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FALL 2007 / Volume 10, number 3

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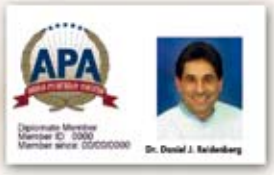

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One new *Annals* feature is the **Mailbag**, where we hope you will respond to the Current Issue or any material presented in *Annals*. This month's Mailbag contains a Letter From the Editor and the issue open for discussion is "Voting Rights."

Dear Members,

As I look ahead to next year and begin to plan for *Annals*, I find myself wanting additional cohesion within each journal issue. We at have decided to use a thematic approach so we may delve more deeply into specific subjects. Each issue will now contain more connectors and common threads. We will continue to accept submissions on any topic about which you may wish to write, and we will continue to feature the regular columns; however, we would like each issue of the journal to offer its own common thread. The general categories presented will be deliberately broad in anticipation of the rich diversity of discourse within each topic. **Articles need to be approved for CE credit prior to the copy deadlines listed below.**

To begin, we would like to have our first issue of 2008 focus on **counseling children**. Any specific aspect within the general discussion of counseling children is an acceptable topic for an article. **The copy deadline for the Spring 2008 issue is December 28, 2007**. Send in your submissions now!

The theme for the Summer issue will likely be **addiction counseling**. Have you counseled clients who have struggled with any type of addiction or the families of someone battling an addiction? Your research on this pervasive topic is needed! We're seeking any articles within the broad range of topics addressing addiction. **The copy deadline for the Summer 2008 issue is March 28, 2008**. It is never too early to submit an article.

Fall 2008 will bring a focus on **autism**. There has been so much recent groundbreaking medical research in this area. Working with autistic children, teenagers, and adults, and those in their lives, is an emotional, yet fulfilling, aspect of psychotherapy. Share your insights, your stories, and your research. Shed light on this often misunderstood area. **The copy deadline for the Fall 2008 issue is June 27, 2008**. Don't wait to submit your article!

The holiday season is often one of the hardest for many people to endure. At this time, particularly, **depression** is on the rise, and therapists in all fields may find their clients experiencing setbacks. Thus, the Winter issue of 2008 will center on depression. All people are susceptible to depression, from babies to grandmothers, from the very rich to the very poor, and everyone in between. Depression affects the lives of the depressed and everyone around them. Submit your articles on depression now—don't wait until next year sneaks up on you! **The copy deadline for the Winter 2008 issue is September 14, 2008**.

Help us transition by submitting manuscripts, articles, case studies, and columns. We want to make *Annals* the journal you turn to when you have professional needs—help us ensure the professionalism of the journal by submitting your articles for peer-review. Further, if there is a topic you'd like to see discussed by your colleagues in *Annals*, please send us your suggestions!

Manuscripts should be sent to Charlyn Ingwerson via email at charlyn@americanpsychotherapy.com or on electronic disk via mail to 2750 E. Sunshine Street, Springfield, MO 65804.

I look forward to receiving your articles!

Kristin A. Crowe

Editor in Chief
Annals of the American Psychotherapy Association

Current Editorial Issue: Voting Rights

Consider two similar, but different, recent issues regarding who is allowed to vote. While only Maine and Vermont allow jailed felons to vote, many states allow those in mental institutions declared *not guilty by reason of insanity* to vote. These people have committed crimes that would have required a prison sentence had the defendants not been judged *insane* at the time of the crime. The crimes committed would have resulted in both conviction and loss of voting privilege until such time as their release. However, because they were declared not guilty by reason of insanity, they are allowed to continue voting. Many law and policy makers, as well as state office holders who have learned of this policy, believe that a person judged not guilty by reason of insanity should be declared too mentally impaired to vote. This raises another question plaguing some state legislatures: *Who* is too mentally impaired to vote? Where is the line drawn?

More than 40 states impose some kind of mental competency requirement for those who have a mental illness, though states vary widely in their processes for revocation of voting rights. Often persons are stripped of their voting rights when they are deemed by the courts as unable to care for themselves in some capacity, resulting in the appointment of a guardian. The reasons for guardianship vary from dementia to bipolar disorder to schizophrenia, or said guardianship may apply to only one area, such as making sure the person under guardianship is taking his or her medication or managing his or her finances. Thirty states categorically prohibit people under guardianship from voting. Some states automatically strip voting rights from any person who is court-appointed a guardian, even if it is only partial guardianship, and the right to vote is subsequently restored

only to individuals who successfully appeal for the right in court. In these cases, a successful appeal will depend upon the judge's reading of the state constitution, precedent, and the circumstances particular to the case. Other states leave voting rights intact for those under partial guardianship, while those under full guardianship are ineligible. Still other states have adjusted the laws to allow those with a mental illness to vote *unless* the right is specifically revoked by the courts. Court proceedings that decide whether a person should receive a guardian typically do not weigh evidence pertaining to voting.

Most states do not remove the right to vote from persons who are admitted into a facility solely because they have been admitted. However, older adults with memory loss or depression could have their voting rights removed if they need a guardian or if their nursing home does not offer them the opportunity to cast their ballot. Those admitted to a hospital due to anorexia, depression, or a suicide attempt are often denied the opportunity to vote. For a person in a vulnerable condition such as any of these described, the opportunity to vote may be inhibited several ways: either by institutional failure to provide a means to the voting process or by denial of the process. Persons who are bipolar or autistic frequently require the declaration of a guardian who will vouch for their cognitive well-being; obviously, many such persons are fully capable of following political policies and deciding on candidates. The right to vote is frequently taken from these individuals, even though their mental illness inhibits neither their understanding of political issues nor their ability to cast a vote. Laws that arbitrarily prohibit those with mental illnesses from voting fail to take into account that a person's capacity to vote is often not affected by their illness.

Some lawmakers posit that individuals with a mental illness should be required to show that they understand what the voting process is about and how elections work; however, when average citizens register to vote, they are not required to do this. The only currently applicable question asked at the polls is, "Are you registered?" Any legislation requiring a qualifying question would serve to make a citizen who has a mental illness subject to more stringent voting requirements than those required of any other citizen.

In a 2001 decision, the United States District Court for the district of Maine declared that in prohibiting the voting rights of persons under guardianship for mental illness, the Maine Constitution violated the Fourteenth Amendment and the Americans with Disabilities Act. The plaintiffs were three women under full guardianship by reason of mental illness. Two were diagnosed with bipolar disorder, and the third was diagnosed with intermittent explosive disorder, antisocial personality, and mild organic brain syndrome (secondary to encephalitis). One of the women diagnosed with bipolar disorder had argued in Probate Court that she was not incapacitated and needed only partial guardianship that would ensure she took her medication. The Probate Court, however, disregarded this argument and placed her under full guardianship. Her doctor stated that he believed she had the mental capacity to understand the nature and effect of voting, despite his belief that she does not have the capacity to make responsible decisions regarding her psychiatric treatment.

The plaintiff diagnosed with intermittent explosive disorder was said by her doctor to have the mental capacity to understand the nature and effect of voting such that she could make an individual decision with regard to candidates and questions on the ballot. The doctor further stated his belief that "a person under guardianship for a severe mental illness 'is more likely to be monitored and receive treatment which will help restore him or her to capacity in areas such as voting,' as compared to a similarly situated mentally ill person not under guardianship;" however, those under guardianship lose their right to vote, while those not under guardianship retain it.

The Court "based its due process analysis on a finding that the denial of the right to vote is a denial of a fundamental liberty." The Court found that "the State has disenfranchised a subset of mentally ill citizens based on a stereotype rather than any actual relevant incapacity." The Court also found that under any reasonable definition, "mental illness" cannot serve as a proxy for mental incapacity with regard to voting, as all definitions were found to be either fatally under-inclusive or over-inclusive. This 2001 decision has become a model for other states, but some have been slower to act than others.

Send us your responses! Should those judged not guilty by reason of insanity be allowed to continue to vote? Why or why not? On what grounds are they sufficiently competent or incompetent? Should states determine who is allowed the right to vote based on mental illness, on guardianship status, or on knowledge of the election process? If you had to decide where to draw the line, what and how would you decide? How does your state decide who is mentally incompetent and who is allowed to vote? Do you agree with those methods?

Please send typed responses of no more than 200 words to Kristin at editor@americanpsychotherapy.com.

Sensory Processing Disorder

MCT Illustration by John Roberge/Talahassee Democrat

There may be hope for children who don't adjust normally to the sensory aspects of the world in which we live. Both therapists and researchers have petitioned the American Psychiatric Association to include sensory processing disorder in the *Diagnostic and Statistical Manual*. Official recognition of the disorder would bring needed research and more complete coverage for treatment; however, the decision is not expected for another 4 years.

Some children with sensory difficulties have developmental disorders, but many otherwise healthy children are either oversensitive, continually recoiling from sights, sounds, and touches that make them uncomfortable, or they are undersensitive, seemingly oblivious and unaffected by what is happening around them. These problems are very real for many children and their families, yet, a sensory integration problem diagnosis is not widely accepted and there is no research to guide treatment. This is changing, though, as sensory integration is becoming more accepted in special-needs situations and as parent groups devoted to sensory problems have tripled in number, to 55 groups nationwide.

The children may react strongly to certain sounds, textures, or other sensations. They may gag when sniffing a common smell, undress when the texture of the fabric is unbearable, or cry when someone touches them. On the other end of the spectrum, they may appear unusually numb to sensory stimulation and may spin or flap their arms as if seeking stimulation or relief of pain. Occupational therapy is a common treatment for children demonstrating symptoms of sensory disorders. The therapy is intended to make the children more comfortable as they engage the sensations that disturb them or to make them more alert to those they usually do not notice.

Information retrieved from http://www.nytimes.com/2007/06/05/health/psychology/05sens.html?ex=1338696000&en=9c85f6483ae15751&ei=5089&partner=rssyahoo&emc=rss

Male Depression Associated with Poor Childhood Sibling Relationships

MCT Illustration by Gary Meader/ Duluth News-Tribune

Poor childhood sibling relationships are strongly associated with depression in men, says a study published in the June issue of *The American Journal of Psychiatry*. Of the participants "who had poor or destructive relationships with siblings, 26% had episodes of major depression as adults." The study involved only men, and does not measure the association between sibling relationships and depression for women.

