



# The San Francisco Psychologist

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## In This Issue

**1** How Does Evidence-Based Treatment Relate to Good Private Practice?  
CANNON THOMAS, PH.D.

**2** The President's Column  
PATRICK O'REILLY, PH.D.

**7** Ethics and Issues  
BRAM FRIDHANDLER, PH.D.

**8** Book and Movie Reviews  
J. PATRICK GANNON, PH.D.  
PATRICK O'REILLY, PH.D.

**13** California Psychological Association  
SUSAN CHANDLER, PH.D.

**15** Conference Reviews  
GARY SEEMAN, PH.D.  
LIZA RAVITZ, PH.D.

**19** Classified Ads

**20** Advertising and Publication Information

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## How Does Evidence-Based Treatment Relate to Good Private Practice?

By Cannon Thomas, Ph.D.

The current relationship between clinical research and good clinical practice leaves many private practitioners in an awkward tension between deeply held convictions about core values. On the one hand is a commitment to science that is central to our field. Clinical psychology's professional claims are predicated in large part on this commitment. It is difficult to argue that our work is shaped by science if research cannot support the claim that the techniques we use lead to the outcomes desired by our clients. The goal of demonstrating effectiveness is at the core of treatment outcome research. On the other hand, we have a commitment to meet our clients' needs as individuals, and there is for many a sense that being guided by existing treatment outcome research and the manuals developed for this research washes out the issues specific to an individual—moving us further away rather than closer to the goals of fully-engaged, effective treatment.

In order to open a dialog in which the diversity of SPPA is represented, we have surveyed our members and learned a bit about their general opinions on this issue. What we have learned is that our readers have some striking similarities in their view points, regardless of theoretical orientation. Nevertheless, there also are some strong differences of opinion. Given the complicated nature of these issues and their centrality to what we do as private practitioners, this diversity is not surprising. In this article, I have elected to represent one position in some depth, rather than attempting to represent all the view points likely to be taken by our members. My hope is that this article will be the beginning of a dialog, with members submitting letters to the editor representing their own positions. While this newsletter has always invited letters, we have rarely received them. Hope-

fully, this is an issue about which there will be strong enough feelings for that to change!

### Members' Opinions

Our survey went out by email to all members of SPPA. We received 18 responses which, while still a small number, did represent an enthusiastic response on the part of our membership (approximately 15 percent of those receiving the email survey). Fifty percent of the people who responded to the survey identified themselves as psychodynamic in orientation, with the remaining clinicians reporting a range of orientations (interpersonal, social learning, systems, humanistic, eclectic, and cognitive-behavioral). Relative to a survey of licensed psychologists randomly selected from APA's database,<sup>1</sup> our sample was more heavily psychodynamic (50 percent vs. 24%) and less cognitive-behavioral (11 percent vs. 43%) in orientation. This difference is largely reflective of the strong psychodynamic community in San Francisco.

The results of the survey suggest a surprisingly strong degree of consensus about the limitations of manualized treatments. This consensus reflected some common, central values shared by a large majority of the clinicians surveyed. No one felt manuals should be used in clinical practice to the exclusion of clinical judgment. Members noted the fact that manuals typically are designed for and validated with a sample of clients that "do not include comorbid groups common in clinical practice" and "do not assess issues such as personal growth, which are a major focus of many clients who present for psychotherapy." Even more striking was the emphasis on a humane and personal connection between

*continued on page 2*

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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 or mailed to the editor at the above address. 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.

Over the last year, the San Francisco Psychological Association membership has grown substantially. This is largely the result of the Board of Directors and Past Presidents Jami Prince and David Bullard, both of whom have been immensely helpful to me as I take over the responsibility of president. We are looking at an exciting future for SFPA. The existing SFPA programs have been consistently successful, and we will continue to hold onto and improve upon them. In addition to those programs, we are very much focused on ways to increase both the association's involvement in the community and our interaction with local doctoral graduate programs.

We intend to expand the reach of our speakers bureau by contacting local community organizations, service groups, synagogues, temples and churches. There is a genuine need and demand for information on psychological issues, and we want to remind the community that this is a service that SFPA provides.

Due to the efforts of Board member Norm Zukowsky, we are contacting Bay Area graduate schools to explain our mentoring program.

## Evidence-Based Treatment

*continued from page 1*

clients and their therapists, with responsiveness to the client's needs, struggles, and reactions being viewed as fundamental to any good therapy. As one member stated, "The basis for providing psychotherapy in a private practice setting is a human relationship with a human client who is making choices about his/her life, not a cookbook application of 'treatments' for people fitting a diagnosis." This statement captures both the emphasis on a caring, humane connection between therapist and a client and the importance of the therapist addressing the unique difficulties of a specific individual, rather than of a generic diagnostic category.

Jacqueline Persons is a member and survey respondent whose publications include such titles as "Results of Randomized Controlled Trials of Cognitive Therapy for Depression Generalize to Private Practice."<sup>2</sup> Since she has been a strong proponent of

Through the mentoring program, interested SFPA members will speak to classes of psychology graduate students and meet individually with interested students about the intricacies of being a practicing psychologist. It is our hope and intention that this will expand our presence in the academic community and make it less difficult for psychology students to segue from internship to professional practice.

A goal of special importance to us is to make SFPA more attractive to psychologists who work in community mental health (as I do), who have not been well represented in our organization. To accomplish this, we intend to increase our CEU course offerings and expand upon the number of educational and social gatherings that we currently offer.

We will also maintain our very active involvement with the California Psychological Association to insure that the professional interests of psychologists are protected in Sacramento. We are a special community of professionals and we are fortunate to be practicing psychology in these times and in a city as remarkable as San Francisco.

basing clinical practice on evidence-based treatments, one might expect her to take a unilaterally positive position on manualized therapies. However, her concerns about doing so were quite similar to those of other members, including members generally opposed to the use of manualized treatments. As she stated, "I think it is often hard to adapt manualized therapies, which typically target single disorders, to the treatment of the multiple disordered patient. Doing this requires a lot of creativity, in fact! In addition, manuals don't address so many of the clinical phenomena and dilemmas that clinicians encounter daily that it is easy to give up on them. This is partly a result of how manuals are written, as if the clinician can move through them, one intervention at a time, in order. In fact, what the clinician needs is a thorough understanding of the model or theory underpinning the treatment, so that s/he can adapt the treatment to the needs of the patient at hand.

*continued on page 3*

## Evidence-Based Treatment

*continued from page 2*

Many manuals don't make this easy."

The question on which members divided was the degree to which the difficult process of wrestling with evidence-based treatments is worth the trouble. Some members felt strongly that manuals were very useful in practice. A few felt they were fundamental to good practice, provided good judgment was used in applying them. On the other hand, many members simply felt like manualized treatments were restricting and saw professional growth as progressing more comfortably without them. Some members referred to manuals as "deadening" or "boring and uninspired." One member commented that "[Manuals] dumb down our profession to be more like technicians." In fact, a large proportion of members saw the potential problems of treatment manuals as significant enough to limit their interest in them. Thirty-nine percent of respondents agreed or strongly agreed that "a treatment manual makes the therapist think more about sticking to the manual than about the needs of the individual client," and 56 percent agreed or strongly agreed that "manuals force individual clients into arbitrary categories." In addition, many clinicians felt that manuals "keep a therapist from using his or her clinical intuition in responding to a client" (56%).

The question here is twofold: Manualizing treatments is one of the primary ways in which the therapeutic techniques we learn can be evaluated. From the perspective of a research-practitioner model of psychology, they thus appear to be fundamental to our field. However, private practitioners—including those with a strong commitment to evidence-based treatment—do not feel comfortable using existing treatment manuals without modification. Is there a way to resolve the conflict between our desire to provide individualized treatment to clients and our commitment to progress through research in our field?

### Why Base Treatment Standards On Randomized Clinical Trials?

Why would it be necessary to base practice on treatment manuals? It may be helpful to define treatment manuals first. They are essentially

the "guidebook" on which a randomized clinical trial is based. They do not have to represent a "cookbook" approach to therapy (although many existing ones do represent such an approach). They can consist of any set of guidelines that represent a consistent and coherent enough approach to therapy to represent an identifiable mode of practice. My assertion here is that holding our psychotherapy methods and beliefs accountable through research that involves a comparison group is the only way that we will continue to grow professionally—both as individual clinicians striving to be more effective and as a profession.

Frankly, I am not sure how much disagreement there is about this idea as a basic principle. Most of us are mindful of psychological research, much of which involves comparison groups, and we think about this research in relation to our practice. However, the crucial issue is putting our basic beliefs forward in a way that they can be shown to be wrong. There is one, fundamental reason that we do not always cling to clinical trials as a life line for maintaining core standards in our careers: We believe that what we are already doing in therapy works well. This belief allows us to get up in the morning and to address each new client with confidence that the services we offer are helpful to them and, indeed, more helpful to them based on the years of training and the clinical expertise that we have developed. The alternative to making this assumption is to work with the research community to evaluate our basic beliefs and assumptions. If we do not, we are unlikely to discover when we are wrong, and we will thus be caught in a perpetuation of errors and misunderstandings through the course of our careers.

Our own profession has shown how easy it is for fallible humans like us to confirm beliefs that are not correct. As private practitioners, we have an investment in our professional identity. That identity involves a belief that people improve because of the work that we do in sessions, and it involves a belief that our training and experience as psychologists contribute to our ability to facilitate positive change. These beliefs are echoed and reinforced by a public that wants relief from emotional suffering and wants to believe that they can trust us to provide it. Because of this desire, they are likely to look to our profes-

sional identities to enhance their confidence.

