose and treat major mental disorders. The language in the bill asserts that several mental/developmental disorders currently treated by psychologists are in fact brain diseases and would mandate that the diagnosis and treatment of these disorders be undertaken only by psychiatrists. The bill is sponsored by the Union

of American Physicians and Dentists.

AB 2793 has its origins in organized psychiatry’s contention that mental disorders are biological; and, therefore, only psychiatrists should lawfully be able to diagnose and provide treatment. The Psychologists’ Practice Act currently provides the authority to diagnose and treat all mental disorders. Since there is a biological component to all mental disorders, the effect of this legislation would be to severely curtail the independent practice of psychology in California.

The CPA Legislative Team has rapidly responded in opposition to the measure and has remained in daily contact with the author’s office since the bill’s introduction in the State Assembly. CPA has also been successful in building a large opposition coalition of mental health care associations who will join CPA in the effort to defeat AB 2793. We will keep you updated about this and other major legislative issues as they arise.

The honor of your presence is requested at the  
**CALIFORNIA PSYCHOLOGICAL ASSOCIATION’S  
ANNUAL PAC FUNDRAISING DINNER**

Join the PAC Trustees and California legislators for a sumptuous dinner, and then step into the exclusive Turf Club for a fun-filled night of satellite horse racing, blackjack, poker, roulette, and craps.

“A Night at the Races”

Friday, March 26, 2004 at 7:00pm

San Diego’s Mission Bay Hilton

\$250.00 per ticket

(includes Dinner and \$500 Casino credit)

With your generous donation, you will be helping to support CPA’s political action committee, realizing the need and importance of our advocacy and candidate support efforts in Sacramento. In a state where there are 15,000 active psychologists, our PAC is only generating \$50,000 in contributions (\$3.33 per psychologist)—so every contribution can have a substantial impact on moving our issues forward. If you cannot attend, your donation can be made towards a ticket to be used by a psychology student.

Call Susan Chandler, 415/252-9576 or email her at [schndler@pacbell.net](mailto:schndler@pacbell.net) for more information or to make a contribution. Or you can mail a check to her at 971 Page St, SE, CA 94117, made out to CPA-PAC.

## Homelessness

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military. He took a series of blue-collar jobs through his 20's and 30's in an attempt to support himself (and his burgeoning habit), but he found it impossible to be a productive employee while simultaneously using drugs. After being fired from his tenth job, his girlfriend ended their relationship and told him he had to leave. In the ensuing years he alienated his friends and family, even stealing from those who provided him a room in their homes, in an attempt to support his drug habit. After running through all the friends and family who were willing to help, he turned to the streets and officially became homeless.

While on the streets he supported himself through panhandling and robbery. He spent nearly every penny on drugs and alcohol, caught in the vicious cycle of the homeless drug addict wishing his life were better but not knowing where to start: Get a job? He had no solid work history and therefore was not attractive to employers. Get an apartment? He had no money to pay the rent, because he had no job. Stop using drugs and alcohol? He was always awash in urges and painful feelings. Drugs were the only way he knew to quell those feelings. Get treatment? It sounded good in principle, but some programs are run like boot camps. When you're being yelled at for the fourth time in two days, the streets start to sound inviting. Besides, you can get high on the streets, and that urge returns with a vengeance after a few days in treatment. Stay in a shelter? The shelters didn't allow being under the influence or the panhandling and crime necessary to obtain money for drugs. Therefore, Martin stayed on the streets where at least his life had a strange homeostasis: He could make enough money through begging and robbery to buy the drugs and alcohol that would allow him to reach, however briefly, the state of bliss (or nothingness) characterized by the absence of pain, hunger, sadness, loneliness, anger, and fear. It was powerful negative reinforcement, and it kept Martin on the streets, furthering his exposure to the very things that were ruining his life.

He finally came to HVRP after being contacted by an outreach worker who convinced him that many veterans just like himself had

completed the program and gone on to lead productive and fulfilling lives. Tired and beaten down by a life on the streets, he agreed to enter treatment, and the decision literally saved his life.

### The Homeless Veterans Rehabilitation Program

HVRP is a 70 bed program housed within the Palo Alto Domiciliary Service that provides residential treatment to homeless and substance abusing veterans. The Domiciliary Service Chief, Dr. Tom Burling, designed and implemented HVRP in 1988 as an integrated Cognitive-Behavioral Therapeutic Community (CBTC). The HVRP treatment protocol is an empirically based approach that employs several best practice models for the rehabilitation of homelessness and substance abuse. HVRP is a Clinical Program of Excellence as designated by the VA Under-Secretary for Health for the treatment of homelessness, and is arguably the most intensive, comprehensive, and effective veterans rehabilitation program in the nation.