The authors of the study found that "poorer relationships with siblings prior to age 20 and a family history of depression independently predicted both the occurrence of major depression and the frequency of use of mood-altering drugs by age 50, even after adjustment for the quality of childhood relationships with parents. Poor relationships with parents in childhood did not predict the occurrence of depression by age 50 when family history of depression and the quality of relationships with siblings were taken into account." A man with an average parental experience, no family history of depression, and a good relationship with at least one sibling would have only a 2.3% chance of becoming depressed. However, a man in similar circumstances but with a poor relationship with siblings would have a 9.9% chance of developing depression. When you combine a family history of depression with a poor sibling relationship, the man's risk for becoming depressed equals 30%. It is unknown whether the depression caused the destructive relationships, the destructive relationships led to the depression, or whether the two act on each other to increase the risk.

Between 1939–42, when they were 18 or 19 years old, the 229 men in the study were first assessed by internists, psychiatrists, psychologists, and anthropologists. After that, they completed questionnaires every other year and had additional interviews when they were about 25, 30, and 50 years of age.

Information retrieved from http://ajp.psychiatryonline.org/cgi/content/abstract/164/6/949

http://www.nytimes.com/2007/06/12/health/psychology/12sibl.html?ei=5090&en=e590a543ecbf8001&ex=1339300800&adxnnl=1&partner=rssuserland&emc=rss&adxnnlx=1183043339-UtdH42LzfqD6t7HDyPGFiA

Bipolar Genes

MCT Illustration by Dennis Balogh/Akron Beacon Journal

A research team has identified specific genes that put an individual at a greater risk of bipolar disorder. Each solitary gene makes only a relatively small contribution to the overall risk, but together the genes affect the way brain cells communicate with each other. The study, published in the British journal *Nature*, was done by comparing and contrasting DNA samples from 17,000 Britons. Teams studied bipolar disorder, diabetes, hypertension, coronary heart disease, Crohn's Disease, rheumatoid arthritis, and other common diseases.

Approximately 100 million people around the world suffer from bipolar disorder. As a result of the discovery of a genetic link, better diagnostics for mental diseases, as well as new treatments, should be forthcoming. New treatments could include medications, but will likely also include talk-based treatments, education, and lifestyle advocacy. Nick Craddock of Cardiff University, the team that led the bipolar research, said, "With the ongoing scientific advances in understanding of [bipolar] illness, we have the opportunity to make things very different for the next generation. This should be a time of great optimism for those individuals and families that have experienced illnesses like bipolar disorder, schizophrenia, and depression."

Information retrieved from http://www.nytimes.com/2007/06/07/health/07disease.html?ex=1338868800&en=d89a6dafe2a432f0&ei=5090&partner=rssuserland&emc=rss

http://ca.news.yahoo.com/s/afp/070607/world/health_disease_biotech

Did You Forget?

MCT Illustration by Brian Williamson/St. Louis Post-Dispatch

Most people experience frustration when trying to recall a piece of information they need, but have forgotten. However, a study published in the journal *Nature Neuroscience* found that names, numbers, and details are hard to remember, not because memory is faltering or failing, but "because it is functioning just as it should."

The ability to block certain memories reduces the demands on the brain when it is trying to recall something important. The study found that accurate remembering became easier, in terms of energy use, when the participants ignored irrelevant words in a word-memorization test. Once you block out a memory that is unneeded at the time, it is harder to recall later. However, that is exactly how the brain works, allowing you to recall most-used memories (like passwords) more quickly than less-used memories (like your second cousin's pet rabbit's birthday). Often, people struggle to remember new passwords or personal identification numbers because they remember the old ones so well. The better the brain can block those old distracting digits, the easier it can bring to mind the new ones. We have a surprising number of things we don't need to remember stored away in our brains. The trick is forgetting what you don't need so that you can remember what you do need.

Information retrieved from http://www.nytimes.com/2007/06/05/health/psychology/05forg.html?ex=1338696000&en=542015b4e0b4b6c1&ei=5090&partner=rssuserland&emc=rss

Angry Decisions

MCT Illustration by Wes Killingbeck/San Jose Mercury News

A study published in the May, 2007, issue of *Personality and Social Psychology Bulletin* found that angry people can and do process analytically. It has long been thought that anger keeps people from processing information "carefully, fully, or rationally," however, the study found that "anger-induced action might well be the result of quite clear-minded and deliberative processing." The study found that angry people may use both analytical reasoning and heuristic cues— simple, efficient rules that have the potential to create a cognitive bias—at the same time. It was also discovered that participants did not use the heuristic cues as a substitute either for thinking rationally or for processing the information carefully. Instead, they used only relevant cues, those they analytically processed and found applicable to the situation.

Information retrieved from http://psp.sagepub.com/cgi/reprint/33/5/706

Being Mindful in School

MCT Illustration by Dennis Balogh/Akron Beacon Journal

Mindfulness training has come to some American schools, and teachers are using the stress-reducing techniques drawn from Buddhist meditation to help their students mentally focus. Techniques being taught include focused breathing and concentrating on a single object. Initial findings showed increased control of attention and a reduction in negative self-talk in students.

In 1979, molecular biologist Jon Kabat-Zinn pioneered the secular use of mindfulness at the University of Massachusetts "to help medical patients cope with chronic pain, anxiety, and depression." The mindfulness techniques currently being taught in schools are loosely adapted from Kabat-Zinn's work. Mindfulness education has been described as "talk yoga," a concentration training without the exercise component. Yoga terms like "being present" and "cultivating compassion" are used. Although mindfulness is derived from Buddhist meditation and involves some similarities to yoga, the mindfulness instruction in schools is void of any spiritual components.

The New York Times reported that a recent study of teenagers by Kaiser Permanente in San Jose, California, found that meditation techniques helped improve "mood disorders, depression, and self-harming behaviors like anorexia and bulimia." Research, however, has been inconclusive concerning the effectiveness of mindfulness training for children who suffer from trauma-related disorders.

Information retrieved from http://www.nytimes.com/2007/06/16/us/16mindful.html?ex=1339646400&en=d90283bf953dd16c&ei=5090&partner=rssuserland&emc=rss

Womb Rooms

MCT Illustration by Dean Hollingsworth/The Dallas Morning News

Premature babies may soon find a much friendlier environment to call home for their first weeks. Hospitals are overhauling their neonatal intensive care units to transform open wards into private spaces that, in essence, "restore the intimate relationship between the mother and child and allow the fragile infants to develop."

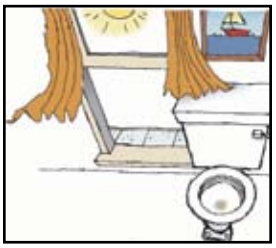
The design of the rooms is intended to closely resemble the mother's womb—the "darkness, relative quiet, and full entanglement with the mother's biological rhythms." These rooms allow babies uninterrupted sleep away from others' ventilators and beeping monitors, indirect light for their sensitive eyes, skin-to-skin contact for long periods of time, and the assuring sounds of parents' voices rather than the harsh sounds of the hospital.

A 2003 study published in *The Journal of Developmental and Behavioral Pediatrics* showed "a faster transition to independent feeding, fewer days needing extra oxygen, better growth, and fewer days in the hospital" for premature babies given individualized care. These infants also showed "improved attention and motor skills, and better cognitive and social skills" after arriving home.

Information retrieved from http://www.starbanner.com/article/20070619/health/206190307/1017/features01&cid=0&ei=tU15RumRMKGeqwOb2Ogl

Ease Irritable Bowl Syndrome with Psychotherapy

MCT Illustration by Chip Bok/Akron Beacon Journal



Growing evidence suggests that Irritable Bowl Syndrome (IBS) may have psychological as well as biological elements. This common and painful medical condition has a wide range of symptoms including regular abdominal pain, diarrhea, and constipation. Conventional medicine often offers only partial relief from the symptoms, and just as often, does not ease them at all.

Many scientists now believe that IBS is not the result of physical factors alone, but that it is a combination of both mental and physical causes. Patients with IBS are more likely to be diagnosed with depression, but doctors are often reluctant to prescribe antidepressants to sufferers, especially when they show no outward signs of being depressed other than IBS.

Dr. Ian Forgacs, a consultant gastoenterologist from Kings College, urges doctors to consider other forms of psychological therapy, including hypnotherapy, for some cases. He found that, in studies, some of the most effective treatments for IBS patients included therapies such as cognitive behavioural therapy and other "talking therapies." These were particularly helpful for those whose symptoms were causing them heightened distress.

One obstacle to providing psychological therapies to IBS patients is a lack of specialists. Dr. Nick Read, a psychologist and adviser to the IBS Network, told the BBC that he felt that the majority of IBS patients had some psychological element to their condition. Doctors and therapists need to work with patients suffering from IBS to understand what lies behind the illness for each patient.

Information retrieved from http://news.bbc.com.uk/go/pr/fr/-/2/hi/health/6688579.stm

Reverse Seasickness—For Life?

MCT Illustration by Josh Ruthnick/The Contra Costa Times

Robert Baloh, a neurologist at the University of California, Los Angeles, hopes to take a closer look at the brain-workings of patients with mal de débaruement, or debarkation sickness (where the brain never seems to readjust to being on land after a sea voyage). Symptoms include dizziness, nausea, and a persistent feeling of rocking from side to side and may persist for decades after the initial trip. Although it is common for passengers to experience a short period—a few days at most—of reverse seasickness as their bodies acclimate to being on land again, no one expects long-term effects.

Baloh is seeking approval to perform MRI studies that would compare the neural activity of mal de débaruement patients with that of normal subjects and patients who are experiencing temporary relief from their symptoms. He is hoping to see if there are differences in the way people process visual motion and believes that the condition may be related to the brain areas that sense movement, the temporal and parietal lobes.

Some patients have found that Valium and other related drugs mute their symptoms. Interestingly, these drugs don't treat the inner ear to affect balance; instead they affect the brain pathways that control dizziness.

Information retrieved from http://www.nytimes.com/2007/06/12/health/12mal.html?ex=1339300800&en=cd164e6bbf58c34b&ei=5088&partner=rssnyt&emc=rss

Memory Loss Stems from Distress

MCT Illustration by John Babcock/The Kansas City Star

A study conducted by researchers at Rush University Medical Center has shown that a maintained high level of distress is linked to increased memory loss later in life. The memory loss occurs as part of mild cognitive impairment, a transitional stage between normal aging and dementia in which a person may have mild memory or cognitive problems, but no significant disability.