The biases that can make it easy to perpetuate erroneous beliefs under these circumstances are well-known. There are positive illusions, a general tendency to exaggerate our strengths and minimize our weaknesses—a tendency shared by the population at large. A substantial majority of middle-aged adults rate themselves as above average at their profession, even though a substantial majority cannot be above average. The bias is not merely reflexive; we re-organize our perceptions of the world around it. Our ability to access relevant information and even our memory become biased in a manner that supports these positive illusions. For instance when college students are asked to remember their high school grades, they recall their A's accurately 89 per cent of the time. However, they recall their D's correctly only 29 percent of the time—remembering them as B's or C's instead. Do we have the same tendency to remember our therapy successes more accurately than our failures? Probably. No wonder most of us tend to believe we are above average.<sup>3</sup>

But general positive illusions only capture a piece of the picture. In cases where improvement is expected over time, people have a tendency to remember the past as worse relative to the present. For instance, students who had just completed a study skills class rated their skills prior to the class as worse than they had rated them at the time the class began. No such bias was seen in a waiting list control. There is an expectation that the group who have taken skills training should have changed, so their memory is biased to support that belief—by remembering their original functioning as worse than their current functioning. It has been speculated that such biases are related to cognitive dissonance reduction. Having invested time and energy in a course that is intended to lead to change, there would be significant psychological discomfort if no change had occurred. Such biases can lead to distortions of memory that exaggerate the benefit of our work.

In addition, hindsight bias gives us a way to account for failures without altering our theories of change. When people read a scenario about a first date and read in the last sentence that it leads to eventual marriage, they falsely remember events earlier in the

## Evidence-Based Treatment

*continued from page 3*

scenario that are consistent with that outcome. If exactly the same scenario ends in date rape in the last sentence, individuals falsely remember events that are consistent with that outcome. If we naturally tend to reconstrue the past in ways that make the eventual outcome expected, it will be easy to dismiss failures as unique cases and successes (perhaps occurring for reasons other than therapy) as confirming of our theories. Research on stereotypes shows a strong tendency in people to remember information consistent with our expectations, as well as a tendency simply not to process information that is inconsistent with those expectations. The result is a self-perpetuating cycle of reinforcing our pre-existing beliefs and deepening our emotional commitment to them.

Such biases make clear how naturally our minds can reinforce what we already believe about therapy, even when an objective view of our work might lead to a strikingly different conclusion. In addition, we are supported in our biases by clients and a public that are as motivated as we are to believe in the power of psychotherapy to relieve their suffering. Given the degree to which our minds are able to confirm our expectations—and the potential of the person in the therapy chair across from us to reinforce that bias, it seems that it would be possible for us to fail to learn or grow. This is true both of us as individuals and as a profession. Even through professional organizations, we can after all collectively reinforce each other's biased expectations that change according to our theories and expectations is occurring.

There are, of course, conditions under which humans can learn from experience—leading to improvement unencumbered by these biases. After all, chess players with intelligence and drive become grandmasters through experience. The research that exists suggests that the conditions under which learning occurs involve clear feedback that can be directly linked to the problem situation. Do the conditions of therapy lead to learning—clearly identifying what is effective and what is not, so that we sharpen skill? Are the guides of experience and extensive clinical

training sufficient, without objective guidance from direct evaluation of the approaches we use? Do we become grandmasters of therapy over time? There is reason to doubt it. The evidence that exists suggests that the path of training and experience alone is not sufficient for us to improve, deepen, and become increasingly effective at our profession.

Results of years of research suggest that psychotherapy is indeed effective for the general client—more effective, in fact, than most medical procedures and than the benefits from living a healthy lifestyle.<sup>4</sup> Dating back to Mary Smith's and Gene Glass' classic meta-analysis,<sup>5</sup> however, research has tended to show that the effects of psychotherapy are (1) largely non-specific and (2) not related to training. In their analysis, the type of psychotherapy was unrelated to effectiveness—with the exception of behavioral techniques which were more effective for some very specifically defined disorders. In addition, therapists' credentials—M.D., Ph.D., or no degree—and experience were unrelated to effectiveness. Subsequent studies, with a few minor exceptions, have tended to support the conclusion that training is largely unrelated to effectiveness at performing psychotherapy.<sup>6</sup>

One study that stands out in this regard was a randomized trial designed by Hans Strupp and Suzanne Hadley.<sup>7</sup> They recruited university professors who had no background in psychology to act as psychotherapists and compared them to professionally trained and credentialed psychologists. The clients were similar to those often seen in private practice: problems “would be classified as neurotic depression or anxiety reactions. Obsessional trends and borderline personalities were common.” Results suggested no differences between the two groups in functioning on the multiple measures used by the investigators at the end of treatment.

Then what does work in psychotherapy? We don't know. Therapists' empathy appears to play a large role in non-specific factors, based on the studies where it has been measured. For instance, one study of problem drinkers found that 67 percent of the variability in success of treatment could be related to accurate empathy.<sup>8</sup> (Years of therapist experience accounted for 1 percent.) This is cer-

tainly consistent with the insights of many of our members regarding the importance of a solid therapist-client relationship. But what do we as professionals offer beyond the value of a human relationship or other non-specific factors? We believe in the specifics of the therapies we offer, not just the non-specifics. If we did not, we would not spend so much time learning the specifics.

Does this mean that all theoretical developments and all clinicians do not improve over time? Not at all. Good theory based on solid judgment is the starting point of any science. But it does leave us having to ask some serious questions. Apparently, believing in our unique expertise, bolstered by our degrees and professional reputations, may not be justified. Talk about producing cognitive dissonance! And the temptation to find dismissive explanations or minimize the findings creeps in. It is, after all, natural and human to have positive illusions about ourselves. To me, once I let myself sit with this dissonance, it leaves me with an urgent need to know: *Which aspects of what I do actually do improve my client's lives and which ones create an illusion of helping without actually touching my clients in a way that is helpful to them?* Answering this question makes it possible to separate the wheat from the chaff—and to cultivate the wheat. The years of experience I have put in include skills that are valuable, and I want to root in those and learn new ones that may also be valuable. At the same time, I want to let go of practices that appeared fruitful but may be getting in the way. Indeed, one of the most central skills we all have learned in our years of training is the skill of utilizing research in order to undertake this sifting process. One effective way to reduce the dissonance, at least for me, is to utilize that skill.

If we are investing resources in the professional approaches we have worked to learn (as well as asking clients to invest *their* resources in these approaches), don't we want to know whether or not the clinical approaches work better than something non-specific that could be administered by a less trained and less expensive provider? If so, the only way we can gain this knowledge is from an honest comparison of the approach we believe in to a non-specific approach. This is a randomized clinical trial. Without this type of objective feedback,

we are prone to perpetuate our belief in approaches when they do not actually work. We may believe absolutely in what we do and still be wrong. As Thomas Henry Huxley is often quoted as saying, “Science is organized common sense where many a beautiful theory was killed by an ugly fact.” Having the humility to be shown by objective evidence that we are wrong is the only way we can claim to be scientist-practitioners. Otherwise, we are using our knowledge of science to support our beautiful theories, but we are not allowing science to expose our biases and thus change them. On a personal level, the way for me to be the most effective clinician I can be, and fundamental to me getting better, is to keep in mind that I am not as good of a clinician as I think I am. To get better, I need a perspective outside of myself, a camera mounted high enough above what I do to allow me to look at it objectively—so that I can see what works and what doesn’t.

## Bridging the Clinician-Researcher Gap

The question is what this would mean in the real world and the current state of our profession. It appears that there is a good deal of consensus within our membership about some limitations of existing, empirically supported treatments. Members see a need to maintain a humane, responsive relationship with clients, and a number of members speak of needing flexible interventions in order to be able to deal with the unique case of the individual client.

Of course, these very principles *can* be manualized, which means that these opinions we hold can be incorporated into treatments and then evaluated empirically. If we are correct, incorporating these elements will improve on existing treatments—a result that can be demonstrated through clinical trials. It may seem strange to think of manualizing guidelines for focusing on the individual as a unique case or manualizing a humane relationship, but there is no contradiction. A manual does not have to be a rigid prescription. It simply has to provide enough structure to result in a coherent approach to treatment. As an example, Dialectical Behavior Therapy, an empirically validated treatment for borderline personality disorder, includes “irreverence strategies” in its manual.<sup>9</sup> Essentially, one of

the rules of that manual is to break the rules, so that clients and therapists stay on their toes and do not fall into a rut with each other. If irreverence can be manualized, surely almost anything can.

And there is a lot of room for the types of interventions we are discussing to improve on current, evidence-based treatments for general affect conditions (like generalized anxiety and major depression). Unlike more specific anxiety disorders (like panic disorder, single trauma PTSD), the size of effects of currently validated treatments for general affect conditions are not particularly strong. Between 50 and 60 percent of clients improve significantly during a 15 to 20 session treatment. This response is stronger than appropriate comparison groups, such as a placebo medication condition that includes supportive check-ins with a clinician.<sup>10</sup> But these results suggest that a large proportion of clients are still not responding. Other issues (e.g., a high relapse rate following termination of treatment) make evident just how far current treatments have to go before we can claim that we have a truly effective intervention for reducing the general emotional distress of our clients.