HVRP's mission is "to provide residential and supportive rehabilitation to homeless and/or substance dependent veterans in an integrated therapeutic home-like environment with the ultimate goal of returning each individual to optimal independent living." The philosophy and values of HVRP are summarized by five key concepts, termed the "5 P's," which are exercised equally by staff and residents. *Personal Responsibility*: We value and promote the commitment to take personal responsibility for all aspects of our lives, recognizing that thoughts and behaviors are critical determinants of what happens to us. *Problem-Solving Attitude*: We value and promote the commitment to take a problem-solving attitude to all aspects of our lives, recognizing that we all have the capacity to make choices that will influence our lives in a positive manner. In this respect, we value the use of open and honest feedback and transparent decision-making, by which we can incorporate new information that informs our choices. *Practice*: We value and promote the commitment to continually practice newly learned behaviors, recognizing that change is a process of mastering new skills. In this respect, we particularly value the use of communication skills in working effectively

with each other. *People*: We value and promote the commitment to develop mutually caring and supportive relationships with each other, recognizing that supportive interpersonal relationships are essential to maintaining a substance-free lifestyle. In this respect, we promote an esprit de corps in which we treat each other with integrity, dignity, and respect, while at the same time holding each other accountable for our behavior. *Play*: We value and promote the commitment to play, recognizing that humor, fun, and a passion for life are essential to maintaining a substance-free lifestyle.

In sum, the program ethic states that the recovery process involves assuming personal responsibility as the primary agent in one's life ("I create what happens to me"), employing a problem-solving attitude and practicing new ways of coping (via the program-taught skills), and making lifestyle changes by affiliating with new, clean-and-sober people and engaging in new recreational activities that function as alternatives (i.e., competing reinforcers) to drug/alcohol use.

A listing of the specific program elements includes the following: outreach, screening and admission, assessment and treatment planning, residential treatment with 24-hour coverage, cognitive behavioral therapy, paraprofessional and peer counseling, medical treatment, discharge planning, aftercare, alumni association, evaluation of the quality of patient care services, and long-term evaluation of treatment outcomes. The treatment is delivered by both professional and paraprofessional staff.

The full course of residential treatment at HVRP lasts 180 days and includes progression through three phases via a performance-based transition system. In phase I (lasting 45-60 days), residents receive treatment for problems that are functionally related to their homelessness (e.g., drug/alcohol addiction, poor interpersonal skills, etc.) via full-time participation in the CBTC milieu. In Phase II (lasting 45 to 60 days), residents engage in job-search preparation activities (e.g., vocational testing, resume writing) while continuing to participate at a more advanced level in the core CBTC program. In Phase III (lasting four to six months), residents obtain

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employment and prepare to transition back into society by saving money and developing outside support systems (e.g., 12-step groups, clubs, etc.). A resident is considered a “completer” when he or she has completed the 180 day residential component of the program. A more prestigious accomplishment (and a more positive predictor of long-term outcomes) occurs when a resident becomes a “graduate,” which requires an additional 13 weeks of outpatient group therapy and involvement with the alumni association. An elaborate graduation ceremony attended by roughly 200 people is held bimonthly to honor the most recent graduates. At present, approximately 2400 individuals have received treatment from HVRP, and approximately 450 have graduated.

At HVRP, patients learn a variety of cognitive behavioral (CB) skills in formal classes that they are required to use at all times, and advancement and added privileges in the program are contingent upon them showing an increasing ability to do so proficiently. The specific CB skills (i.e., “tools”) that are taught include double and triple column (managing thoughts and feelings; Burns, 1980), active listening (communicating productively; Bower & Bower, 1976), DESCription (asserting oneself in potential conflicts; Bower & Bower, 1976), disarm and empathy (responding to a verbal attack; Burns, 1980), and relapse prevention (Marlatt & Gordon, 1985). Patients employ the CB skills in settings ranging from the morning community meeting, to meal time in the chow hall, to basketball practice. It is heartening to see a patient at basketball practice begin to lose his temper with another player, only to be rapidly reminded by four other patients to “use your tools”. What follows typically involves the player taking a deep breath and then either active listening, DESCription, or disarming the person with whom he was angry. In this manner, conflict is dealt with respectfully, immediately, and openly, and both participants in the conflict develop a sense of interpersonal efficacy with its resolution.