The study tested the hypothesis that "chronic psychological distress is associated with an increased incidence of mild cognitive impairment in old age." Researchers found that, over a 12-year period, a distress-prone person was about 40% more likely to develop mild cognitive impairment than someone not prone to distress.

The study author, Robert S. Wilson, PhD, a neuropsychologist at Rush Alzheimer's Disease Center told Medical News Today that, "These findings suggest that, over a lifetime, chronic experience of stress affects the area of the brain that governs stress response. Unfortunately, that part of the brain also regulates memory."

Although the level of distress does not appear to increase in old age, the changes in the brain related to memory problems and Alzheimer's disease do increase with age, leading researchers to believe that proneness to stress is a risk factor for memory problems, not an early sign of disease.

Information retrieved from http://www.medicalnewstoday.com/medicalnews.php?newsid=73948

Wilson, R. S., Schneider, J. A., Boyle, P. A., Arnold, S. E., Tang, Y., & Bennett, D. A. (2007, June 12). Chronic distress and incidence of mild cognitive impairment. Neurology, 68*(24), 2085–209*2.

Personalized Antidepressants

MCT Illustration by Dean Hollingsworth/The Dallas Morning News

Soon it may be possible for therapists to know exactly which medication will best treat their patient's depression without the trial-and-error process and the months of waiting. Biologically personalized treatments may still be a thing of the future, but they are undoubtedly in the near future.

Some depressed individuals have abnormally low levels of serotonin and respond well to SSRI's, while other patients who have an abnormality in other neurotransmitters that regulate mood, such as norepinephrine or dopamine, may not respond to SSRI's. A study reported last October in the journal *Science* implies that persons with a specific genetic variant will not be able to respond to any SSRI medication. If a doctor discovers the patient has that variant, he or she will know to suggest antidepressants other than SSRI's for that patient. Routine screening for genetic variations could also show which drugs might produce toxic side effects for certain patients, and which patients may feel more suicidal when exposed to antidepressants. These personalized treatments, coupled with traditional therapy, could largely reduce the amount of time a patient must wait to experience results.

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Helping Clients Create the Partners They Want: Specific Psycho-educational Tools for Promoting Relationship Success

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By Leo Gorelkin, MD

Keywords: couples' therapy, psycho-education, cultural conditioning, socialization

Abstract

Psycho-education is but one of many techniques used in cognitive behavioral psychotherapeutic approaches. In dealing with couples, we have found this technique to be especially helpful by including specific information and discussions based on the impact of socialization and cultural conditioning in our society. This paper offers support in the use of such specific information by demonstrating its application in therapeutic settings and its potential effects on helping clients to achieve their goals, while also enhancing therapist-client alliances. This article is not written as, nor is it meant to be, a general literature review of psycho-educational information relating to couples' therapy, but is intended as a demonstration of one therapist's particular use of such information and techniques to other colleagues. Although much of the information may not be new, it is hoped that the manner of presentation and use will be both novel, and of practical use to other therapists.

Introduction

Many psychotherapists who deal with couples in their practices are aware of how often individuals come into therapy requesting or demanding that their partners change or be "fixed." Of course, such one-sided and superficial expectations are as meaningless as they are counterproductive. Yet, change is often required to overcome the negative results of obviously damaging behavioral habits that plague and divide such troubled couples. But habits die hard—especially bad ones.

My wife, a licensed marriage and family therapist and mental health counselor, and I practice as co-therapists, seeing couples as a team. We have found that adding psycho-education in the form of rhetorical questioning, mini lectures and discussions, together with other cognitive-behavioral techniques and systemic approaches, can significantly enhance therapeutic goals. Such psycho-educational information, although tending to be stereotypic in nature, remains currently applicable in enhancing both stronger therapist-client alliances and acting as a powerful tool for change. We apply such teaching by sharing specific and pertinent information tailored to fit the opportunities that arise within sessions. With such information, receptive clients often enhance their skills in overcoming

Characteristics and Strategies for Healthy Relationships

Kristin A. Crowe, Editor in Chief

There are many strategies for developing and maintaining healthy relationships. Because each relationship is different, every couple will find that certain strategies work best for them in their particular relational situation, while others do not fit them at all. However, before seeking strategies for healthy relationship maintenance, or to develop a healthy beginning, therapists can help each individual couple establish a shared concept of what a healthy relationship is. Again, this can differ between dyads (groups of two), as relational characteristics change within each relationship.

Characteristics of a Healthy Relationship

Sarah Trenholm and Arthur Jensen, in their book *Interpersonal Communication*, share four possible characteristics of a healthy relationship. These include "a shared vision of where the relationship is and where it is going," "clear rules that have been mutually negotiated and that work to the benefit of the relationship itself," "a shared work ethic," and valued metacommunication, or communication about communication (2000, p. 41–42).

A Shared Vision

A relationship in which the members share a common vision concerning the relationship status at the time of evaluation (at any time) and a common sense of direction about where they see the relationship going tends to be healthier than one in which the members are either ambivalent or apathetic. When each member has different expectations, there will likely be at least one member who feels dissatisfied with the direction of the relationship. If neither cares, they will experience an unexpected sense of disassociation within the relationship, which they may not know how to handle. Often, one partner cares about the relationship and wants to see it succeed, while the other does not feel as if relationships require effort. In this case, the concerned partner becomes the "relational monitor" who is "expected to pay attention to the relationship, diagnose problems, and, when the relationship goes off track, do something to get it back on" (Trenholm & Jensen, 2000, p. 41). However, problems and in enriching their relationships. This article will demonstrate both the use and validity of such psycho-educational tools and, most especially, will impart the manner in which such tools and information are delivered in our sessions with clients.

Setting The Stage

Of course, if timely, any information is valuable. However, in establishing a foundation for the use of the information we intend to impart to our clients, we attempt to insert into our sessions, as early as feasible, a discussion of the cultural icons of Mr. and Ms. "Right." The timing of this will vary, depending on our clients' needs.

We start by asking the following questions: "How is it that the wonderful knight in shining armor (Mr. "Right"), so attentive and exciting, often becomes a lazy, unhelpful, frustrating sloppy frog who habitually leaves his clothes on the bedroom or bathroom floor?" and, "How is it that the beautiful, adoring, and most willing princess (Ms. "Right"), often becomes the screaming, ugly, nagging, wicked witch of the West?" After allowing our clients to offer their opinions, we explain that what really happens when a man and a woman marry is that they are actually marrying, not Mr. or Ms. "Right", but Mr. or Ms. "Right-Enough." The reality is that Mr. and Ms. "Right" have to be created within the marriage itself. We assert that such will not happen by itself, nor is anyone simply entitled to such a partner.

How does one create such a spouse? There is a recipe for such a creation. Some of the most important ingredients include the kind of deeper understanding that is achieved by getting to really know who one's partner is—his or her desires and vulnerabilities, what makes him/her tick— and a healthy dose of developing accurate communication and other relationship skills. The recipe also includes a large "tablespoon" of intention.

At this point the clients have, hopefully, developed an appetite for more information, and we add a critical concept to the mix.

Getting What One Wants

The question is, "Why do people get into relationships?" Obviously, it is because they want something. So, what happens if one does not get what he or she wants within a relationship? All too often, therapists, and eventually lawyers, are engaged by clients who are in conflicts that have arisen from irrational demands and/or feelings of entitlement, feelings that stem from family-of-origin issues. What else can be done, beyond handling such dysfunctional conflicts in therapy, to help our clients achieve more reasonable goals in getting what they want from their partners?

Our approach starts by reviewing and discussing the possible strategies people may actually employ to get what they want from their respective partners. In this re-

this can cause one partner to feel overworked and undervalued, while the other suffocates. Partners who are willing to pay equal attention to their relationship and to discuss its status now and their vision for the future may find their relationship becoming more resilient.

Clear Rules

Rather than confining or limiting the relationship, rules give security and predictability to relationships. These guidelines of appropriate behaviors may not be stated outright, but should apply to each partner equally and fairly, even when implicit. All rules should benefit the relationship, rather than one partner, and should be agreed upon by both parties. Relationships do not flourish when unfair rules are in place, when rules are inconsistent, or when only one party imposes the rules, in effect, ruling over the other partner.

Shared Work Ethic

All relationships take work to develop and continual maintenance work to stay healthy. Relationships "need 'servicing.' They need contact; they need involvement; they need a sense of being 'worked at'" (Allan, 1993, p. 7). If only one partner is working to develop or maintain the relationship, the relationship likely is not healthy—a healthy relationship takes time and effort from all involved.

Metacommunication is Valued

Metacommunication is communication about communication. Each partner needs to be willing to talk about how he or she communicates within the relationship and be willing to listen to and respect the other partner. There will be times when partners can come to an agreement without directly talking about the relationship, but at other times, this will be necessary. To find a shared vision, to establish rules, and to agree upon a work ethic, each person must be willing to create an atmosphere that enables both persons to share their feelings and concerns about the relationship. This "relationship talk" is furthered by symbols and metaphors the partners share, making them comfortable and intimate within the discussion of relationship.

Strategies

Two strategies for maintaining healthy communication that therapists can teach their clients are (1) active listening, and (2) I-statements rather than you-statements.

Active Listening

Thomas Gordon developed what is referred to as the active listening technique in 1975. Active listening, according to Joseph DeVito, is "a process of sending back to the speaker what you as a listener think the speaker meant—both the content and the associated feelings. Active listening, then, is . . . putting together your understanding of the speaker's total message into a meaningful whole" (2004, p. 126). By using active listening, each partner can check to see if he or she

view process, we emphasize the positive/negative effects and success/failure rates for each ploy used. Among the stratagems discussed are coercion, deception, taking turns, and compromise. When all is said and done, we finally ask, "Is there not yet a more empowering strategy for all concerned?"

The answer is a resounding *yes*. The best way to get what you want from your partner is to make it good for him or her to give it to you.

We may have to repeat this a couple of times, as it may appear to some to be counterintuitive, especially in the presence of conflict. It is an idea that all too often solicits client responses such as, "But when do I get mine?" a revealing statement masquerading as a question. Of course, anger, hurt, and frustration all need to be addressed, and, eventually, they are. But we also assure our clients that this is a powerful win/win strategy, and compromise may still play some role. We remind them that in a loving and caring relationship, if one partner loses, then both lose.

In this process, we have come full circle. In order to make it good for one partner to give that which the other wishes to receive, one needs to know his or her partner very well indeed—the bright path to creating a Mr. or Ms. "Right."