The fact is that there is already evidence that existing, empirically supported treatments *can* be improved by taking into account the kinds of issues that our members have identified as important—such as maintaining a solid, personal relationship with the client. As an example, Louis Castonguay and his colleagues showed several years ago that dealing with ruptures in the therapeutic relationship by following cognitive-behavioral protocols was correlated with *worse* therapeutic outcomes. In other words, the therapist breaking with CBT protocol when there was a problem in the relationship with the client improved outcome. As a result, Castonguay and colleagues have developed an “integrative cognitive therapy” (ICT) that incorporates elements of humanistic and interpersonal interventions to resolve problems in the therapeutic relationship. There have been limited data gathered so far, but initial results are very promising: 92 percent of clients with major depression showed clinically significant improvement in depressive symptoms, as opposed to 20 percent for waiting list controls.<sup>11</sup>

This is just one example of a strong trend among researchers, who are recognizing that studies to date have not adequately met the needs of clinicians operating in the real world. Researchers want to identify more effective treatments, and they want to demonstrate these treatments are flexible enough to work with the types of clients who actually present for psychotherapy. As a result, they are looking more than ever to collaborate with clinicians in order to identify more effective interventions. As Drew Westen and colleagues have recently asserted, “Perhaps most important is the need to reconsider the top-down, unidirectional model of science and practice that has been increasingly prevalent in recent years . . . . As a field, we might be better served by a more transactional philosophy of clinical science, in which the laboratory and the clinic are both seen as resources for hypothesis generation and testing, albeit with different strengths and limitations.”<sup>12</sup>

It is true that evidence-based treatment has been dominated for several decades by individuals with a cognitive-behavioral or interpersonal orientation, but there is no reason that this needs to continue. Some researchers have argued that psychodynamic approaches may be most consistent with recent advances in cognitive neuroscience, which has shown how just how much affect, motivation, and attitudes are processed at an automatic, pre-conscious level.<sup>13</sup> There also have been some suggestions that focusing on parenting issues, a traditionally psychodynamic focus, may improve outcomes in cognitive-behavioral treatments.<sup>14</sup> Our field could only benefit from increased collaboration between psychodynamic theorists and clinical researchers who are focused on validating treatments.

## What Can We Do?

If we as clinicians do want to bridge the gap between ourselves and researchers, there is still a serious question of how to do it. We find ourselves in the awkward position of having a large and growing number of validated treatments that work quite well, although many of these are for specific disorders and do not appear to be flexible in being applied to complex, individual cases. In addition, there are some empirically-validated treatments that

have relatively small effect sizes—particularly for general affect conditions. If the validated treatment does not appear very strong, we are not going to want to leap to embrace it wholeheartedly. In fact, doing so would probably slow down scientific progress rather than accelerate it. We would be stuck with mediocre treatments rather than advocating for further research and continued improvement.

One place to start, of course, is to know the outcome literature. If something works well for treatment of a condition, I believe we have an ethical responsibility to make a client aware of that treatment option and the research outcomes associated with it. In addition, having many treatments now that have been validated is a treasure trove of information that can lead to our growth as clinicians. As noted above, the general rule of treatment research has typically been that the specifics of a treatment rarely exceed the benefits of the non-specifics. When a treatment is developed that does facilitate change at a level higher than a non-specific treatment, it is an opportunity to learn how to provide a greater possibility of change for our clients.

But how does this translate to actual practice? Many of us come from different theoretical orientations, and we are going to have different perspectives on how to implement outcome research in the context of our own practice. In addition to making an effort to incorporate validated treatment methods into your practice, it can be useful to standardize our own methods as far as possible. Standardizing our process makes us think carefully about why we make certain decisions at certain points in time and results in a more consistent and coherent approach to treatment. I am not implying here that therapy has to be rigid. Even if you think of psychotherapy as being like jazz music in its spontaneity, you can define a coherent framework for that process. As the psychodynamic researcher and clinician Peter Fonagy has noted, based on his own review of outcome studies, “Treatments that are unstructured, unfocused, and delivered without predetermined goals and objectives tend to be ineffective when contrasted with carefully

crafted, well-thought-out, clearly specified and, above all, structured interventions.”<sup>15</sup> In addition to leading to greater thoughtfulness in our interventions, clearly defining our approach should make it more clear when research supports or refutes our work.

My second suggestion is to use outcome measures regularly with clients. I realize that this suggestion makes some clinicians uneasy. It has been one of the most difficult for me to implement, and I realize it is even more complicated for a psychodynamic therapist who is less immediately focused on symptoms. Nevertheless, I think that it is essential. The first reason is that it makes the “change bias” discussed above much more difficult to maintain. We are looking objectively at when a client is and is not getting better. Doing so brings us more directly and candidly in touch with what is actually working (and is not working) for a client. It makes it possible to test hypotheses with individual clients, trying conceptualizations with them and discovering which lead to improvements and which do not.<sup>16</sup>

For me, the most humbling and powerful use of outcome measures in practice has been to evaluate where my own work stands in relationship to the research. If I am making modifications to an evidence-based technique or diverging from it entirely on a regular basis, I try to ensure that the outcomes in my own practice are at least roughly comparable to those seen in the outcome studies. Examining this has been scary for me, and I am sure it is for others as well. However, it has been useful. On one occasion, I did move back towards a more structured, by-the-book approach to treating a condition (panic disorder) precisely because my results were not as strong as those seen in the outcome studies.

Another advantage of keeping measures on our clients is that we *can* contribute to the process of defining therapeutic approaches for the field. There are many journals that publish individual case studies as well as studies of several patients from an individual practice. When there is objective data from outcome measures, such presentations can be particularly compelling. By contributing to the literature in this way, we are contributing ideas that can form the basis of therapies that will be tested on a more systematic basis in the future.

But why stop there? We can also talk to researchers at conferences and let them know what it is that we see as limited in their therapies as they apply to real-world practice, discuss our own ideas with them, and show them any data we do have from our practice that supports our position. Researchers are recognizing more and more that they depend on active dialog with clinicians and responsiveness to our ideas for their work to move out of the ivory tower and into the world of improving the lives of the public. It is our job to help them shape the therapies that they test—so that their work can shape our practice more and more effectively.

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**Cannon Thomas, Ph.D.**, is a clinical psychologist in private practice in San Francisco. He is also editor of *The San Francisco Psychologist*. The opinions expressed in this article are his own and do not represent the position of the San Francisco Psychological Association.

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## Informed Consent Forms: Who are they for?

When I talk to colleagues about legal and ethical issues, or teach workshops, probably no topic provokes more irritation than informed consent. Many psychologists feel coerced into incorporating a lengthy, obscure, legalistic form into their intake processes, which, in other respects, are carefully designed to be individualized, responsive, and conducive to the treatment on which they are embarking. They feel they are given no choice about this part of the intake, that professional judgment has been trumped by an ill-explained imperative.

I sympathize with these reactions, and I believe there are good grounds on which to take issue with the conventional wisdom in this domain. First, though, it must be acknowledged that the principle of informed consent is well established for psychologists. Legal and ethical sources, binding for psychologists, agree that clients must receive enough information to permit informed choices about whether to accept the services we offer. These authorities also effectively require us to make every effort to insure that clients are free from coercion (Fridhandler et al., 2004). The principle of autonomous choice is one we must honor and promote in the opening phase of our work.

The following disclaimer was inadvertently excluded from Bram Fridhandler's article "Commentary on 'Confidentiality, informed consent, and the USA Patriot Act'" in the July edition of this bulletin: "The opinions and interpretations expressed here are my own and do not constitute an official position of the San Francisco Psychological Association."

But is this what the forms are about? Are they designed with the primary goal of helping clients make free and informed choices? The language of existing informed consent forms can make one skeptical. The APAIT form (APAIT, 2004) is the most pertinent, because it is widely known, recommended by one of the primary insurance providers for psychologists and, not least, because it is probably the best of its kind. Among its virtues are a plain-language discussion of the nature of psychotherapy, a clear presentation of the psychologist's fees and other business practices, and an invitation to the psychologist to modify the document to conform to his or her own practice and professional judgment. The language and tone are direct and respectful.

And yet, the nature of the document is perplexing. At first glance, it appears to be a tool to enhance the informed consent process. It is called "Sample Informed Consent Contract,"<sup>1</sup> the introduction states, "most commentators suggest that full informed consent is both ethically necessary and a good risk management strategy," and the discussion about potential risks and benefits seems to place it squarely within the domain of informed consent.

However, there is the anomalous word "contract." One is also told that the document "allows the psychologist to establish a legally enforceable business relationship with the patient." The patient, by the same token, is presented with a document boldly titled "Out-patient Services Contract" and is informed, "When you sign this document, it will represent an agreement between us." He or she is then told of various fees (for report writing, telephone calls, authorized meetings with other professionals) and instructed that payments are due within 60 days and that the psychol-

ogist has the option of collection agencies and small claims court if fees remain unpaid.

What is going on here? Actually, APAIT is explicit: "This draft psychotherapist-patient contract has been prepared for two reasons," namely, informed consent *and* the establishment of the business relationship. The drafters, and their advisors, have seen fit to kill two birds with one stone. The consequence is that psychologists and their patients are left with a document, and a strategy, that completely blurs the distinction between helping the patient make a free choice about services and obtaining his or her signed agreement to a laundry list of contractual obligations.