HVRP is a very rewarding place to be. It is designed to be home-like, not only in appear-

ance, but in “feel.” Residents are required to learn and use all staff and resident first names within two weeks of admission, calling to mind the theme song from Cheers: it’s a place where “everybody knows your name.” When I first began working at HVRP, I brought my wife to a formal dance that was held a week after I started and she was amazed that everyone called me by name. Even more striking was the culture of positive, polite, and engaging social interaction. Driven by the “people” and “play” components of the program ethic, HVRP takes homeless veterans who were essentially dead to the world and imbues them with excitement and interest in their fellow human beings.

A unique aspect of HVRP is the magnitude of the focus on play/recreation, with frequent activities such as camping, fishing, ski trips, participation in sports teams (e.g., city-league softball and basketball), program dances, and holiday, birthday, and graduation parties. These activities involve both current and former program residents, and they create opportunities for practicing and modeling CB skills, exercising increased agency, and enhancing positive affiliations both inside and outside the program. These activities also appear to increase the reinforcement value of the program and hence the willingness of patients to work for access to it (i.e., to persist at learning to change their attitudes and behaviors and staying abstinent, so they can continue to be a part of the program and participate in its recreational activities). Our clinical observations suggest that recreation (play) and affiliation (people) are powerful reinforcers that have not been fully operationalized or used in traditional TCs. We also believe that the use of CB techniques facilitates the program’s ability to have a focus on “play” because the program-taught skills reduce unnecessary conflict and enhance patient affiliation.

In recent years, the people and play components have grown considerably. For example, our Alumni Association now has annual vacations that they fund themselves. In the last three years, they have organized week long vacations to Hawaii and Cancun, Mexico, and plan to continue to do so in the future. These sorts of activities model appropriate recreational activities for inpatients and give them something to strive for in

completing the program. We also have seen a dramatic increase in funds raised by the program to support the recreational activities, including involvement in a “Human Race” fundraiser and volunteering at Stanford concession stands to raise money for the program. Patients report increased self-worth and affiliation with the program as a result of participating in these activities.

### Data Supporting the Effectiveness of HVRP

One of the truly unique aspects of HVRP has been the empirical evaluation of the treatment model. Considerable data from multiple sources have been gathered over the past 16 years that support the viability and effectiveness of the CBTC approach. In addition to the general efficacy information reported at the end of this article, two representative studies of more specific outcomes are presented here.

Between 1991 and 1996, we conducted one of the first large-scale trials to evaluate the feasibility and efficacy of providing smoking treatment to drug/alcohol dependent inpatients via a NIDA-funded project (see Burling, Burling, & Latini, 2001). We conducted face-to-face interviews and obtained biochemically-verified self-report measures of drug/alcohol use (and other measures) at 1, 3, 6, and 12 months post-discharge. Among all study participants (N = 200), our 30-day point-prevalence abstinence rates were 66%, 60%, 63%, and 52% at 1-, 3-, 6-, and 12-months postdischarge, respectively, and our stringent continuous abstinence rate at 12-months posttreatment was 43% (subjects with missing data were treated as non-abstinent). These findings clearly compare favorably to those of other studies on drug/alcohol treatment, and they are especially impressive given the highly impaired nature of our population (homeless, unemployed, and drug/alcohol dependent).

In 1992, Drs. T.A. and A.S. Burling and colleagues examined the effectiveness of using a city-league softball team as a vehicle for providing Relapse Prevention Training in the context of a CBTC (Burling et al., 1992). Softball participation was offered as an optional activity to inpatients, and 34 participated. As

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team members, they practiced the CB skills they were acquiring in treatment in a natural social-recreational setting. They were confronted with high-risk situations such as interpersonal conflict, environmental cues, and emotional states that had previously triggered problematic coping responses. When faced with these “triggers,” team members were provided with support and feedback for trying new coping strategies. Compared to non-participants, participants stayed in treatment longer and were more likely to complete all aspects of the CBTC (inpatient and outpatient). They also were more likely to be abstinent from drugs/alcohol, employed, and housed 3 months post-discharge. Participation appeared to enhance outcomes by providing in vivo opportunities for practicing cognitive-behavioral coping skills and developing supportive relationships. We determined that a softball program may be a viable adjunct treatment in which formally taught cognitive-behavioral skills can be applied in a natural, but semi-structured setting.

### Where do we go from here?

We have just submitted a grant for funding to formally manualize the CBTC treatment and to conduct a pilot trial of the new treatment manual at a treatment center in San Francisco. If the pilot trial is successful, the next step would be to conduct a full-scale controlled clinical trial. Effectiveness studies would follow, perhaps at other domiciliaries nationwide. Considering the confluence of positive feedback from residents and positive evidence from our initial treatment outcome studies, we believe it is our duty to disseminate this treatment approach in an effort to reduce the rate of homelessness and its devastating impact on individuals, families, and society.