Some of the skills we teach to affect this goal follow.

Beyond Communication

As the impact of both the civil rights movement and women's liberation became substantive, patriarchy lost its grip on our society, and communication between the sexes became more of a two-way street (we note however, that patriarchy, though politically incorrect, still slumbers beneath the surface and is easily awakened). Interest in this highly important topic of communication between the sexes continues to grow, and since the arrival of such works as Deborah Tannen's (1990), communication has taken center stage as the key to relationship success.

The active listening technique evolved as a highly effective means to get couples to really hear their respective spouse's issues. Is it any wonder, however, that when used in the context of adversity, this technique ultimately failed (Gottman, 1999)? Still, Dr. Gottman supports its use for couples in non-adversarial situations.

How does one get one's spouse to listen from the start of a conversation without losing him or her with the first words uttered? Dr. Gottman (1999) suggests using a "softened start-up," totally devoid of criticism, as opposed to the disruptive "harsh start-up." In our practice, we offer a different approach to our clients. It is a technique we have referred to in the past as the "training cycle" (Gorelkin and Gorelkin, 1990), which, in this context, could be called a "positive start-up." We advise our clients that the most productive way to get their spouses' attention is to start with

understood what the other said and meant. The original speaker can then clarify and correct misunderstood statements. Also, active listening acknowledges, validates, and accepts the speaker's feelings, rather than challenging them. By explicitly identifying those feelings, the listener gives the speaker the opportunity to correct the listener if the feelings are misidentified. In addition, the speaker is encouraged to explore and elaborate on his or her feelings and thoughts, enabling him or her to talk them through because the listener has already accepted the speaker's feelings.

Three techniques are inherent to the process of active listening, according to DeVito's *The Interpersonal Communication Book* (2004, p. 126–127):

First, paraphrase the speaker's meaning. Listeners should use their own words to say what they think the speaker means and feels. This fosters understanding and shows the speaker that the listener is interested. Additionally, the speaker then has a chance to clarify and add to what his or her original statement was. When a partner paraphrases effectively, often there will follow a moment when the speaker feels completely understood and lets his or her partner know that by saying, "yes!" "exactly," or another such affirmative interjection. There are two warnings to attend to when paraphrasing: the listener should not lead the speaker, but should be objective, and he or she should not overdo the paraphrasing. A statement only needs paraphrasing when there is a possibility the listener misunderstood or when he or she wishes to offer support to the other person and keep the conversation going.

Second, express understanding of the speaker's feelings. The speaker expresses or implies feelings, and the listener's explicit naming of those feelings helps make sure he or she truly understood the emotion the speaker was conveying. The listener is able to give validation and acceptance to the speaker for having those feelings when they are named during paraphrasing. The speaker is then able to more objectively see and elaborate on his or her feelings.

Third, ask questions. The listener should ask open-ended rather than yes/no questions to further his or her understanding and to gain additional information. This process should support and encourage the speaker so he or she can give more information concerning his or her thoughts and feelings. This process of open-ended discourse also gives the speaker the opportunity to change his or her mind, to explore in conversation a perspective he or she had not imagined previously. However, the questions should not challenge the speaker or pry, but rather should show the speaker his or her partner's interest and concern.

a statement that is positive, honest, and related to the issue at hand.

To demonstrate, consider a couple I will call Tom and Mary. Weeks have gone by, and Tom still has not reorganized the shelves in the garage as promised. As another weekend looms on the horizon, Mary approaches him with several options. She could say harshly, "Why have you not done those shelves in the garage?" Or she could say, softened, "I would really like those shelves to be done." Our positive approach would be, "Honey, you are so good at organizing things. I would really appreciate it if you would get to those shelves this weekend." We definitely promote this last form of start-up, especially if something specific is wanted. And, if Tom does the shelves, genuine acknowledgement from Mary is in order. We strongly advise our female clients to be generous with such praise. We also suggest that they succumb neither to their anger nor to the thought, "If I thank him too much, he will not do anything else." At this point we may be confronted with a client response or objection such as, "Why should I have to be nice to get him to do what he is supposed to do?" Our answer to this question is: because it has the best chance of working. We also remind our female client that acknowledgement and praise are infrequently given, even when deserved, and are, therefore, most likely overdue. Of course, we also eventually address her anger and sense of entitlement, but such is beyond the focus of this article.

Sometimes a client will say, "This is just manipulation," in response to our suggestion to use a positive start-up. Of course, it is manipulation. But not all manipulation is necessarily bad. If used to promote one's agenda at the expense of the other's, manipulation could be considered inappropriate. But how is it wrong if the situation is genuine and honest? Remember that a positive start-up, one that begins with praise, is based on fact. Whenever we communicate, something is wanted; so, whenever we communicate, we are in essence attempting to manipulate—to affect a change in a given situation. We advise our male clients to put the words *I want* in front of most of what their wives say. In this way, they will at least be on the way to getting it right. Further, because accomplishing something that is really appreciated can be strong motivation, we also advise our male clients that when their wives begin with a positive start-up, consider it an opportunity to win, to "get it right," as opposed to being taken advantage of.

Another question offered to the men of our couples is "What do you think it means if your wife asks, 'Honey, would you like to take a walk with me?'" A lot of men, even without the benefit of the foregoing discussion, will understand she wants him to take a walk with her, but that is only half the answer. If he chooses to go on the walk and goes half-heartedly or resentfully, then the result will be make-do or a lot worse.

Active listening is not appropriate in all situations, just as not all utterances require paraphrase. This is just one strategy to help maintain a healthy relationship. Other kinds of listening strategies include continuums between empathetic and objective listening, nonjudgmental and critical listening, and surface and depth listening. Researching and using these strategies appropriately will add to the tools therapists can offer to their clients to help them maintain their relationships at a healthy level.

I-Statements

Another strategy is using *I-messages* or statements rather than *you-messages*. I-messages allow patients to own their own feelings and thoughts, as they state facts rather than accusations. A you-statement would sound something like this: "You make me feel unloved when you ignore me." An example of the corresponding I-message is: "I feel unloved when you do not greet me when you come home from work." Notice how the emphasis in the I-statement is on the speaker's feelings as a result of outside actions and the outside action is specific and defined. DeVito says, "When you use I-messages, you make it explicit that your feelings result from the interaction between what is going on outside your skin (what others say, for example) and what is going on inside your skin (your preconceptions, attitudes, and prejudices, for example)" (2004, p. 119). Client couples should be instructed on how to own their actions, explain clearly how they feel without placing blame, and provide their partners with an opportunity to discuss the situation and modify behavior.

Conclusion

Active listening and using I-statements are just two of the many communication strategies therapists can employ to help dyads create and maintain healthy relationships at any level. When both partners are invested in the relationship and working together to help it succeed, these strategies can enhance the health of their relationship.

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What she is actually saying is, "Honey, I want you to take a walk with me, and I want you to love doing it." She is really not interested in him simply giving in or doing her a favor. He must embrace the decision or lose.

Our clients begin to see that deeper understanding is beyond conventional communication; it is being aware of the importance of the thoughts and feelings that lie beneath the surface of another's verbalization. From here, we share with our clients other information that moves beyond communication, affording them greater insight in their quest to create Mr. or Ms. "Right."

Deeper Understanding

What forces drive some grooms and brides, at a moment of potentially great tenderness, significance, and symbolism, to mush mounds of wedding cake into each other's faces? Granted, one such act may be retaliatory. But why does it happen at all? Her special day and glorious appearance are belittled and denigrated by such a cavalier, slapstick, "pie in your face" antic by the one who professes such love for her. It is too simplistic to argue that it is *just tradition*. Although not privy to all the answers, we posit that such acts may also be symptomatic of a persistent and deep-seated, easily awakened adversity between the sexes.

There may be less hype and attention given to the importance of the differences between men and women in our society these days, but "Mars and Venus" (Gray, 1992) language is still part of our vernacular. And, it would be a mistake to assume that such differences through our biology, socialization, and cultural conditioning are not of great importance in understanding interpersonal gender dynamics and discord (Real, 2002). We, too, have written about and are sensitive to these particular issues (Gorelkin and Gorelkin, 1990 & 1993). In our practice, we use these ideas not only to help clients better understand their partners, but also to help subdue discord and enrich their relationships. Granted, some will view these ideas either as obvious or as gross generalizations, characteristics we admit to in our sessions; yet, the reader would be quite surprised at the effectiveness of this information when judiciously used in the context of a therapeutic session.

Masculine Characteristics

Assuming that the "Four Horsemen of the Apocalypse," criticism, contempt, defensiveness, and stonewalling (Gottman, 1999), are not already driving the marriage into oblivion, at appropriate moments we insert and discuss the following concepts with our client pairs. First, some masculine characteristics and issues:

- A man's value, in our society, is still mainly based on his ability to produce, often translated into his capacity to make money.
- Our society is driven by a win/lose para-

digm; that is, winning is everything, and in order to win, someone has to lose.

- Although everyone wants to win in his or her own way, from a very early age, men especially are raised to compete in this arena of life. Consequently, a man's greatest vulnerability is losing or being a "loser." Unfortunately, the strong drive to be number one, or at least one up, spills over from appropriate venues—the playing field or work—to the inappropriate arena of their relationships with their significant others. A man nearly always needs to be right, and often believes that if he lets his partner have her way too much, he will be a wimp. He needs to be in control, a part of which is to refuse to accept being told what to do.
- Men too, unless they are significant risk takers, tend to "aim short." That is, in the service of not losing by getting it wrong, they will be reluctant to take on a project before all the *i*'s are dotted and the *t*'s are crossed.
- In short, men are production freaks and success junkies.

Such masculine conditioning can actually promote greater success within relationships, if properly channeled. This can be accomplished by redirecting a man's need to win from one-upping his partner to winning by more fully satisfying his partner emotionally and sexually. What man would not want to be fully confident in his capacity to do this?

The above information can also help the women of our couples begin to depersonalize that which she, all too often, feels as a direct attack on her. She begins to understand, for example, that it may sometimes just be her partner's fear of losing and deeply conditioned sense of masculinity that lie beneath his "no's" or his failure to act (garage shelves), as opposed to an uncaring, selfish, or contemptuous attitude toward her. And, with some love and caring still intact, she may become more sensitive to and appreciative of the relentless pressures brought to bear on her man by our society and culture. Less overall hostility opens the door to developing softer and more positive approaches in attaining her goals with him, which are decidedly more productive.