Where does that leave informed consent, per se? In a fuller discussion, one could analyze the risk management considerations intrinsic to informed consent and weigh those against the clinical costs of a legalistic introduction to psychotherapy. For the moment, let me simply describe my own approach. I provide my patients with basic, written information about my practice and about the limits of confidentiality, because I believe that written materials are sometimes easier to comprehend than an oral presentation delivered at a time that the patient's attention is generally focused on the initiation of the treatment relationship.<sup>2</sup> I ask for no signatures, but I record, in my notes, the fact that I have provided the information. From there, in essence, my handling of informed consent consists of paying attention. That is, I look for opportunities to help the patient understand the process of his or her own therapy and to get past the inner and outer obstacles to autonomous decision-making. Thus, the boundary between informed consent and ther-

*continued on page 16*

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## The Character of George W. Bush: Reviews of “Fahrenheit 9/11” and “Bush On the Couch”

J. Patrick Gannon, Ph.D.

Character. It's a theme rooted in the campaign message of George Bush and the attacks on his opponent John Kerry. As defined by George Bush, character reflects the moral, ethical make-up of the man, specifically the traits of honesty, courage and integrity. George Bush casts himself as a

moral figure: a devoted family man, a devout Christian, the protector of marriage, the author of faith-based initiatives and an opponent of abortion and stem cell research.

The theme of moral character became an even stronger part of his political identity in the aftermath of September 11th when strength, conviction, and determination in the face of adversity was needed to restore a sense of national security and to lead the war on terrorism. Many Americans perceived these moral qualities in the President when he stood at Ground Zero in the days following the attacks and supported his decision to strike back militarily. Politically, the use of moral character as a theme also played well with his core constituency: the 81 million Americans identifying themselves as either “born again” or evangelical Christians.

But there is a second definition of character that reveals his personal vulnerability; character as defined by the features, traits and behaviors that form the nature of his personality. Who is George Bush based on his past and current behavior, his psychological make-up and his conduct in office? Has he been the “compassionate conservative” that he said he would be during the 2000 campaign? Has he delivered on his campaign promise to “leave no child behind”? Has he been a man of the people when designing his tax cuts? Many would say no—that his conduct runs counter to his commitments. This too speaks to character. For his critics, character in the form of George Bush's duplicity and deception is very much

The content of this article, like all articles published in *The San Francisco Psychologist*, represents the opinions and interpretations of the author and is not representative of the views of the organization. This publication invites members to submit critiques of this article as letters to the editor or to represent differing views and opinions in their own book or movie reviews.

*continued on page 9*

## Re-Reading *Surviving Schizophrenia*

Patrick O'Reilly, Ph.D.

### *Surviving Schizophrenia: A Manual for Families, Consumers and Providers, Fourth Edition*

E. Fuller Torrey M.D. (HarperCollins Publishers, New York, New York, 2001).

I work at the University of California, San Francisco Forensic Project. The Forensic Project clinicians work exclusively with Mentally Ill Offenders. Because a high percentage of our clients are diagnosed with schizophrenia, every year I give a copy of *Surviving Schizophrenia* to the first year interns whom I supervise. I decided that it was time to give *Surviving Schizophrenia* a re-reading myself, particularly because it's now in its fourth edition.

I was not disappointed in my re-reading. Although written for the lay reader, *Surviving*

*Schizophrenia* remains an indispensable text for clinicians in understanding a disease that affects 2.2 million people in this country. Its detail, compassion, and scientific validity remain undimmed with this new edition. Dr. Fuller Torrey describes and explains the symptoms of the illness, reviews legal and ethical issues related to working with persons with this dysfunction, and, with remarkable scientific acumen, discusses the etiology and scientifically-validated treatments for schizophrenia.

*Surviving Schizophrenia* is not a book that needs to be read cover to cover. It's divided into chapters, each of which stands up independently. Nearly every chapter includes a list of additional recommended readings on the chapter subject. Chapter One describes the dimensions of schizophrenia. Dr. Torrey points out the dismaying fact that a third of the homeless in this country have serious bio-

logical mental disorders and that there are more persons diagnosed with schizophrenia living in jails and prisons than in hospitals. He also explains why there is a dearth of good mental health programs for persons with schizophrenia and tragically points out the often inadequate training most clinicians receive in working with this population.

Although psychologists are trained to be empathic, it is often prohibitively difficult to maintain empathy when a client's suffering is so far outside of anything the psychologist has experienced. The chapter entitled “The Inner World of Madness” dramatically presents persons with schizophrenia discussing their symptoms, the overwhelming stimuli the illness assaults them with, and the limitations placed on them as a consequence of

*continued on page 12*

the issue and what drives them to organize his defeat.

In many ways, the polarization of the electorate in the 2004 election as symbolized by red and blue states, rural and urban populations, and evangelical and secular groups can be explained by the identification with either of these two definitions of character, the moral and the psychological. If there are two Americas, as the pundits say, with each group perceiving George Bush according to their own meaning of character, how can the issue of character be deconstructed to reveal the truth behind the campaign image?

This split in the perception of character is significant because it dovetails with research on voter decision-making suggesting that voters elect presidents based on who they are as people rather than their record or campaign positions. According to recent polls, a majority of Americans have soured on their support for the war in Iraq and feel the country is going in the wrong direction but still hold to their slight preference for the President. How can we understand this apparent contradiction?

Part of this identification with the person rather than the record, seems related to the President being the leader of our country, a father figure of sorts who we need to feel good about. Considering that whoever is elected President is invited into our living rooms almost every night during the evening news, our personal identification with that person may shape our voting preferences. Other research indicates that many Americans have trouble matching their self-interest with the campaign platforms of the candidates. Is it possible that some voters' confusion in figuring out which candidate reflects their interests causes them to downgrade the importance of the record in favor of the person when deciding whom to vote for?

How can we understand the personality of George W. Bush? What motivates him and how confident should we be in his ability to lead us? For mental health professionals, we are also curious about how he functions as a person, not just a leader. How healthy is he psychologically? How does he process information and make judgments in complex situations? And how do we understand specific—and troubling—aspects of his per-

sonality such as his self-admitted twenty-year problem with alcohol, possible learning disabilities and questions about his military service in the Texas Air National Guard.

With these questions in mind, what follows are two reviews—a film review of the highly popular documentary *Fahrenheit 9/11* and a book review of the hardly noticed *Bush On The Couch: Inside the Mind of the President*. Each makes a contribution to a deeper understanding of the character issues presented by George Bush. While each is highly critical of the President, they both present facts that can be useful to the voters' own judgment of the character of George Bush.

### *Fahrenheit 9/11*

**Produced and Directed by Michael Moore, 2004**

If you are Michael Moore, raising questions about the character of George W. Bush is an act of patriotism, if not a moral obligation. To be sure, the characters of George Bush and his family as well as their political and business dealings are targets in *Fahrenheit 9/11*. And there's plenty to take aim at, according to Michael Moore. Moore zeros in on the many personal characteristics of George Bush that raise questions about his moral character.

Early on in the film, Moore suggests that Bush is "lazy," as demonstrated by the fact that he was on vacation some 42 percent of the time during the first eight months on the job. Moore claims that Bush was a "deserter" during his service with the Texas Air National Guard and documents how he tried to cover up his absences. Later on in the film, when focusing on how Bush's Arbusto Oil Company was bought by Harkin Energy, Moore states that Bush illegally sold 848,000 shares of Harkin stock in violation of Securities and Exchange Commission guidelines. These are not simply allegations by Michael Moore but rather are strongly corroborated by other sources as well.

Moore includes several segments featuring Washington State congressman and psychiatrist Jim McDermott, who accuses Bush of being a "manipulator" of the American public. Moore illustrates how Bush gave con-

tradictory public statements telling the American public they are "no longer safe" from terrorism at the same time he urges them to "take your families down to Florida to Disney World." Besides being a booster for his brother Jeb's state economy, Moore has some fun with the irony that Bush is promoting Disney World in his film, considering how the Disney Company refused to distribute *Fahrenheit 9/11*.

Moore goes on to include segments showing Bush's insincerity, insensitivity and overall shallowness when he mixes serious topics with off-hand attempts at humor, such as when he proclaims on the golf course that we must "stop the terrorist killers . . . Now watch this drive." Bush's impulse for the telling remark belies his cultivated image as an average American when he labels an audience of well-heeled supporters as his "base" and teasingly distinguishes them from "the haves" by telling them they are "the have mores." Moore is asking viewers who are struggling to pay their bills to reconsider their perception of George Bush as "one of them."

Moore makes the claim that Bush is untrustworthy and deceptive in his motivation and justification for leading America into war with Iraq. Here Moore indicts Bush for the ultimate deception—leading America into a costly and unjustified war. He suggests Bush's motivation is to access Iraqi oil and to continue his family's agenda of using politics to generate profits. To be fair, Moore fails to acknowledge that there were probably several motivations to attack Iraq—as there often are in complex geo-political actions—but slips into the same unidimensional thinking that many accuse George Bush of.

Perhaps the most revealing moment in the film is the infamous seven minute delay to action in the Florida classroom on the morning of September 11th. After being told of the attacks by his chief of staff, Bush sat frozen, looking scared, confused, perhaps even traumatized. That image alone may represent the acid test for presidential character during these challenging times. In a moment of crisis, when the nation needed strong, immediate leadership, George Bush's indecisiveness was exposed for all to see. But how will viewers choose to see and interpret

what these images and actions say about the character of the man?