### What happened to Martin?

In his first week of treatment, Martin was nearly overwhelmed by the urges to use drugs, the structure imposed on his life by the staff and residents, the rules—all the rules!, the requirement to memorize and use everyone’s first name, the groups, classes, meetings, etc. But a couple things occurred that helped him settle in. First, he saw the HVRP movie that Dr. Burling created in the program orientation class, and it highlighted

for him the focus on affiliation—people and play—here at HVRP. Frankly, it made living here look healthy and fun, two qualities in precious short supply in his life in the past decade. Second, he was comforted by the family-like atmosphere and the camaraderie exhibited by both residents and staff. By the time he fully grasped just how much effort he would have to expend to complete the program—completing contracts, preparing for community events, etc.—he was committed to stay at HVRP, to overcome homelessness, and to make a new life for himself.

Martin made significant progress through the phases of the program, citing the following elements as most beneficial: The “tools” taught and practiced in the community helped him learn not only to manage his own affect but also to better interact with others in emotional situations (both positive and negative). The honest feedback from staff and peers, coupled with the continual reminder that “I create what happens to me,” also helped him to take personal responsibility for his wellbeing. This stance enabled him to stop blaming others for his problems and to take a problem-solving approach to life’s challenges. It also helped him take responsibility for managing his own thoughts, feelings, and behavior. He also cited the opportunity to resolve legal issues, such as suspended licenses and DUI’s, as integral to his achievement of a stable life. Finally, the opportunity to reconnect with estranged family and friends through HVRP events enabled him to begin the task of rebuilding trust.

Near the end of his stay at HVRP, Martin obtained a Compensated Work Therapy job through the VA and found an apartment to share with another completer of the program. He had a steady income, a stable home, and at least one clean and sober peer nearby. He joined the “grad group” that meets on Wednesday nights as part of his plan to graduate. In this group, members discussed the challenges of re-entry into society, maintaining a clean and sober lifestyle, relapse prevention, etc.

After 13 weeks of outpatient participation in the grad group, Martin graduated from HVRP. He dressed up in his finest suit (you’d be surprised at the suits these homeless residents are able to find) and stood, along with

four other graduates, in front of 200 people to be honored for his achievement. In the audience were the staff and residents of HVRP. More importantly, the friends and family with whom he had reconnected and begun the process of healing were also in attendance. The event was at times raucous and at others pensive, alternating between happy and sad, as the graduates told stories both of their pain and suffering and of their happiness at achieving sobriety and stability. Afterwards, friends, family, residents, and staff joined in a feast and then danced into the night.

What will Martin do with his life? If he is like most *graduates*, he will not become homeless again (over 90% of graduates remain housed after discharge, based on follow-up of up to 14 years for some individuals). He might lose his job, although probably not (80% remain continuously employed after discharge). He might relapse, although this also is unlikely (85% remain continuously abstinent). If he does falter in his sobriety or stability, it is likely to be for only a short time before he returns to clean, sober, stable living. In other words, for HVRP graduates, if there is a story to tell, it is usually a success story. And in the treatment field, can we really ask for anything more?

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Keith Harris, Ph.D. is a Staff Psychologist at the Homeless Veterans Rehabilitation Program. He can be contacted at 650/493-5000 x23163



*At the annual December holiday party, Ethics Chair Bram Fridhandler thanks Jami Prince for her year of dedicated service as 2003 SFPA President. Many thanks from all of us, Jami, for your hard work and dedication!*

## New Member Profiles

**Eric Nicely, Psy.D.**, received his degree from the California School of Professional Psychology in 2001 and completed a post-doctoral fellowship in the Employee Assistance Program at UC-San Francisco. After receiving his license in 2003, he opened a full-time private practice in the Financial District to serve adults in individual and couples therapy.

Dr. Nicely specializes in brief, solution-focused psychotherapy for adjustment disorders and couples issues. He also practices cognitive-behavioral therapy for clients with anxiety, depression, and bipolar disorders. In addition to working with gay, lesbian, and bisexual clients, Dr. Nicely provides personal and executive coaching services.

"I'm pleased to be your Membership Chair and Website Coordinator for 2004. My goals this year include making several

improvements to the SFPA website and continuing to work with our ad hoc marketing committee to increase membership and improve member benefits."

Dr. Nicely can be contacted at 415/955-1975.