Feminine Characteristics

The reader should keep in mind that the client learning curve is extremely dynamic and a two-way street; the outcomes are strongly influenced by what both do to and for each other. What follows is a summary of the kind of general information men can learn about the women in their lives:

- Notwithstanding the obvious changes our society has witnessed in recent years as women have become more assertive, competitive, and independent than ever before, most still want to marry and have families, and continue to have a strong tendency to be nurturing.
- Women are still vilified both overtly and covertly by men (Gilmore, 2001) and remain second-class citizens economically in our society (Rhode, 1997).
- If she wants something done, she usually wants it done yesterday, rather than tomorrow.
- A woman may be valued (or possibly disliked) by the money she makes, but her main power, when it comes to the opposite sex, resides in her attractiveness, determined especially by her looks, but also her personality.
- Her vulnerability is certainly also about losing. But for her, the main source of losing lies in her being rejected.
- In contrast to a man's "aiming short," a woman's fear of rejection may result in her "ordering short;" that is, to avoid the rejection of having her request denied, she may ask for less than she really wants. She may think, "I can not ask for too much or he will just say no." One can easily argue that aiming and ordering short are basically similar, but we have found that keeping each distinct and separate works best.

Of course, in general, men are aware of how indirect women can be in their communication. Though there are multiple reasons for this, when a man is sensitive to a woman's underlying fear of rejection, the result can be quite productive.

As noted earlier, the reality is that a man wants to please that special woman in his life. As she helps by complaining less and acknowledging his accomplishments more, success is at hand. Armed with the aforementioned clues about her, he has a far better chance of answering that age old question of, "What does a woman want?" For example, his faster-than-usual (the sooner, the better) response to her given request, if feasible, is powerful acknowledgement of her. At least, it is a good place to begin. In this context, unless we are talking about something completely outrageous, it is of critical importance that he not find her wrong for her desires and feelings. The denigration of her feelings communicates deep meanings of personal rejection for a woman. Genuine compliments are always welcome. And what a wonderful "knight in shining armor" he will become when, sensitive to her "ordering short," he gives her more than she asks for. Of course, what the "more" specifically is must be something she actually would want.

The ultimate objective is to have him relinquish any competitive tendency in his relationship with his wife and to begin to clearly recognize that there are powerful wins for him by knowing how to actually fulfill her. It is amazing how much more empowered and attractive she will become in this process, as well as how much he will be winning as a man. Further, because many wins and especially losses are experienced in the bedroom, delicate sexual issues also need to be addressed when possible, and though the author does not intentionally disregard the elephant in the room, this aspect is too complex an issue to address here.

At some point we also offer a concise, metaphorical aid to our clients to reinforce important information imparted earlier.

We propose that we compare a relationship to a car. Keeping in mind that it takes a key to start a car and gasoline to keep it going, we ask, "What would be the key and fuel for a relationship?" Then we impart that, from our perspective, the key to getting a relationship started in the right direction is approval, and that the fuel is pleasure and acknowledgement. One would be amazed at the "mileage" possible when, within the relationship, each approves of the other (or something in the relationship), and each has the capacity to create pleasure and be appreciated for such accomplishments.

Assignments

Finally, what follows is a selection from homework assignments we usually give our clients, which we have found to be very productive:

1. Love Lists: We ask our clients to think about and create a list of action behaviors that their partners can do for them that would mean *love*. Specificity and feasibility are required for this exercise. For example, if one lists, "I want him to be more loving," such a generalization would be totally impractical. However, a statement such as "spontaneous hugs and kisses would make me feel loved" or "giving me a call during the day" would work. In this way, our clients are able to share and put into practice meaningful and endearing actions.

2. Want Lists: (A similar assignment, but quite distinct from the above.) Here we have our clients list items and possibly experiences that each would want to receive from the other. In this way, each has an opportunity to purchase or produce what is actually desired by the other, especially, but not exclusively, for special occasions, such as birthdays and anniversaries. This takes the guesswork out of getting the right gift, but because both the *what* and *when* remain unknown, an element of mystery is retained; anything from a simple walk in the park, to massages, dinners out, jewelry, etc., are applicable.

After sharing these lists, they should be posted or exchanged.

Final Thoughts

The experience of having another person *get* you is extremely satisfying and acknowledging. Few things empower more than congruence, and this is most especially true within our closest personal relationships. When our clients get to a level of deeper understanding and acceptance, where they can even embrace the differences and conditioning of men and women in our society, including communication styles, needs, and vulnerabilities, then our clients become more skilled in navigating the inevitably turbulent waters of their relationships. Compromise and negotiation begin to play second fiddle to being more concerned with each other's needs and desires, leading to greater growth in closeness and enjoyment. Each learns how to make it good for the other, and each translates this into a personal win for him or her self, above and beyond getting what he or she wants from the other.

Finally, we close with an anecdote from one of our actual sessions. It's an example of what happens not infrequently, as a result of teaching this material to our clients. I had just ended my explanation of the full meaning of the question, "Honey, would you like to take a walk with me?" when suddenly the woman of the client couple blurted out, "He read my mind!" Now *that* is *being gotten*.

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Therapists may refer clients who would benefit from this residential-style therapy to the R.E.A.C.H clinic. Although the client would become a patient of the on-staff therapist at the clinic, that therapist will consult with the patient's stateside therapist concerning the patient's history, and the therapist in the United States will be paid $500 per client for his or her consultation.

R.E.A.C.H.

The acronym R.E.A.C.H. stands for *Research*, *Education*, *Attitude*, *Change*, and *Health*. *Research* is the most basic component of the REACH program because of its importance. This aspect of the program is defined by investigating the psychological aspects involved in behavior and in behavioral changes. The *Education* component is characterized by a focus on teaching relevant information to those who seek to make changes in their lives. The *Attitude* element reminds all involved that attitudes are demonstrative of the relationship between a person's wants and needs in the decision making process. These attitudes need to be assessed and evaluated, especially in an addictive situation. *Change* is about moving from illness and sick-role behaviors to healthy behaviors. *Health*, to those at REACH clinic, means *soundness*. The client must exhibit a sense of readiness and must be able to perceive the benefits of good health before it can be attained.

Therapy Components

Treatment at the REACH clinic may include these components:

- Cognitive Behavioral Therapy
- Educational Lectures
- Cinema Therapy
- Massage Therapy
- Spirituality
- Music Therapy
- Art Therapy
- Nutritional Therapy
- 12-Step Work
- Therapeutic Horseback Riding
- Journaling
- Psycho Drama
- Recreation Therapy
- Relapse Prevention
- Aftercare Planning

This sampling of treatment options shows the REACH clinic's holistic approach to mental, emotional, and spiritual health. Therapists seek to foster spiritual growth in self-esteem, psychological well-being in emotional difficulties, and dignity in a person's relationships at work and in the community, while being sensitive to the personal, social, and religious backgrounds and values of the clients they serve.

Journaling

One of the possible components clients may encounter on their therapy schedules is *journaling*. There are no rules concerning how to keep a journal, but clients are encouraged to continue journaling through all times in their lives, not just when things are going well for them. Journaling provides many therapeutic advantages, including:

- Help in self-understanding and evaluation
- Help in meditation
- Help in expressing thoughts and feelings
- Help in remembering
- Help in creating and preserving a spiritual heritage
- Help in clarifying and articulating insights and impressions
- Help in monitoring goals and priorities

The value of journaling cannot be fully explained; it can only be experienced by actually journaling.

Music Therapy

Music therapy is another possible component of a client's therapy. Music therapy is especially helpful in group therapy situations, but can be equally beneficial in single-client therapy when used correctly. The REACH clinic's website states that "music therapy promotes social responses by fostering interpersonal relationships and group cohesion, advancing social skills, enhancing verbal and nonverbal communication, and providing a healthy and non-threatening outlet for emotional expression" (www.reachclinic.org). Group members grow closer together in sessions that include music therapy, and in both single-client and group therapy, music therapy can encourage a better relationship between the client and therapist. Often, music therapy allows patients to have a more positive outlook on their progress. Music therapy does not have to be used alone, and is frequently combined with other kinds of therapy to create a dual-purpose therapy.

Art Therapy

Art therapy provides a valuable outlet to clients of any age. For those who struggle to talk through their struggles, art therapy provides a way to speak without words. Many clients find their reactions easier to record in an art form, rather than through linear language expression. Art therapy allows clients to express themselves concerning

- repressed or suppressed emotions and experiences;
- dissociative disorders;
- eating disorders, self-injurious behaviors, and psychosomatic complaints;
- physical distress and its accompanying emotions;
- early narcissistic injury and the attempt to cover it.

Art therapy allows clients to use mixed media to express themselves in a variety of ways.

Nutritional Therapy

Although much of the focus at the REACH clinic is the psychological and inner self, the patient's physical self is not neglected. *Nutritional therapy* equips the body with the necessary physical ability and energy to complete therapy. The meals prepared at the clinic help the client move toward health and healthy choices. Each individualized nutrition regimen takes into account the specific patient and his or her situation. The focus is to reestablish the anabolic nutritional state in the client's body, restore health and vitality, and counter the catabolic effects of addiction. The nutritional aspect of the REACH clinic's program is an extremely important part of recovery.

Additional Benefits of the R.E.A.C.H. Program

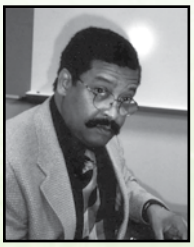
If your clients have alcohol or drug addictions, consider how this extensive and intensive program could benefit them. The anonymity of being out-of-country, along with the quiet campus, may lead to greater results than a traditional rehab facility. A person well known in the community may find him or herself in need of therapy for addictions just like anyone else. However, that type of person may experience greater success in therapy that takes place away from the distractions of the community and the people in that community. Two weeks in Costa Rica and continued treatment upon returning to the United States may allow them to break through the addiction in a manner not available through in-country programs, oftentimes avoiding a public scandal in the process.

Others of your clients may have been referred to you via the American court system, requiring mandatory therapy. When they have finished treatment, clients will receive an affidavit verifying completion of the program. Because the REACH programs are approved by the US federal government, clients may be assured that their certificates of completion will meet the requirements of a state or court mandate. However, because the program is located in Costa Rica, REACH is not required by law to keep the same kinds of records as required of an in-country clinic. Thus, the U.S. court system cannot legally subpoena the records from the REACH clinic. Your clients can fulfill their court-mandated therapy at the REACH clinic and not worry that their therapy records will ever be admissible evidence in court.