One problem with the film acting as a change agent is the effect of the “Michael Moore approach” to documentary filmmaking. *Fahrenheit 9/11* does not leave the viewer with a sense of journalistic balance, fairness or non-partisan discourse. It is political propaganda, pure and simple. Moore’s use of evocative music, quick cutting, slow motion, voice-over narration and other dramatic techniques make viewers who are sensitive to balance and fairness uncomfortable. We know the power of the media and we know the partisan showmanship of Michael Moore. We are caught between enjoying the bandwagon appeal of deriding George Bush and reaching for the truth behind the images and spoken words. Viewers must adjust their expectations for this new, partisan-style filmmaking. But will viewers go the extra step to employ some critical thinking about what they have seen that may reveal some essential truths about the character of George Bush?

### ***Bush On the Couch: Inside the Mind of the President***

Justin A. Frank, M.D.

(ReganBooks/HarperCollins: New York, 2004, 238 pp.)

Adopting more of the psychological definition of character as it applies to George Bush is the focus of a new book called *Bush On The Couch: Inside the Mind of the President*. Author Justin A. Frank, M.D. is a Washington-based psychiatrist, psychoanalyst, and clinical professor of psychiatry at George Washington University Medical Center.

Frank is disturbed by what he sees in the character of George Bush and undertakes a formal study of the president using a method that he describes as applied psychoanalysis. He defines “applied psychoanalysis (or AP)” as the study of personality through indirect sources including personal writings, photographs, movies, second-hand accounts and academic biographies.”

AP dates back to the 1940’s when the US Government commissioned two studies of the personality of Adolf Hitler that were considered such a success that a new organization was established that exists to this day. Called

the Center for the Analysis of Personality and Political Behavior, the unit is currently part of the Directorate of Intelligence branch of the CIA and is charged with the application of psychological profiling techniques to the understanding of contemporary world leaders.

Frank develops his assessment of the personality and current psychological functioning of George Bush by focusing on the Bush family history, his alcoholism, questions about his speech, learning and attentional disabilities, as well as his “born again” religious faith and his sense of entitlement as a favored son of a privileged family. Not surprisingly, (considering the analytic approach being utilized), Frank delves into the relationship between father and son, which he tellingly refers to as “Oedipus Wrecks.”

### **The Bush Family History**

Based on a variety of sources in the public record, Frank goes to work building a picture of what family life was like for the young George Bush. The picture that emerges is one of an absent, emotionally limited father and an authoritarian mother who developed a reputation as a cold disciplinarian, a characterization made more believable by the children’s nicknaming her “the Enforcer.” Even the father, although mostly absent, also was limited in his personal emotional expression, as demonstrated by his preference to write letters to his children to convey fatherly feelings rather than speaking directly to them.

Frank delves more deeply into the childhood of Barbara Bush, who he reports was often spanked with a hairbrush and wooden clothes hanger by a chronically depressed mother. The mother, Pauline Pierce, a descendant of President Franklin Pierce, was “too preoccupied with her own pain to engage her daughter with maternal nurturing or teaching basic household skills.” Frank describes Barbara Bush as an under-nurtured, unappreciated child who needed to befriend a neighboring family to receive any substantive nurturing. Frank cites evidence that the adult Barbara developed into a hardened personality by quoting a family friend in *Matriarch of a Dynasty*, the biography of Barbara Bush by Pamela Kilian. In that book, the author quotes June Beidler who described Barbara Bush as a “sort of the leader bully. We were

all pretty afraid of her because she could be sarcastic and mean.” Not surprisingly, Frank identifies her lack of empathic capacities as having a core impact on young George.

Perhaps the most pivotal event in the childhood of George W. Bush and one that psychoanalyst Frank identifies as causal in explaining the denial of affect and the subsequent development of anxiety in the Bush personality is the death of his younger sister Robin when he was seven years old. Diagnosed with leukemia in the early months of 1953, Robin and her parents traveled frequently to New York for treatment. However, George was never told that his sister was gravely ill, despite the fact they were quite close. When she would return to Texas for a respite between treatments, George was prevented from playing with her. No explanation was given. Frank reports that when Robin finally died during one of these visits to New York, the parents played golf the following day. They held a small memorial the day after, then returned to Texas before Robin was buried in a family plot in Connecticut. There was no funeral.

Frank writes that “deprived of the chance to mourn his sister’s death, George W. was never able to hold and integrate the feelings of loss and mourning necessary for the development of empathy.” This event coupled with the family-wide discomfort with handling any emotional content—anger excepted—cast young George adrift in a sea of impacted grief, emotional isolation and family disconnection, which Frank asserts is the source for his emotional dysregulation. Like his mother, Bush learned to cut off his feelings, relying instead on “humor, antic behavior and at times sarcasm to distance himself.” Frank cites this as the beginning of his lifelong struggle with anxiety.

### **Anxiety, Disability and Language**

Bush developed the affable, teasing persona that he is known for following the death of his sister—to provide comic relief for his depressed mother and perhaps as a tool to manage his own grief. With his father off tending to his oil business, George was the man of the house, only now he had responsibility for caring for his mother. Barbara Bush acknowledges in her memoirs how she was “too much of a burden for a seven-year old to carry.”

Around this time, young George's energy level continued to escalate, raising the possibility that he was managing his bereavement through sheer physical exertion. Today, he might be referred for hyperactivity; but back then in the Fifties in West Texas, the boy who was now known as "Bushtail" probably looked no different than other action-oriented boys.

Frank speculates that his anxiety and grief had no place to go and began to interfere with his cognitive development. Thinking, problem solving, and building a fund of knowledge cannot develop if the child must devote needed psychological resources to anxiety management. Those who knew him during primary school report his inability to sit still, a tendency toward impulsive actions and reliance on funny, clown-like antics designed to disrupt the classroom. As George Bush grew up, there was increasing evidence that he met the clinical picture of attentional deficit disorder with hyperactivity (ADHD). Frank identifies distractibility, hypervigilance, impatience, low frustration tolerance, risk taking and impulsiveness as the key indicators of ADHD.

Many of these symptoms emerge in first person accounts of George Bush's functioning as President. Reporters question if Bush is not being focused enough or sufficiently attentive to the details of his job. According to a U.S. News and World Report cover story, presidential aides indicated that Bush "never anguishes over decisions, preferring to gather information, make a decision, and move on." Other aides have acknowledged that his staff limits him to only three or four 30—45 minutes policy sessions a week, or about what Bill Clinton put in per day. Frank cites Bush's need for a rigid daily schedule, including time for several exercise and prayer breaks during the day, frequent vacations, and the need to sleep 10 hours per night as indicative of his attempts to manage his anxiety and/or his hyperactivity.

Frank suggests that failing to read lengthy reports or being disinterested in the details underlying complex issues or being driven to take action without adequate contemplation have the hallmarks of an impulsive, learning disabled ADHD sufferer. The war in Iraq is an excellent example of this process, with the lack of planning for the occupation and the failure to appreciate the complexity

of building a democratic state after years of despotic rule. His reported tendency to rely on highly condensed briefing papers and his preference that information be presented to him orally may explain how he missed the alarm contained in the now famous August 6th memo about how Osama Bin Laden was preparing to attack the United States.

Those with ADHD are often likely to be diagnosed with learning disabilities, especially dyslexia. Misreading words, confusing meanings of words, word substitutions, pronoun reversals, and mispronunciations—all mistakes well documented in the Bush public record—are among the signs of a reading disability. Interestingly, some members of the Washington press refer to him as "the English patient." Although George Bush has never been diagnosed with a learning disability, his brother Neil has, which increases the likelihood that it may be true for him as well. Frank concludes that the signs and symptoms of anxiety, hyperactivity, and learning disabilities are all present in the public record of George Bush, which may render him functionally impaired if not disabled—especially when measured against the performance requirements of the presidency.

### **Alcoholism and the "Dry Drunk" Personality**

Frank points to George Bush's history of alcohol abuse and lack of treatment for it as yet another question mark regarding his psychological character. George Bush began drinking during his teen years while at Prep school and continued up to his 40th birthday. Despite contradictory statements over the years about his drinking and alcoholism, Frank has found Bush public admissions that his drinking was at times heavy, daily, and interfering with his family life. When he was 30, Bush was arrested in Maine for driving under the influence. Despite this indication that his drinking was out of control, he continued to drink for another 10 years before deciding to quit. In all, his drinking career spanned some twenty plus years, with the heaviest drinking probably starting during his college years at Yale where he was head of his fraternity.

Although alcoholism had been in his family for generations, dating back to President Franklin Pierce on his mother's side, who pres-

idential historian Dean Simonton cites was an alcoholic, George Bush has never admitted to being an alcoholic. However, Frank reports that David Frum, one of his speechwriters, has written that Bush admitted to a group of religious leaders early in his first term that he "had a drinking problem" and "... should be in a bar, not the Oval Office."

Considering what is known about his drinking history and coupled with his admirable-but apparently necessary—decision to give alcohol up, George Bush would be considered an alcoholic by most professional standards. The important point is that while George Bush stopped drinking on his own, he never attended AA or received treatment for the other problems associated with the disease. Instead he relied on Bible study, conversations with evangelist Billy Graham and daily prayer. George Bush's choice of recovery method ensures only abstinence, and does nothing to address the associated problems of alcoholic thinking, defense structure, and many other personality characteristics that AA refers to as the "dry drunk" personality.

Although not a term endorsed by the medical or mental health professions, AA identifies the following symptoms of the "dry drunk": grandiosity, judgmentalism, intolerance, projection, emotional detachment, denial of responsibility, all or nothing thinking, a tendency toward over-reaction and a difficulty with introspection.