**Gary Seeman, Ph.D.**, became licensed (PSY19356) October 24 and now practices in downtown San Francisco and Marin. At 53, he brings life and business experience and a successful personal analysis to his work. Gary works exclusively with adults, offering solution-focused therapy with depth for individuals and couples. His specialties are: 1) relationship issues, including communications and commitment; 2) bereavement; 3) individuation, approaching personal fulfillment through Jungian psychotherapy and

dreamwork; 4) managing life transitions; 5) psychotherapy for substance abuse and self-esteem recovery for those not currently using; 6) spiritual and religious concerns, including spiritual emergence and non-dogmatic help for 12 step participants trying to relate to a higher power (spiritual awakening brought him to this work); 7) aging, including psychotherapy with elders; 8) stress management for professionals; 8) creativity and writer's block, such as helping students produce dissertations and theses, assisted by Gary's experience from an award-winning writing career. Gary's non-judgmental, practical style combines solid, creative thinking with emotional and intuitive sensitivity. He quickly puts clients at ease to facilitate facing

*continued on page 9*

### PTSD

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sitization Reprocessing therapy (EMDR), pioneered by Francine Shapiro. EMDR is based on the hypothesis that traumatic material can be effectively integrated and reprocessed by reviewing it while simultaneously having the client follow a back and forth stimulus with his or her eyes; this allegedly activates the limbic system and leads to integration of material and decrease of distress. Heralded by many clinicians as a breakthrough new treatment, it has been equally derided by researchers as unempirical, unvalidated, and smacking of snake oil.

Trauma researcher Bessel van der Kolk has particularly challenged the field to better integrate research and practice. One of the pioneering PTSD researchers, van der Kolk was originally known for his empirical approach to quantification of PTSD symptomatology. An unabashed proponent of EMDR, he has been somewhat marginalized by some more traditional researchers for his more recent exploration of mind-body connection and treatments. Van der Kolk may appear to have cut ties with more traditional, hard line researchers, but perhaps he can serve as a mediator between the two seemingly disparate worlds.

Some evidence of the bridging of the gap has emerged. Neuroimaging studies of traumatized persons are yielding results that may help to explain common clinical presentations, such as the seeming inability to or difficulty in articulating or describing one's cognitive or emotional state when overwhelmed by traumatic material. Such research suggests that there could be a very real neurological component to this, as deliberate activation of traumatic memories is associated with decreased activity in Broca's area, a key brain center for speech production. Alterations in size and functioning of the hippocampus, implicated in the consolidation of experience, emotion, and memory, have also been detailed in persons with PTSD. Given that language and linear processing appear to be impaired during activation of traumatic material, this could go a long way toward validating the clinical observations and concerns of therapists witnessing their clients strangely unable to discuss or move beyond a particularly distressing traumatic memory.

Similarly, based on her findings of chronically lowered levels of plasma cortisol in persons meeting diagnostic criteria for PTSD, Yehuda has speculated that the decrease in cortisol may result in a lack of expected counteraction of the effects of adrenaline. Without this

hypothesized reciprocal control, adrenaline may over facilitate the encoding of particularly distressing traumatic memories, particularly in a more emotional and affect-laden manner.

Hopefully these research findings will help inform clinicians about the mechanisms of any existing or new mind-body treatments, especially as to how or why a particular approach works. Additionally, researchers hopefully will also be open to the rich amount of professional experience and acumen, including hands-on experience with what really does work in the real-world therapy session, clinicians bring to the table. It is clear that both research and clinical camps need to work toward a mutually beneficial middle ground in trauma where the undeniable physiological sequelae of PTSD are understood and utilized in practical, compassionate, and efficacious treatment approaches. The role of the body in trauma symptomatology is increasingly important to both sides; the dichotomization of research and practice is ultimately extremely unproductive and a significant lost opportunity for cross-information and exploration.

**Kasey Saltzman, Ph.D.**, is a psychologist on staff in the Department of Psychiatry at Stanford University Medical Center. She also maintains a private practice in Palo Alto, CA. She can be reached at 650/324-8634.

difficult issues and building affect tolerance, as demonstrated by client ratings higher than the average for the licensed clinicians at his Kaiser fellowship. For more, see [www.drgary-seeman.com](http://www.drgary-seeman.com) or call 415/271-2350.