Costs include housing, three meals a day, and therapy service. Transportation, airfare, and follow-up care are not included. The total cost to the client for 14 days of REACH therapy is $9,160.00.

An Interview with Rev. Roger Pumphrey

Roger Pumphrey, D. Min., is the founder and executive director of the REACH clinic. He has extensive experience working with emotionally disturbed adjudicated delinquents, developmentally disabled individuals, and addicted youth and adults. He is a certified hypnotist with the National Guild of Hypnotists. He has been an adjunct professor of undergraduate and graduate courses on educating African American males and at-risk students at the University of Wisconsin-Milwaukee in the Department of Educational Policy and Community Studies, and is a past president of the American College of Counselors. Pumphrey received his clinical training in Clinical Pastoral Education at the Milwaukee Lutheran Hospital and his psychotherapy and counseling training at the Martin Center Residential Treatment Center, Personal Growth Inc., and Blue Care Network, an affiliate of Blue Cross/Blue Shield of Michigan. His other credentials include: Certified Psychotherapist, Licensed Professional Counselor, Certified Vocational Rehabilitation Counselor, Certified AODA Counselor, Certified Diplomate—Addictionology, Certified Hypnotherapist, and Diplomate in Psychotherapy.



Annals contacted Rev. Pumphrey to find out more about the REACH clinic. This interview is comprised of his responses.

Annals: What is your position at the REACH clinic?

Pumphrey: My position at REACH is founder and executive director. I oversee areas of development and administration.

Annals: How did you realize the need for such a clinic, and how did you implement the steps necessary to create it?

Pumphrey: After operating a clinic in the States for 20 years, I saw a need for a program with strict confidentiality and less bureaucratic interference and restrictions than what we find in the States. A colleague in the AODA (Alcohol and Other Drug Abuse) field encouraged me to visit Costa Rica and experience the beauty and peacefulness of the country and its people.

Annals: When was the REACH clinic founded?

Pumphrey: It was founded in 1989. I have served as Executive Director and Therapist.

Annals: What are the primary benefits for clients/patients at REACH? What are the distinct advantages of the REACH clinic, as opposed to in-country programs?

Pumphrey: At REACH, patients are provided with cost-effective treatment, confidentiality, a secluded location, and adjunct therapies such as nutritional therapy and massage therapy.

Annals: Why is the REACH Clinic located in Costa Rica?

Pumphrey: REACH is located in Costa Rica because of the open-minded population, the exquisite beauty, and the fewer constraints on the practice of non-traditional approaches, such as massage therapy and art/music therapy, in conjunction with traditional modalities.

Annals: What is the purpose of opening the clinic to APA therapists and their clients? What are the benefits for the clinic, the APA therapists, and the patients involved?

Pumphrey: The purpose is to provide APA therapists with an alternative setting in referring clients and they will receive a network consultation fee of $500 per case. They can provide direct service in Costa Rica and be compensated for the fourteen-day program.

Annals: Do therapists have to be licensed to bring a group of clients to the REACH clinic?

Pumphrey: No. The clients enrolling in the program become patients of Hilda M. Paniagua Sanchaz, a Costa Rican psychologist. The U.S. therapists act as adjuncts working under Ms. Sanchaz.

Annals: How does REACH define success?

Pumphrey: REACH defines success as redirecting lives, acknowledgement of addiction, and making a commitment to the recovery process with continued treatment in the United States.

Annals: Are the majority of your clients American? Do you serve non-American patients?

Pumphrey: The majority of patients are from the States; however, there is an international appeal.

Annals: What does the three-month follow-up entail? Do you stay in contact with your clients?

Pumphrey: The-three-month follow up entails continued therapy in the United States with an APA therapist in their hometown or city. Clients are provided a choice of continued support with REACH post-Costa-Rica-program to include a 9-day retreat coordinated by Mr. Charles Hill's "The Learning Trips."

Annals: Do most clients use the referral given them to see APA therapists in the States after their 14-day therapy?

Pumphrey: Those that are referred by APA therapists generally continue treatment with the original APA provider. Those who are not APA referred tend to follow recommendations for continued treatment with an APA provider of their choice.

Pumphrey asks you to consider leading a group therapy session in Costa Rica with ten of your own clients. The 14-day intensive therapy could put your clients on the road to recovery much faster than traditional methods alone, and you will be able to continue follow-up after the 2-week experience. If you are not able to leave your practice for two weeks, but have clients that would benefit from the therapy, refer them to the program. They will still reap the benefits of the program and follow-up with you. For more information, visit http://www.reachclinic.org.

All information in this article was obtained from the REACH clinic website, http://www.reachclinic.org, or from Rev. Roger Pumphrey.

Take the Annals Online Survey and Earn $25 in Membership Bucks!

The *Annals* editorial staff has designed an online opinion survey, accessible by clicking the Members-Only tab on the APA website. Because we appreciate the time you'll take to submit the survey, **you will receive $25 in membership bucks upon completion.** We recognize we can't make changes to improve your experience of the journal if we don't know what you like and dislike. Your opinion is crucial, so please don't miss the opportunity to be heard!

The entire APA staff wants *Annals* to be the journal you turn to for professional information, CE credits, news that concerns your field, and opportunities to network with others. However, to ensure that *Annals* will continue to serve your needs, we need to know what you, an important member, think and want. We are working to bring a fresh, clear focus to each issue and looking for ways to serve you better. Several features are under contemplation, including a name change and some new design options.

I look forward to our continued partnership, and I can't wait to see the new-and-improved *Annals*. Remember, even though we are making some changes, our focus is still on serving you to the best of our ability.

Login to the Members-Only Area on the APA website and fill out the survey. I am anxiously anticipating the results!

Sincerely,

Kristin A. Crowe

Editor in Chief
Annals of the American Psychotherapy Association

Article Update

In the Spring, 2007, issue of *Annals*, in an article titled "Romeo and Juliet Laws—When the Punishment Does Not Fit the Crime," columnist Bruce Gross relates the story of Genarlow Wilson. Since publication of that issue, there have been several major developments concerning that case.

You may recall, Wilson was convicted of aggravated child molestation and sentenced to 10 years in prison and mandatory sex offender registration for having consensual oral sex with a 15-year-old girl. Wilson was 17 at the time. Now 21, he has served more than 27 months in prison. Some members of the jury that convicted him have denounced his sentence, saying they did not realize the conviction carried such a stringent and disproportionate mandatory sentence. The 1995 law's author, former state Representative Matt Towery has said, "It was never intended to put kids in jail for oral sex."

On Monday, June 11, 2007, a judge voided Wilson's original sentence of 10 years and replaced it with a 12-month misdemeanor sentence with credit for time already served. In addition, Wilson would not be required to register as a sex offender. However, within minutes the state attorney filed a notice of appeal that kept Wilson in jail. Georgia's Attorney General Thurbert E. Baker said he would ask the Georgia Supreme Court to expedite the ruling, but that the judge who voided Wilson's sentence did not have the authority "to reduce or modify the judgment of the trial court," because in Georgia, "while a habeas court may grant habeas relief, there is absolutely no authority for a habeas court to reduce or modify the judgment of the trial court." Thus Wilson remained in prison.

Wilson was denied bond even though the earlier court had reduced the sentence to a misdemeanor and the case is an appeal. Wilson's case came before Superior Court Judge David Emerson, who ruled that Wilson's conviction made him ineligible for bail on June 27, 2007. Because he is ineligible for bail, it is likely that Wilson will remain incarcerated at least until October, when the Georgia Supreme Court is expected to hear his appeal.

A plea bargain has been offered to Wilson that would reduce his sentence and place him in a program for first-time offenders. The plea could reduce the sentence to time already served. Under the plea, after his sentence is completed, the conviction would be removed from his record and he would be removed from the sex-offender registry. However, Wilson has not accepted the plea because it would "require him to plead guilty to a felony with a 15-year sentence, which would hang over him until the sentence had been served, despite the judges' view that his conduct should be punished as a misdemeanor," according to Wilson's lawyer. Wilson remains in jail, waiting for the Georgia Supreme Court to hear his case, a hearing we hope will take place in October.

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Ten-year sentence thrown out in teen sex case. (2007, June 11). *CNN.com*. Retrieved June 11, 2007, from http://www.cnn.com/2007/US/06/11/teen.sex.case.ap/index.html?eref=rss_topstories

APA's 2007 National Conference

October 4–6 • Kansas City, Missouri

Don't Miss the Special Presentations by John Douglas, author of *Inside the Mind of BTK*, and Greg Cooper, author of *Predators: Who They Are and How to Stop Them*. Register to attend the National Conference Today!

APA's 2007 National Conference at the luxurious Hyatt Regency in Kansas City, Missouri, is just around the corner, but it is not too late to register.

With all of the cutting-edge presentations and workshops offered at this year's conference, including special day-long presentations by legendary criminal profiler **John Douglas** and former FBI agent and chief of police **Greg Cooper**, this conference promises to be an educational experience you will not want to miss!

In addition, the banquet reunion will give you the opportunity to reunite with your friends and colleagues from previous conferences and meet many more fascinating people who share your passion for psychotherapy.

Do not miss your opportunity to attend this exciting conference. Continue reading through page 25 for more information about the 2007 National conference, and register on pages 26 and 27.

Call toll free (800) 205-9165 or visit www.americanpsychotherapy.com for more information. See you in Kansas City!