Frank cites many examples where George Bush reflects these particular traits in various situations and crises before and during his Presidency. The most glaring example is his behavior and reaction post September 11th and the rush to war in Iraq despite strong national and international opposition. Even after it became clear that there were no weapons of mass destruction or any solid evidence linking Saddam Hussein to Al Qaeda, Bush was unable to take any responsibility for mistakes in judgment, preferring to deny the accepted findings of various commissions and blaming the CIA for distorted intelligence. In late August, 2004, he did admit to some "miscalculations" in the Iraq situation.

Research has shown that heavy drinking over the long-term can cause particular deficits in cognitive functioning, including judgment, memory, attention, and the ability to process

new information. Here the diagnostic picture becomes more cloudy, as some of the learning disabilities—especially those involving speech—could overlap with the symptoms related to his alcohol abuse. George Bush's simplistic understanding of complex issues, his tendency to perseverate in repeating phrases, even showing signs of confabulation, are all signs that that he may be impaired by his history of alcoholism and lack of treatment for it.

The looming question—the elephant in the Oval Office in this case—is what are the chances that George Bush has relapsed or could relapse while in office? As any clinician knows, a person with a longstanding addiction who has never received treatment is particularly vulnerable to relapse. Considering the enormous pressure placed on the President, could George Bush be one crisis away from a slip? Does the American voter regard alcoholism as a character flaw? And are they prepared to accept the risk of relapse in selecting George Bush to lead the nation for another four years?

## Diagnostic Impressions

Frank's impressive, arms-length analysis draws to a close with his diagnostic impressions of the man he has come to believe is unfit to be President. Frank concludes that George Bush suffers from a mild thought disorder brought on by his anxiety, his undiagnosed ADHD and learning disabilities and history of alcoholism that impairs his functioning. In terms of his psychological character, Frank believes that Bush shows some paranoid ideation in his tendency to see the world as threatening, when the enemy is only a very small contingent of aggressors. He describes Bush relying on a "protective delusion" that holds that he—George Bush—is right, all-knowing and supported by his faith in God while everyone else is wrong, misguided and regarded as a threat. Bush's oft-repeated phrase "They hate us because we are the greatest nation on earth" reflects this attitude of moral superiority. This defense, Frank suggests, is what holds at bay his paranoid thoughts and fears.

Despite the thoroughness of his research, there are weaknesses in the conclusions that Frank arrives at that raise questions about his objectivity. Frank takes the diagnostic leap that Bush's paranoia and delusional system

amounts to a diagnosis of "megalomania," citing his singular drive to "remake the Middle East" while showing indifference to the damage and loss of life, lack of guilt or compassion, and his inability to take responsibility for his mistakes, miscalculations or unintended effects. However, this diagnosis seems a bit of a stretch, especially since this diagnosis is no longer found in the DSM-IV. Since Frank believes that George Bush has a character or personality disorder, a diagnosis on axis two of narcissism with paranoid and grandiose features would seem more prudent.

Furthermore, although Frank has exhaustively reviewed the public record in assessing pathology and declaring the president unfit, one must consider his conclusions in its proper psychotherapeutic context—he never examined the patient he is talking about. For some readers, what he has done may seem unprofessional or even unethical. However, considering that ethical and practice guidelines are designed primarily for clinical practice rather than political discourse, and the Bush campaign has made character an issue for their advantage, Frank has every right to use his psychiatric knowledge to assess character about a public figure as controversial—and critical to our overall wellbeing—as George Bush.

Finally, in an election so crucial to the future of this country—and especially so considering the actions taken by George Bush during his first term—voters would be well advised to consider all reasonable sources of information about the character of the candidates before making their choice for president. Character should count and so should the respective records of the candidates. But, character should not be defined solely by one candidate's preferred criteria. If we are to consider the moral character of George Bush, it is only fair that we assess the psychological side of character as well. And in this definition, the available evidence does not seem to favor George Bush.

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## Surviving Schizophrenia

*continued from page 8*

their illness. It takes a remarkable amount of courage to fight back against such a disabling condition, and the heroism of such persons is clearly evident in this chapter. It is must reading for psychologists who work with clients with delusional disorders.

Clinicians with an academic bent may find the chapter entitled "Theories About The Causes Of Schizophrenia" particularly interesting. Dr. Torrey covers current theories of genetic, neurochemical, developmental, nutritional, stress-related, and infectious and immune causes of the disorder. He is equally thorough in explaining such obsolete and totally scientifically discredited theories as those of Dr. Thomas Szasz, who denies that schizophrenia exists, and Dr. R. D. Laing, who believed that schizophrenia was a sane response to an insane world and was potentially a growth experience. Additionally, in Appendix A, "The 15 Worst Books on Schizophrenia," Dr. Torrey excoriates the nonscientific writings of Dr. Peter Breggin, who has become the darling of the anti-psychiatry movement. Dr. Breggin wrote that people who are mentally ill are responsible for making themselves that way and remains adamantly opposed to all psychiatric medication, despite the overwhelming scientific research that supports its use.

There is frequently confusion, even among clinicians, as to what schizophrenia is. Chapter Four, entitled "Conditions Sometimes Confused With Schizophrenia," differentiates between schizophrenia and other psychotic disorders. This chapter is important to clinicians, particularly clinicians who do not regularly work with serious biological mental disorders, because often symptoms of schizophrenia are remarkably similar to those of other disorders. For example, a few years ago, I began working with a new client whose tentative diagnosis was schizophrenia, paranoid type. In fact, the client was addicted to methamphetamine and suffered from methamphetamine-induced psychosis. When he finally entered a residential treatment program and stopped using drugs, his psychotic symptoms gradually disappeared. As I was re-reading this chapter in *Surviving Schizophrenia*, I was reminded of a

*continued on page 18*

The California Psychological Association is the organization most directly involved in protecting and advancing the interests of our profession in a state where the profession of psychology has not always been well-supported. For this reason, the direction that CPA takes in coming years will have a substantial effect on the future of our practices. In this issue, we have chosen to present the platforms of the two candidates currently running for the position of 2005 CPA President-Elect. Both of these candidates have worked with members of our board for years, and both are highly respected. Their platforms codify some of the most central issues facing CPA today. Ballots for the election went out in the September issue of the California Psychologist and are due by October 1st. We hope all CPA members will take this opportunity to consider carefully the future evolution of our organization—and be sure to vote!



## Expanding and Protecting Our Profession Gilbert Newman, Ph.D., [www.NewmanForCPA.org](http://www.NewmanForCPA.org) These Aren't Promises—This is What I'm Doing...

### Protecting Licensing Laws

I'll help protect our professional licensing laws. I don't want psychology being regulated by the same Board as masters level clinicians. This would not be good—I'm working to preserve our Board.

### Protecting Scope of Practice

I'm currently involved in protecting State employed psychologists from unfair practice restrictions and I'm also involved in helping to prevent other professions from being permitted to perform psychological activities without proper training.

### Advocating for Parity—Improving Access

I've supported federal parity and will continue working to see this bill passed. I'm supporting the ballot measure to expand

mental health services. I've designed access oriented mental health programs to address the needs of homeless people, incarcerated populations and others. I'm directing a project to investigate ways for psychologists to address inner-city violence.

### Working for Prescribing Privileges (RxP)

RxP will benefit all psychologists. I'll protect psychology's core values and that we aren't compromised by insurance and pharmaceutical company's special interests. I'm developing a fundraising plan to support RxP. Every psychologist needs to contribute to the welfare and development of our profession—not just the paying members. I am reaching out to the non-members to contribute to our causes.

*continued on page 14*

## A Strong and Responsive CPA—Richard Sherman, Ph.D.

When I talk with psychologists, many say, "Why should I join CPA? It's just not relevant." My proposed agenda, which is **strong on both advocacy and value added benefits**, will assist in retaining and attracting members, help us become fiscally robust, and move us forward in keeping with my theme of "A STRONG AND RESPONSIVE CPA":

[www.sherman4cpa.com](http://www.sherman4cpa.com)

### Reverse the Significant Devaluation of Our Profession and of Health Care

The devaluation of our profession, being reimbursed by some insurance companies at 1987 rates, has to stop. The Professional Practice Division (for which I was 2003 Chair) initiated an extensive lobbying campaign to effect United Behavioral Health's finally agreeing to increase rates for 90801's (initial evaluations). We need to activate our role in assisting our members as they interface with insurance companies, while advocating for a full review of outdated reimbursement rates and broadened access to care.

### Serve All California Psychologists by Enhancing Membership Benefits

As I worked for LACPA (2000 President), I will highlight and promote CPA as an inclusive organization that will address the needs of psychologists in different specialties and settings and provide more outreach to graduate students, new professionals, and diverse groups. I propose a Mentoring and Career Development program to maximize professional growth.

*continued on page 14*

## **Gilbert Newman, Ph.D., *continued***

### **Working for Education**

I'm one of the first recipients of APA's Board of Educational Affairs Education Advocacy Distinguished Service. I've lobbied for the Graduate Psychology Education Act—supporting training for psychologists working with underserved, aged and rural populations. To this end, I've met with senators, congressmen, and I've worked closely with APA. I established the only exclusively California pre and postdoctoral training publications.

### **I Will Work to Achieve...**

#### **Building Membership and Services**

CPA must grow. Increased membership will afford improved services. We need to appeal to the 80% of psychologists who aren't members. As a clinician, educator and advocate, I can reach more of our colleagues and bring new life into CPA.