**Anne M. Vano, Ph.D.**, has recently started a private practice in the Laurel Heights/Pacific Heights area. She hopes this will balance out her other clinical work which includes treating the severely mental ill in a forensic inpatient hospital (Napa State Hospital). Anne is a native Texan, completing her Ph.D. at UT Austin prior to moving to the bay area in 2000. Her parents are native Spaniards and are currently living in Madrid. Because of her heritage, Anne can provide psychotherapy and assessment in Spanish and welcomes any Spanish speaking referrals. In her private practice, she will be providing individual, group and family therapy to treat the following disorders: Adjustment disorders; grief/loss; anxiety; depression; eating disorders; emotional,

sexual, and physical abuse; substance dependence and sexuality issues. Of particular interest, however, is treating medical patients who are either facing surgery or recovering from surgery. She would like to offer support to persons undergoing medical procedures that specifically and directly impact their sense of self/identity. These include plastic surgery and weight loss surgery candidates, although are not limited only to these areas. She is also interested in chronic illness and pain management. Her office is conveniently located one block from Calif. of the Pacific Medical Center. Her theoretical orientation is eclectic with a heavy emphasis on psychodynamic, existential, and interpersonal theory. She can be contacted at 415/595-3778.

*If you are a new member of the San Francisco Psychological Association and would like to introduce yourself to our community, please submit a brief profile to the editor, Cannon Thomas, at [cannonthomas@sbcglobal.net](mailto:cannonthomas@sbcglobal.net).*

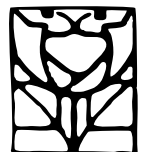
## President's Column

*continued from page 2*

[www.sfpa.net](http://www.sfpa.net)). Liza Ravitz is watching over our fiscal health as Treasurer. (We are more "sound" than the State of California!) Gerald Werckle keeps us from too-many "senior moments" by serving as Secretary. Eric Nicely is creatively engaged as Membership Chair and is in charge of our website. The informative newsletter you are currently reading is due to the editorial intelligence of Cannon Thomas. A recently-constituted task force led by Norman Zukowsky is exploring new and creative ways the organization can impact our community and also be of greater benefit to our members. Loren Krane heads the important Disaster Response Committee. Bram Fridhandler continues as Ethics Chair and as a provider of excellent continuing education workshops. Aply assisting in all the above are Members-at-Large Rebecca Bauknight, Maureen Cook, Judith Katz, and Megan Lehmer.

As members, you will have the opportunity to get to know these people through this newsletter and to participate in SFPA functions throughout the coming years. At the recent board meeting, there was a spirit of renewal and enthusiasm for the year ahead. I was learning once again about commitment to something bigger than our selves and our individual practices of psychology: community. It made me recall the first meeting I attended back in 1976, warmly welcomed by members Jack Blumenkrantz and Stan Lipsitz. Jack continues to be an active member of our community. Stan continues to be a valued personal friend and colleague, as have many others that I have met through SFPA. Please help us continue to welcome new members, both the newly-licensed and those who have been "practicing" for quite awhile. The networking and growing can continue for all of us. Please consider joining us at our monthly meetings (3rd Friday of the month, 6:30-8 PM or so, Hellman Conference Hall, UCSF Mt. Zion), and come to one of the upcoming social or continuing education events to enjoy participating with your colleagues and friends.

Learning and growing . . . together, in community. Please join us.



## INVITATIONS FROM THE PRESIDENT

### *Social Gathering*

All members of the SFPA are invited to a wine-and-cheese gathering at Laurel Heights Conference Center, UCSF on Friday, April 2 at 6:30 PM. Please join us and connect to old friends and new members of the psychological community! We will also be inviting people to share about the approach to therapy that is most interesting to them right now (e.g., EMDR, Emotionally Focused Couples Therapy, Systems Centered Therapy—whatever approach you have been mastering and finding useful in your work). For more information, contact Patrick O'Reilly at 415/597-8080. An RSVP is appreciated.

### *Invited Address*

On May 14th, at 8 PM, SFPA President-Elect Patrick O'Reilly will be speaking about his research on cults, conducted with the late Margaret Singer. The talk will be held at Delancey Street Private Dining, 600 Embarcadero (overlooking the Bay) following a 7 PM dinner. Please email David Bullard at [dgbullard@yahoo.com](mailto:dgbullard@yahoo.com) or call him at 415/239-1584 to be included in the dinner reservation. Space is limited, so let us hear from you as soon as possible. Dinner will be \$45 per person, plus the cost of wine. We hope you will be able to join us for what promises to be a pleasant and intriguing evening together.