Schedule-at-a-Glance

Thursday, October 4th

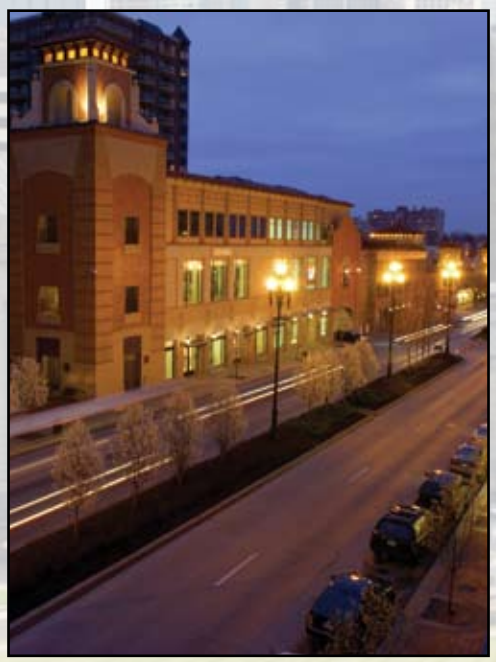
4:00–8:00 p.m.	Registration
5:00–7:00 p.m.	Welcome Reception

Friday, October 5th

7:00–8:00 a.m.	Continental Breakfast/Registration
8:00–9:30 a.m.	General Session
10:00 a.m.–5:00 p.m.	John Douglas Seminar
10:00–11:30 a.m.	Workshops
11:30 a.m.–12:30 p.m.	Lunch On Your Own
12:30–2:00 p.m.	Workshops
2:00–3:30 p.m.	Workshops
4:30–5:00 p.m.	Workshops
7:00–9:00 p.m.	Banquet

Saturday, October 6th

7:00–8:00 a.m.	Continental Breakfast
8:00 a.m.–2:00 p.m.	Greg Cooper Seminar
8:00 a.m.–9:30 a.m.	Workshops
10:00–11:30 a.m.	Workshops
11:30 a.m.–12:30 p.m.	Lunch On Your Own
12:30–2:00 p.m.	Workshops
2:30–5:30 p.m.	Mock Trial



For more information or to view a detailed presentation schedule, visit www.americanpsychotherapy.com or call (800) 205-9165.

Conference Workshops

Workshops planned for the conference will include, but are not limited to, the following. Presentations offered are subject to change.

The Journey of Inward Peace & Outward Power
Instructors: Charles Leviton, MA, EdD, DAPA, and Patti Leviton

New Beginnings
Instructor: Sally Danenberg, MA, FAPA

Overtoning: The Vibrational Healing Power of the Human Voice
Instructor: Wayne Perry

D.I.R./Floor Time: A Developmental/ Relational Approach to the Treatment of Selective Mutism in Children
Instructor: Esther Hess, DAPA

So You Want to Hang a Shingle
Instructor: Kristie Cato, LPC, DAPA

Gaslighting: How People Try to Get Inside Your Head and What You Can Do to Stop It
Instructor: Robin Stern, PhD, DAPA

How Should Competency in Psychotherapy Be Measured
Instructor: Alan Schmetzer, MD, FAPA

Reichian-Myofascial Release Therapy: Healing the Whole Person Emotionally and Physically
Instructor: Peter Bernstein, PhD, FAPA

Psychotheraptic Interventions in Chronic Illness: Integrating Meditative and Stress Management Strategies to Enhance Quality of Life
Instructors: Suzanne Harris, PhD, and Alicia Price, PhD

Playing With a Full Deck: How to Help Your Clients Trump Terror, Leave Childhood Behind, and Deal Themselves a Winning Hand
Instructor: Sally Wright, PsyD

Cognitive-Behavioral Therapy
Instructor: Karl Ullrich, PhD, DMIN, FAPA

Clinical Issues in Treating Dissociative Identity Disorder
Instructors: Andre Sagrera-Cuartas, PhD, and Kristie Cato, LPC, DAPA

Psychotherapy for Wellness
Instructor: Yukio Ishizuka, PsyD, DAPA

Treating Mental Illness Using Spiritual Practices
Instructor: James Westly, MC, LPC

The Jekyll & Hyde Syndrome
Instructor: Beverly Engel, MA, DAPA

Maternal Depression & Disrupted Attachment
Instructor: Diana Lynn Barnes, PsyD, DAPA

Myth in the Mirror: Using Metaphors in Psychotherapy
Instructor: Stephanie K. Scott, PhD, LMHC, BCPC, DAPA

2007 National Conference Exhibitors

Be sure to check out the exhibitor area!

- Visit vendors and receive information on the latest psychotherapy products and services.
- Network with other professionals who share your expertise.
- Attend hands-on martial arts seminars with top martial arts instructors.
- See products and services showcased on the vendor stage.

There are still exhibitor spaces available! Register to become an exhibitor by September 24, 2007, and receive $250 off the normal exhibitor price.

Exhibitor price includes the following:

- 8' x 10' booth
- One 6' table topped in white vinyl and skirted on three sides
- Two folding chairs
- One wastebasket
- One 7" x 44" one-line, black-on-white identification sign including booth number

Price: $100

For more information or to sign-up, contact Samantha Cloud, conference coordinator, by phone at 800-205-9165, ext. 168, or by email at conference@american-psychotherapy.com.

** SAVE 30% when you register for the CHS Conference and the ACFEI, APA, or AAIM Conference **

2007 NATIONAL CONFERENCE

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October 4–6, 2007

- ❑ **The American Psychotherapy Association (APA) 2007 National Conference**
- ❑ **The American College of Forensic Examiners (ACFEI) 2007 National Conference**
- ❑ **The American Association of Integrative Medicine (AAIM) 2007 National Conference**

Please check which of the above three associations' conferences you wish to attend. (Check only one.) Registration with APA, ACFEI, or AAIM grants you full access to the sessions of ALL three associations. However, you will only receive the complimentary conference merchandise for the association with which you register.

	Early Early Bird	Early Bird (before 8/21)	Regular (before 9/30)	Onsite/Late (10/1 or after)	Totals
CHS Certification Conference Attendee	Date has passed	Date has passed	**$245**	**$245**	$ _____
Member			$395	$445	$ _____
Non-Member			$540	$590	$ _____
Life Member (save 10%)			$370	$420	$ _____

Banquet & Reunion Tickets: $50 (must be purchased in advance by Friday, Sept. 28th) # of tickets:____ x $50 = $ _____
*no on-site tickets available

October 2–4, 2007

CHS NATIONAL CONFERENCE REGISTRATION

- ❑ **The Certified in Homeland Security (CHS) National Conference**

	Early Early Bird	Early Bird (before 8/21)	Regular (before 9/30)	Late (10/1 or after)	Totals
CHS Certification Conference Attendee	Date has passed	Date has passed	**$245**	**$245**	$ _____
Member			$395	$445	$ _____
Non-Member			$540	$590	$ _____
Life Member (save 10%)			$370	$420	$ _____

Banquet & Reunion Tickets: $50 (must be purchased in advance by Friday, Sept. 28th) # of tickets:____ x $50 = $ _____
*no on-site tickets available

October 1–2, 2007

CHS CERTIFICATION CONFERENCE REGISTRATION

The Certified in Homeland Security (CHS) Levels IV & V Certification Conference

❑ **CHS-IV: Incident Awareness, Response, and Terrorism (Monday, October 1, 2007)** $425 _____
Note: You must be Certified in Homeland Security at Level III and have completed the IS 700 and IS 800A prerequisites to take the CHS-IV Course and Exam. Upon successful completion of the CHS-IV exam, you will earn CHS-IV status.

❑ **CHS-V: CBRNE (Chemical, Biological, Radiological, Nuclear, Explosives) Preparedness (Tuesday, October 2, 2007)** $495 _____
You may enroll in both the CHS-IV and CHS-V courses, but you must successfully complete BOTH the CHS-IV and CHS-V courses to earn CHS-V status.

If you are not currently Certified in Homeland Security or need further information, please call (800) 423-9737 or email marianne@acfei.com.
The CHS-IV course is also available online; call (800) 423-9737 for more information.
***You may also choose to audit either course. No certification will be awarded for auditing courses.**

Members who wish to stay at the Hyatt Regency Hotel will receive a special group rate of $139/night. For room reservations call (800) 233-1234. **Mention the discount code ACFEI.**

SUBTOTAL $ _____

** SAVE 30% when you register for the CHS Conference and the ACFEI, APA, or AAIM Conference **

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Saturday, October 6th (8 a.m. to 2 p.m.)
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All requests for cancellation of conference registration must be made to Association Headquarters in writing by fax, mail, or email. Phone cancellations will not be accepted. All cancelled/refunded registrations will be assessed a $50 administrative fee. All refunds will be issued in the form of credit vouchers and are pro-rated as follows: cancellations received 4 or more weeks prior to the conference=100% refund (less $50 administrative fee); cancellations received less than 4 weeks but more than 1 week prior to the conference=50% refund (less $50 administrative fee); cancellations received 1 week or less prior to the conference=no refund. For more information on administrative policies, such as grievances, call (800) 423-9737. The performance of this conference is subject to the acts of God, war, government regulation, disaster, strikes, civil disorder, curtailment of transportation facilities, or any other emergency making it impossible to hold the conference. In the event of such occurrences, credit vouchers will be issued in lieu of cash. Conference schedule is subject to change. Please be prepared to show photo identification upon arrival at the conference.

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Subliminal Information Theory Revisited:
Casting Light on a Controversy

This 1-credit continuing education opportunity is co-sponsored by the American College of Forensic Examiners International (ACFEI) and the American Psychotherapy Association. ACFEI maintains responsibility for all continuing education accreditations. This article is approved by the following for 1 continuing education credit:

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By Eldon Taylor, PhD, FAPA

Keywords: subliminal research, subliminal advertising, subliminal learning, subliminal controversy

Abstract

Subliminal information theory proposes that information is not only processed without awareness, but that it is also acted upon without awareness. Some research suggests such information is even prioritized over other forms of information processing. Where there remains some controversy over the extent or nature of the behavior that can be influenced by subliminal messages, there is little doubt that properly presented subliminal information is processed, retained, and acted upon. Contrary to popular opinion, the literature and evidence supporting subliminal information theory is robust. Indeed, meta-analysis clearly demonstrates very strong statistical support for this modality of care. There are many areas of research remaining to further enable taking advantage of subliminal information processing; however, because of the mis- and dis-information in the public domain, many scientists avoid this area, because of either a lack of knowledge or a fear of the kind of criticism that can influence careers.

Casting Light on a Controversy

A recent telephone conversation with a television producer who is filming a special on the uses and abuses of subliminal communication brought to mind how little has actually changed since the first congressional hearings on the subject in 1984. There are still no laws necessarily protecting the public; although the state of Nevada did give rise to a constitutional interpretation by Judge Whitehead in the Judas Priest case in Reno. In his opinion, the presence of a subliminal message without informed consent constitutes a violation of the First Amendment.

Subliminal communication is still misunderstood, and an abundance of disinformation regarding its efficacy remains. In addition, there can be significant disagreements about the definition of subliminal communication. For the purpose of clarity in what follows, Wolman's categories are offered here.