#### **Promoting Diversity**

I'll continue current and develop new efforts strengthening CPA's diversity. We must provide opportunities directing youth toward psychology—we need training stipends and other means for diverse students to afford school.

#### **Revamping CPA's Image**

I want CPA's to be the best association website. We must provide useful, sophisticated information that supports you as clinicians, consultants and as business owners. Our online information is great—we should continue to build online services.

#### **Facilitating Board Effectiveness—Retaining and Attracting Staff**

A team player with a track record directing successful programs, I enjoy my relationships with CPA Staff. I'll work to improve our capacity to pay competitive salaries and expand staff. My leadership experience and group relations expertise will serve in maintaining Board efficiency.

#### **I am Committed to:**

- Reinstating face-to-face Governmental Affairs Representative meetings
- Building Lobbying Capacity
- Developing Early Career Resources
- Providing quality, affordable CE—accessible in-person and online

E-mail: [gnewman@wrightinst.edu](mailto:gnewman@wrightinst.edu)—Let me know your response to my goals and if you'd like to help achieve them.

## **Richard Sherman, Ph.D., *continued***

We need to make CPA much more “resource rich and user friendly” by assisting at every stage of a psychologist's career. The CPA website will be modernized with online CE courses offered for all mandatory course requirements. At Division I, we are already working on developing valuable resources (e.g., the Expertise series).

### **Amplify Statewide Public Education**

Many in the public still do not know or appreciate the difference between psychologists and others in related professions. I have started working with 2005 APA President Dr. Ron Levant on his objective of “Making Psychology a Household Word” or as I add “A Positive Household Word”. Towards this end, CPA will provide consumer education forums throughout the state.

### **Protect and Increase Our Scope of Practice through Expanded Advocacy**

We must further develop our grassroots efforts and devote more time, energy, and funds to protect and increase our scope of practice. I have actively engaged in advocacy efforts for close to 20 years. (e.g., lobbying to prevent an earlier attempt to sunset our licensing laws). Obtaining prescriptive authority in California, full mental health parity at the federal level, and guaranteeing that laws are followed so that public sector psychologists can practice independently are priorities for which I will continue to work.

I bring to CPA **PROVEN EFFECTIVE LEADERSHIP**. Since 1977 I have been actively involved in every facet of local and California state psychology organizations. I am committed to our members and the community. With my passion for our profession, strong leadership experience, ability to build consensus, earn staff respect, and effect change, **I will work for you at CPA**. In the process, I want us all to celebrate our **UNITED STRENGTH AS A PROFESSION**.

Visit me at [www.sherman4cpa.com](http://www.sherman4cpa.com) to address issues important to you and remember to vote.

# Conference Reviews

## Hawaii Dreams: Notes from APA's 2004 Convention

By Gary Seeman, Ph.D.

A week after returning from this year's APA convention, I still dreamed I was carefree in Hawaii. I experienced the convention itself as a dreamscape—joining throngs of psychologists to ride a three-story escalator with dizzying skyline views, attending a slide presentation with a stunning view of Diamond Head out the side window, squinting at exchange rates posted in Japanese, debating theory over beachside umbrella drinks, and sampling local specialties at a restaurant whose menu features “squid pizza” that “tastes kinda like pumpkin pie.” Like a dreamer, one experiences an APA convention as colorful fragments of a much larger picture. This article shares impressions of the events I attended in the hunt for current knowledge from recognized experts.

On the first day, I had to pinch myself at symposia on spiritual intelligence and inte-

grating Buddhist principles into psychotherapy. I was unprepared for the inclusiveness of such offerings and the presentation of current research on bisexuality.

Participants at the first symposium discussed development of a spiritual intelligence factor based on Gardner's model of multiple intelligences and objections by Gardner about their doing so. In addition, Jean Kristeller presented her research on using mindfulness meditation in the treatment of Binge Eating Disorder.

C. Peter Bankhart opened the psychotherapy and Buddhism symposium by describing his teaching of mindfulness meditation to angry teen males, counteracting the ignorance that often lies at the root of anger. Belinda S. L. Khong highlighted the role of detachment to reduce the suffering of trauma victims who often find it difficult to “forgive the unforgivable.”

The symposium on research in bisexuality offered a wealth of new perspectives in this under-researched area. I learned that

sexual self-identification is now considered to include both romantic desires and sexual attraction. Also, many bisexuals initially self-identify as homosexual before discovering that their desires lie along a spectrum.

Participants noted that “biphobia is alive and well” in those of other orientations and in religious communities. They also noted that bisexuals often struggle to assert their identity rather than be defined by others.

I spent two days studying assessment and treatment of Adult Attention-Deficit/Hyperactivity Disorder (ADHD), with the first day devoted to evaluation and management. I was struck with the depth of material presented on research and assessment and a lack of detailed discussion of psychotherapy and case management. The assessment seminar taught by Robert Mapou was much better organized. All presenters stated that results of a test battery are insufficient to diagnose adult ADHD, with thorough history-taking,

*continued on page 16*

## International Workshop on Analytical Psychology in Childhood and Adolescence

By Liza Ravitz, Ph.D.

This May I attended the International Workshop of Analytical Psychology in Childhood and Adolescence in Denmark. It took place in a beautiful setting right on the ocean of the North Coast. The model for this workshop was novel to me. The first 40 people to sign up were accepted. The ethic was that there was no hierarchy among us. We were there to equally share our work and to equally help each other with new thoughts and ideas. At the workshop people were divided into groups of 6-8 people based on language. I was in the “English” group, which consisted of 3 Italians, 2 French women, 1 Englishman, 1 Dane, and myself. The Europeans struggled gallantly to keep the discussion in English but at times broke into their native tongues—sometimes all at once!

Each day was organized around discussion of a case presentation or theoretical paper by

one member of the group. For example on the first day, the Englishman presented a case about an African child. The African boy, age 11, was a refugee who had to flee his native Somalia to avoid being killed in their civil war. He was a victim of severe trauma. In fact he was conceived as a result of rape. His mother was barely functional and could not take care of him. The therapist presenting the case saw the boy in an institution for juvenile offenders. Throughout the treatment he tried to get the boy into a more appropriate setting, but to no avail. The treatment ended with the therapist having to leave the institution and the boy getting involved in violent activities. During the presentation, the group discussed the artwork the boy had done. It was an interesting experience to be with these Europeans and to see that we basically all came to the case in the same way, analyzed the pictures in a similar way, and were able to discuss the case as if we had been in our home countries with our usual colleagues. The therapist expressed his distress at the futility of the situation. All of us were able to empathize with his position, having experi-

enced such situations ourselves in our own child cases. A lot of pain was expressed in the group about the plight of children and the lack of control we often have over cases that involve trauma and chaotic environmental conditions. I experienced a sense of bonding with these Europeans realizing that we all have had similar experiences. The therapist felt this presentation had been healing for him as a result of sharing with others his frustration and pain at the failure of the case and having genuine empathy returned—albeit in three different languages!

What I found interesting was that many of the child therapists were working with different ethnic groups that had immigrated to their countries as a result of traumatic events. In Denmark it was the Turks and Palestinians, in England it was the Somalians, in Italy and France it was the Algerians. I again realized the universality of our work. Although they were dealing with different ethnic groups than I, the same problems of poverty

*continued on page 18*

including observer interviews, being key to documenting its necessary inception in childhood. Kevin Murphy and co-presenter Sam

Goldstein saw medication as the most effective treatment, discussing psychotherapy as a means of helping a person recognize the condition and cope with the assistance of ongoing coaching.

My next symposium offered current findings about psychotherapy effectiveness for coronary heart disease patients. The consensus is that targeted, brief psychotherapy helps achieve better mental and physical health outcomes. Gill Furze found that misconceptions about angina can result in worse coping and health outcomes. She presented a psychotherapy model that includes the patient's spouse and targets misconceptions about the cause of disease and one's ability to affect physical outcomes through attitude and lifestyle changes. Stanton Newman presented his research on differences in patient expectations following different levels of physical intervention (bypass surgery or angioplasty versus medication alone). He said that patients receiving more intensive treatments have higher expectations of a successful outcome; and, when these expectations are not met, their attitude and coping skills can be adversely affected.

We now know that women typically show heart disease symptoms at least a decade after men and present with different symptom clusters than men, resulting in underdiagnosis. Karen Matthews addressed this dilemma by discussing her research that uses innovative diagnostic techniques to detect early heart disease markers in women. Empowered with this knowledge, health care

providers have the opportunity to institute preventive psychotherapy early to alleviate depression, promote optimism, and improve mental and physical health outcomes.

On the last day, I attended an eye-opening symposium on current findings in bereavement therapy. George Bonnano began by countering common myths. For instance, the absence of prolonged distress or depression is not disordered mourning, as Bowlby claimed. He also said that there is no such thing as delayed grief, a different finding than what we know about delayed trauma reactions. The current research he presented reveals that the largest group of bereaved people is resilient, heterogeneous, and comprises 45 percent of the bereaved. This group recovers normal functioning within one to two months of their loss, without therapy. Others recover gradually over one to two years, with about 17 percent comprising the chronically bereaved. Members of this last group are often anxiously attached and/or overly dependent, with most factors predicting chronic grief also predicting chronic depression. Robert Neimeyer presenting troubling findings that psychotherapy for bereavement is generally ineffective. He said that more research needs to be done about the cause of this. He shared current thinking that interventions are often too early or too late. He recommended waiting for more problematic reactions to crystallize so they can be addressed. He said that people more likely to benefit from bereavement counseling are the young, those experiencing chronic, intense grief, and people who have experienced high-risk losses, such as death of a loved one by homicide, suicide, or death of a child. In general, he recommended that

we do a better job of screening people for a high-risk complicated grief profile, and that we offer therapy of longer duration for those who need it.