## Reviews of Recent Continuing Education Training Sponsored by the SFPA

### Domestic Violence Brought to Life for Child Custody Evaluators

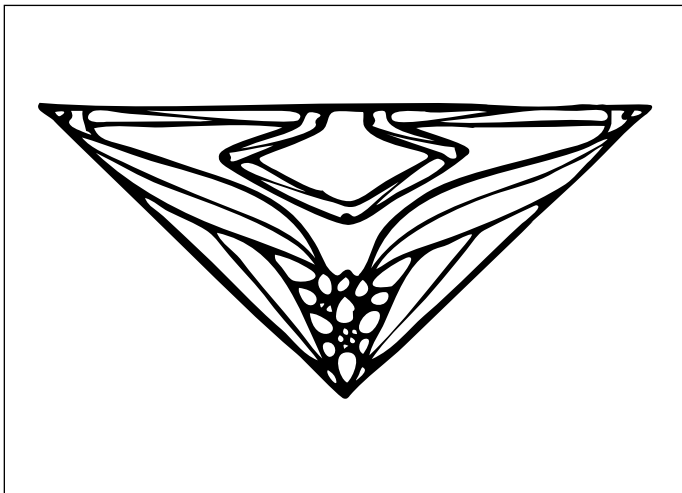
by Megan Lehmer, Ph.D.

To support our goal of offering members required CE training, the SFPA offered a four hour course of Domestic Violence (DV) update training for Child Custody Evaluators on January 24, 2004, co-sponsored with Alliant University. Michael Donner, Ph.D., gave a lively and informative presentation which brought Child Custody Evaluators up to date on current legislation and provided a solid theoretical framework brought to life by fascinating case examples. The annual DV requirement for our members who do child custody work can often be tedious, but Dr. Donner's presentation was so well received that several attendees commented that it was the best DV update training they had ever attended. Dr. Donner, a highly experienced Child Custody Evaluator, works as a Special Master in child custody matters, consults for the courts, and has been the ethics chair for the Alameda County Psychological Association. We want to thank him for providing us with such an exciting workshop.

### Law and Ethics for Psychologists

by Maureen Cook, Ph.D.

*Law and Ethics for Psychologists: A Psychodynamic Perspective* was sponsored by the SFPA and Alliant University on December 6, 2003 at UCSF Laurel Campus. Our closely packed room included a bank of windows looking onto a garden, where rain fell steadily throughout most of the four hours that Bram Fridhandler, Ph.D., Ethics Chairman for the SFPA and Chief Psychologist, CPMC, presented what one participating senior psychologist called 'the best ethics workshop I have attended. It provided a well-considered and balanced approach—neither overly legalistic, like many are, nor too loose.' Dr. Fridhandler's presentation (including very helpful hand-outs) was efficient, thorough, amusing, and highlighted opposing interpretations of thorny ethical and legal dilemmas.



## Geropsychological Overview: An Introduction to the Biological, Social, and Psychological Aspect of Aging and Long-term Care

Presented by Michael Drexler, Ph.D.,  
sponsored by San Mateo County Psychological Association

**May 8, 2004 9 am–12 pm**

*3 MCEP Units:*

Fulfills mandatory requirements for all psychologists  
applying for re-licensure in California after January, 2005

\_\_\_\_\_ \$65 for members of San Mateo County  
Psychological Association

\_\_\_\_\_ \$90 for non-members

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\$160 total

*Complimentary lunch included after completing the course at  
Bella Mangiata Restaurant, San Mateo*

*Send application to:*

SMCPA

P.O. B. 1486

Burlingame, CA 94011

*or call:* Dr. Stan Friedman, MCEP Chair  
at 650/342-5900

The Institute of Contemporary  
Psychoanalysis presents:

Estelle Shane, Ph.D.

**RAGING PATIENTS,  
PAINFUL COUNTERTRANSFERENCE:  
Shame and Aggression,  
Interlocking Concepts:  
One Analyst's Experience**

Saturday, April 10  
9:00 a.m.–1:00 p.m.

UCSF Laurel Heights  
Conference Center  
3333 California Street  
San Francisco

Contact:

Jane Jordan

415/931-5730

bwootten@cats.ucsc.edu

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# Classified Ads

## PSYCHOTHERAPY OFFICES

LOVELY OFFICE SPACE to sublet. Financial district, prestige address, congenial colleagues. Available immediately. June Carrin, 415/733-2033.

SAN FRANCISCO: TWO PSYCHOTHERAPY OFFICES across from Mt. Zion. Three office suite, current remodel, natural light, south facing, in medical building. ADA accessible, parking, waiting room, bathroom, kitchen, storage. No more searching for parking and worries about unexpected evictions. Contact Maria Pease, M.D. 415/921-1398. mpease@itsa.ucsf.edu

LARGE PSYCHOTHERAPY OFFICE in historic art deco building, Inner Sunset district near UCSF Medical Center, available for sublet one to four days per week beginning May 1st. Congenial suite with three psychologists and one psychiatrist. Many amenities, 1/2 block from MUNI. Psychological testing resources available to share. Contact Megan Lehmer or Anne Kopp 415/681-7670.