Spending two full days in classes necessarily excludes other events. I missed the opportunity, for instance, to attend panels featuring Marsha Linehan, Albert Bandura, and Philip Zimbardo, and a debate between APA President-Elect Ron Levant and Bruce Wampold about the clinical relevance of evidence-based therapies.

As the convention ended, I felt that it could have been better organized. I would have loved the opportunity to visit booths on the convention floor but afternoon lectures and all-day classes prevented doing so with all exhibits but the APA bookstore closing at 2 PM I found the registration process unnecessarily chaotic, with long queues and little advance notice given to register for CEUs before arrival. However, the overall excellence of the presentations and the location more than made up for these shortcomings. Like many, I took the opportunity to island hop for another week and dream about Hawaii's laid-back aloha spirit for many days after my return. And in case any culinary adventurers reading this article are still wondering, that squid pizza was actually good, and it did taste like pumpkin pie!

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**Gary Seeman, Ph.D.**, is a clinical 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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## Ethics and Issues

*continued from page 7*

apy itself grows deliberately indistinct.

Granted, this approach relies more on my clinical judgment and conscientiousness than does an approach based on a conventional form. And granted, too, this approach is probably riskier; I have no trouble imagining a plaintiff's attorney mockingly saying to me, under oath, "... and where is this approach presented in the professional literature ... ah, in other words, you made it up yourself?" But

despite these concerns, this is the approach that makes the most sense to me.

## References

- APAIT. (2004). Sample Informed Consent Contract. Downloaded from [www.apait.org/resources/riskmanagement/inf.asp](http://www.apait.org/resources/riskmanagement/inf.asp). (The document appears largely unchanged since 1999.)
- Fridhandler, B. & 2004 Expertise Series Task Force. (2004). Informed consent. (Contained in The Expertise Series, provided to members of CPA Division I, and available soon to all CPA members at cost.)

## Notes

1. Actually, the APAIT Web site refers to it by this title but also by the more generic "Sample Psychother-

apist-Patient Contract."

2. The Expertise Series document puts it this way: "Informed consent forms and notices may facilitate this process and the psychologist may *choose* to use them." (Emphasis added.)

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**Bram Fridhandler, Ph.D.** is Ethics Chair for the San Francisco Psychological Association, and is 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.

# This man is smiling because:



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- B) He networked with colleagues over an appetizing lunch.
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## Surviving Schizophrenia

*continued from page 12*

conversation I had nearly a decade ago with a mental health practitioner who claimed that he had a remarkably high cure rate for clients with schizophrenia—despite the fact that he was adamantly opposed, on philosophical grounds, to psychiatric medication and psychiatric care. However, his claimed cure rate soon became understandable as we talked. Because he considered the DSM-4 to be an artificial construct, he did not use the DSM-4 for diagnosis and thus was not differentiating between psychotic disorders. He would likely have considered schizophrenia and say, psychosis caused by lack of sleep or psychosis caused by prescription drugs as being the same.

Because trying to get treatment through the labyrinth of city and county mental health systems can be daunting and because treatment for schizophrenia can potentially be expensive, chapter eight, “the Treatment of Schizophrenia: Nonmedication Aspects” and Chapter Nine “The Treatment of Schizophrenia: Medications” are an invaluable resource for families trying to get treatment for a family member afflicted with schizophrenia. Chapter Eight is subdivided into such topics as “how to find a

good doctor,” “hospitalization: voluntary and involuntary,” “alternatives to hospitalization,” “outpatient treatment and managed care,” and “payment for treatment and insurance parity.” The chapter on medications clearly explains what each of the most common anti-psychotic medications do and what their side effects are. There is even a section of the chapter entitled “Drug prices and the Use of Generics.” All of this information is useful, clear, and succinct. Dr. Torrey also identifies treatment fallacies and places them squarely where they belong: outside the world of scientific treatment for this tragic illness.

The final chapter, “Issues For Advocates” is a fine introduction in how to educate the public in decreasing the stigma of schizophrenia and how to advocate for increased services for persons with schizophrenia. Among many suggestions, Dr. Torrey recommends developing a speakers’ bureau that offers to talk to community service organization and churches, temples and synagogues, law enforcement groups, and schools about schizophrenia and its treatment. Because chronic biological mental disorders are seldom taught in depth at universities, he also suggests guest speaking to college and

university psychology classes on the subject. He gives concrete advice on how to communicate with community mental health and hospital officials in getting better treatment for persons with schizophrenia in one’s own community. He also lists useful videos and books and organizations where one can get detailed information on treatment and support for persons diagnosed with schizophrenia.

*Surviving Schizophrenia* is actually a book that does more than what its title claims. It answers just about any question about schizophrenia a person might have. It lists the finest journals to read in order to keep up with current research. It is an excellent resource for families, consumers and mental health practitioners and a recommended text for clinicians, even those who don’t work with schizophrenia.

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**Patrick O’Reilly, Ph.D.**, 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.

## International Workshop

*continued from page 15*

and emotional trauma were present. Again we shared a common experience.

I came away from the conference feeling a sense of renewal about my work, a sense of global community, and a sense of a much wider perspective than when I arrived. The conference helped me realize that I am part of a much greater community of therapists who have similar experiences in their work day. I would highly recommend attending an International Conference. It is an antidote to the isolation of our therapy rooms.

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**Liza Ravitz, Ph.D.**, is a licensed psychologist in private practice in San Francisco and Petaluma. She also is the current Treasurer for SPPA.



## New Member Profile

**Introducing new member Robert A. Liss, Ph.D., J.D.**

I have been practicing psychoanalysis and psychotherapy in San Francisco since 1985, one year after completing analytic training at the New York University Postdoctoral Program, where I also taught, focusing on pre-oedipal issues and addictive disorders.

In my subsequent teaching, including at CSPP, I have used the comprehensive model of the mind developed by Chicago psychoanalyst John Gedo as a guide. Gedo’s hierarchical-epigenetic model has deepened my thinking, helping me combine a genuinely psychoanalytic approach with a developmental focus, and propounding a model that both legitimates and makes room for responding in a deeply personal way.

I also see couples, both as a therapist and as a mediator, and have worked in diverse milieu and residential settings, especially with adolescents. Having studied law before psy-

chology, I maintain familiarity with the workings of the legal system by serving as an expert witness, most often in cases involving PTSD. Bridging the communication gap between law and dynamic psychology has been an interest for several decades, following up on a 1975 paper I published on the subject of court-mandated treatment.

I am in full-time private practice in San Francisco and Kentfield, with a sliding fee scale, especially for patients coming more than once a week. My previous affiliations have been with PINC, CSPP, the VA, and Boyer House Foundation.

*If you are a new member of the San Francisco Psychological Association in 2004 and would like to introduce yourself to our community, please submit a profile of approximately 150 words to the editor, Cannon Thomas, at [cannonthomas@sbcglobal.net](mailto:cannonthomas@sbcglobal.net).*

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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.

**SPECIAL TRAINING FOR LICENSURE**

Co-sponsored by the San Francisco Psychological Association and Alliant International University

**Spousal Abuse, Partner Abuse and Domestic Violence: A Review of the Literature**

Michael Donner, Ph.D.

3 hours—\$75\*

Saturday, October 16, 2004 · 9 a.m.—12 p.m.

All psychologists are required to have attended a course that contains training in spousal or partner abuse assessment, detection and intervention strategies. Fulfilling that requirement, this course also reviews the distinction between abuse and violence. The legal system sometimes confounds the two resulting in problematic interventions. This course will also cover community resources and review current literature on cultural factors and same-gender abuse dynamics.

*This course meets and exceeds the Board of Psychology (BOP) one-time requirement for training in spousal or partner abuse.*

**\*Register for both workshops for \$165—save \$10. A 10 percent discount is available to SFPA members if you are only taking a single course.**

**Psychological and Legal Aspects of Aging**

Abraham Nievod, Ph.D., JD

4 hours—\$100\*

Saturday, October 16, 2004 · 1 PM—5 p.m.

This course emphasized an integrative approach to the biological, social, and psychological issues on aging, emphasizing clinical assessment and legal issues for treating and consulting psychologists. The course begins by examining the cognitive and biological processes of normal aging, contrasting them with major disease processes such as dementia. Participants will learn about neuropsychological changes and issues related to diagnostic testing, psychotherapy issues such as diagnosing and treating depression, and placement and care issues. The course also covers age-related legal issues such as elder abuse involving financial fraud, undue influence or crimes against the elderly, assessment of competency, need for conservatorships, durable power of attorney for health care and advance directives, and California Probate Code issues involving opinions by mental health professionals.

*This course meets and exceeds the Board of Psychology (BOP) one-time requirement for training in aging and long-term care.*

These workshops will take place at the San Francisco Campus of Alliant International University at One Beach Street. To register, call the AIU CE office at 800/457-1273 or complete the online form on Alliant's Web site: [www.alliant.edu/ce](http://www.alliant.edu/ce)

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

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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 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
July issue	June 1
September issue	September 1
December issue	December 1

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