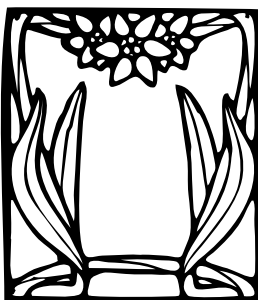
PSYCHOTHERAPY OFFICE FOR RENT F/T or P/T in two-office suite in downtown San Mateo near Mills Hospital in prestigious medical building. Beautifully furnished, waiting and storage rooms, use of phone, fax, microwave. Call Dr. Stan Friedman at 650/342-5900.

## REFERRALS AND GROUPS

SPANISH SPEAKING PSYCHOTHERAPY REFERRALS WELCOME. I am a bilingual, licensed clinical psychologist (PSY 19082) providing therapy to English and Spanish speaking adults and families. Pacific heights office, evenings and Saturdays. Contact Anne M. Vano, Ph.D. 415/595-3778.

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.



## Paula A. Sitelman, Psy.D.

Licensed Psychologist PSY 9569  
3628 Sacramento Street, #2  
San Francisco, CA 94118  
415/346-6636

## Long Term Psychotherapy Groups

since 1990 in San Francisco for

## Adult Children of Alcoholics & Dysfunctional Families

### Women

Ages 30–60

Mondays 5:45–7:15 pm

### Men & Women

Ages 30–60

Thursdays 6–7:30 pm

*In-depth, process-oriented groups to improve self-esteem, capacity for intimate relationships, healthy expression of feelings, needs, and empathy.*

**Openings in both groups \$40/session**



## The Masterson Institute for Psychoanalytic Psychotherapy 27th Annual Conference

### Attachment Disruptions in The Personality Disorders: Focus On Treatment

James F. Masterson, MD, will bring together Attachment Theory with Object Relations Theory and Neurobiological Theory of the development of the Self to show how they are clinically applied. This will be further elaborated in the Workshops by the Institute Faculty.

New York, Saturday & Sunday, February 28, 29, 2004

San Francisco, Friday & Saturday, April 16, 17, 2004

11 CEU's: NY-A Psychologist A.; NYS Chapter NASW  
SF-A. Psychological A.; BBSE (PCE 572) CA for  
MFT's & LCSW's

### MASTERSON INSTITUTE POSTGRADUATE TRAINING PROGRAM NOW ACCEPTING APPLICATIONS FOR SEPTEMBER 2004 NEW YORK AND SAN FRANCISCO

A Development, Self, and Object Relations Approach.  
Intensive three-year part-time certificate program Sept. thru May,  
NY: Fridays 8am -12 noon; SF Wednesday 8:45-11:45

Please call or e-mail and visit our website  
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# Submitting Articles and Advertisements to *The San Francisco Psychologist*

## **ADVERTISEMENTS**

We invite advertising submissions from anyone with services that would be of interest to our membership. The per-issue cost of advertisements is as follows:

DISPLAY ADS	MEMBER	NON-MEMBER
Eighth Page (3 <sup>3</sup> / <sub>4</sub> " x 2 <sup>1</sup> / <sub>2</sub> " )	\$35	\$50
Quarter Page (4 <sup>3</sup> / <sub>4</sub> " x 3 <sup>3</sup> / <sub>4</sub> " )	\$50	\$65
Half Page (4 <sup>3</sup> / <sub>4</sub> " x 7 <sup>1</sup> / <sub>2</sub> " )	\$75	\$90
Full Page (9 <sup>1</sup> / <sub>2</sub> " x 7 <sup>1</sup> / <sub>2</sub> " )	\$135	\$150

Display ads must be submitted camera-ready or as QuarkX-Press format, EPS or a TIFF file. If you submit an electronic file, be sure to include all needed artwork and fonts. Your **Business Card** can be submitted as a camera-ready ad at a rate of \$15 for members and \$20 for non-members.

Prices for classified ads are computed on a per word basis.

CLASSIFIED ADS	MEMBER	NON-MEMBER
	\$.60/word, (\$25 minimum)	\$.75/word, (\$30 minimum)

## **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.

If you would like to submit an article, place an advertisement, or just have comments or ideas to share, please contact Cannon Thomas at [cannonthomas@sbcglobal.net](mailto:cannonthomas@sbcglobal.net) or 415/771-9999.

### **Publication Schedule and Deadlines for 2004**

March issue	March 1
June issue	June 1
September issue	September 1
December issue	December 1

*Please note:* The San Francisco Psychological Association does not recommend or endorse any of the services, products or information represented in the ads or articles published by *The San Francisco Psychologist*.



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