Definition

There are general categories applied to the definition of subliminal communication through any media. Professor Benjamin B. Wolman's modified categorization of subliminal stimuli divides descriptive values into four criteria of awareness and unawareness (1973). The stimuli are as follows:

Is It Subliminal?

Charlyn Ingwerson, Associate Editor

It matters what we call things. Most of what is called "Subliminal suggestion," isn't. Take the advertising media, for example.

"Everyday, an estimated 12 billion display ads, 3 million radio commercials, and more than 200,000 TV commercials are dumped into North America's collective un-conscious" (Lasn, 1999). But, advertising that works must appeal to some aspect of our personalities. Just because we are unaware of, or do not wish to admit to the particular inclination to which an advertisement may make its appeal, it does not follow that the successful appeal will require a "subliminal suggestion." Let's face it: human rationality is contested by the all too human wish for unreason. Advertising is predicated upon this wish.

To make a claim of subliminal suggestion is to say that something not otherwise a part of your personality has been suggested/inserted into your personality by a source that is not you. Some advertisements certainly exploit aspects of human weakness or flaws of character or reveal secret wishes, but these things have not been planted, as it were, from the outside, but originate from within.

We hold both the advertising and entertainment industries suspect, and we wonder, "Are we perniciously influenced beyond our cognitive wills to do that which is suggested by messaging deliberately posited beneath cognitive recognition?" The observation has been made—ad nauseam—that "sex sells," but the appeal is one of human interest, sometimes illicit, and not a suggestion of non-human nature. Public reaction to the use of subliminal suggestion has erupted when the nature of that which has been allegedly suggested by subliminal means is antithetical to the ideals of humanness or humanism (e.g.: the anti-civility of a child's premature exposure to sexual content). But such meanness hardly requires a subliminal medium. Though far from ideal, it is utterly human to act, not only in one's own self interest, but also with guile. Most religion is predicated upon this.

Do advertisers and rock stars use subliminal messaging (insert images or messages into frames of visual or audio media)? You bet. But professor John R. Vokey notes a "fallacious confusion between the simple demonstration of the use of subliminals . . . and the conclusion that they are therefore effective" (Vokey, 2002, p. 240). Some of the confusion is definitional in nature: What does "subliminal" mean? Vokey writes: "the term 'subliminal' is derived from the construct of a 'limen of consciousness,' a threshold or line separating conscious from unconscious. The concept

1. Below the level of registration
2. Above the level of registration but below the level of detection
3. Above the level of detection and discrimination, but below the level of identification
4. Below the level of identification only because of a defensive action

Although these categories seem clear, the failure to use these definitions in actual research designs, replications, and subsequent reports constitutes a large portion of the disinformation that exists and surrounds the subject today. It is this author's belief that much of that disinformation was generated intentionally. A personal look at some controversies in recent history should help clarify this assertion.

History: The Judas Priest Trial

The case involved two young men who, after drinking a few beers while repeatedly playing the song "Better by You, Better Than Me," from the *Stained Class* album by Judas Priest, took a shotgun to the playground and shot themselves.

These two teenage boys had had difficulty adjusting to life. Ray had just split up with his girlfriend. James had just lost his job. Neither of them was blameless. Both were confused.

Two days before Christmas, Ray gave James a gift of music that had particular significance to the boys. James had once collected the music of this particular artist, but when he found the music violated his Christian beliefs, he threw it all away. That was a few years before, and James no longer pursued any religious affiliation.

The boys decided to play the album while they drank beer. The words and music of one song held their interest. They played it repeatedly. The lyrics in several songs encouraged suicide with such rhymes as "Leave this life with all its sin. It's not fit for living in."

Picture these two young men: attractive, on the slight side—skinny, according to more than one description—unskilled, not doing well in school, anticipating a life of difficulty, and with delusions of grandeur driven by frustration, pretending to be mercenaries, or imagining themselves as heroes.

By mid-afternoon, the lyrics going around in their heads included, "Why do you have to die to be a hero?" The two looked at each other as though acting in some movie. The hero says, "Let's do it!" just before mayhem begins. One of the boys said, "Do it!" The two began chanting, "Do it." One of them grabbed a shotgun. They went out the bedroom window to the church playground. Ray placed a shotgun under his jaw. James chanted, "Do it!" Ray fired the gun. The blast stunned James. Ray was dead.

James lifted the gun, wet with blood. He said later that he trembled. He felt afraid. He could be blamed for Ray's death. He

dates back to the literal beginning of psychology as an empirical science separate from philosophy" (Vokey, 2002, p. 240–241). There are two problems:

> *First, contrary to the common caricature of psychology in the popular media, no modern theory posits "an unconscious," . . . Rather, perceptual and cognitive processes can and often do occur without our awareness, and without our having to or, in may cases, even being able to consciously control them.*
>
> *. . . The important point is that these processes may occur unconsciously—that is, without all the internal chatter that normally accompanies what we refer to as "conscious" processes, but there is no reason to suggest that they therefore occur in some special mind-place called "the unconscious" . . . .*
>
> *Second, few current perceptual or cognitive theories hold to the idea of an absolute sensory or information threshold dividing those events we are aware of from those we are not. Rather, it is viewed as a continuum.* (Vokey, 2002, p. 241–242)

It comes to this: Is the unconscious a 'place' or a 'process'? Vokey makes an authoritative case for the latter, concluding:

> *if it can be shown for some event that it is above observers' objective thresholds, and if it can be shown that it is simultaneously below their subjective thresholds (and we are willing to accept that being below the subjective threshold completely exhausts all possibilities for awareness), and if we can show some effect on the observers' behaviour consistent with the meaning of the event that doesn't also occur in the absence of the event, then, we would have a demonstration of subliminal perception and subliminal influence.* (Vokey, 2002, p. 243)

"None of the popular claims for subliminal influence," he writes, "come even close to meeting this criterion" (Vokey, 2002, p. 243). He adds however, "this does not mean that unconscious perception does not happen, only that it does not happen without concomitant awareness" (Vokey, 2002).

To say that the rational free will of human beings can be subverted, either intentionally or unintentionally, puts one on an ethical slippery slope concerning questions of personal responsibility. Am I responsible for my spending if I am merely a victim of the advertiser's barrage of subliminal messages exerted upon my subconscious against which my rational mind is no match? Morality is premised on both rationality and free will, and to assert that subliminal suggestion can circumvent these is an idea any despot could love.

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wondered why they had chanted, "Do it." He placed the gun under his own jaw. He pulled the trigger.

But James failed to brace the shotgun, and as he pulled the trigger, the gun lurched forward. The blast shot off the front of his face, but did not kill him. It left him severely wounded and disfigured, but he lived for nearly 3 years.

Although it was an unpopular position, it seemed, after reviewing the case, that the subliminal command "Do it!" was a causal factor in the double shooting. The interest is not in the details of the case, but rather in the birth of a scientific controversy. Prior to this case, Congressional hearings in 1984 had led to the most significant source of scientific controversy, which was simply whether a subliminal message could affect behavior. Lloyd Silverman said yes; Howard Shevrin was doubtful (Taylor, Sadana, & Bey, 1990). In the Judas Priest case, Shevrin switched positions based on newer research and agreed that the subliminal "Do it" command was a causal factor (Taylor, 1995).

The actual controversy began with a study conducted by a marketing student. This study on the influence of labels was being announced everywhere—from *Seventeen* magazine to prime time news. The study purportedly proved that subliminal messages did not work to influence behavior. The details of this study and the Congressional hearings can be read in *Thinking Without Thinking* (Taylor, 1995).

A greatly respected psychologist supervised the study. Unfortunately, the study itself did not achieve what the media or the pundits who sided with CBS claimed it did.

By design, the study evaluated the influence of labels on the consumer. To do this, the doctoral student who set up the research project sought and obtained subliminal audiotapes from five different companies. The tapes were of two kinds, one to improve memory and one to build esteem. The labels on the tapes were then changed so that the esteem tapes were labeled memory and vice versa. The pre-test instruments measured memory and esteem. After the test period, subjects were brought back and tested for actual improvement. Subjects who thought they were listening to memory subliminal messages reported an improvement in memory and subjects who believed they were listening to esteem messages reported an increase in their esteem. The instruments failed to identify a statistically meaningful change in either. It is fair, at this point, to state a definite label influence; however, this does not contribute to a real effect regarding subliminal communication.

The five tape companies all claimed different methods and messages for their programs, including messages in the second person and messages in the first person.

Audio analysis failed to recover messages on any of the programs. According to an affidavit from the sound engineer, at least one major manufacturer of audio subliminal programs mixed messages 40 decibels beneath the carrier (music or ocean sounds). This is beneath the theoretical limit of most players. In other words, the signal strength might be compared to the influence of a whisper two blocks away. It might be that the messages were not recoverable because the secret method used included such a mixing procedure. Other companies used questionable affirmations and in other ways produced material that differentiated one company from another. All shared the label *subliminal*, but that certainly did not mean they were the *same*.

An example might clarify the importance of this difference. Assume a scientist pressurizes a trapped atmosphere to, say, 10 atmospheric pressures, applies an exact electric charge, and then heats the result. To replicate this study, a researcher would determine the nature of the atmosphere that was trapped and replicate the process, including the exact degree of heat and electric current applied. Now assume that someone attempts to replicate the study by catching room atmosphere in a fish bowl and covering it with plastic wrap so it is trapped. He places a 9-volt battery inside the fish bowl and then heats it with a cigarette lighter. This is hardly the same experiment. Now take it a step further. Imagine that five fish bowl makers all use different elements but claim the same outcome. Is testing all five bowl makers the same as replicating the original study? The answer is clear: No! Even if one of the bowl makers has it right, the other four would contaminate the outcome.

This was not a scientific study with a single variable. The study mixed multiple variables and came up with a single conclusion—and that is simply not good science. Nevertheless, this study was everywhere in the media, and those testifying for CBS and Judas Priest were touting it almost as if it were the Holy Grail.

This case comes down to a few facts. Judas Priest admitted to putting subliminal content on some recordings, but not on this one. When the messages were demonstrated to be present, the counter argument was that it occurred only as a "coincidence of sound." CBS was fined more than once by the judge for impeding the discovery process and manipulating the press. The original disclosure of the boys chanting *do it* was made by CBS Records. However, CBS's own investigator, a former Scotland Yard detective, stated that he was unable to locate the original 24-track master and that he was never allowed to look in the CBS vault. The original master was needed in order to prove the message was not a coincidence of sound. In a wrongful death action, intent must be demonstrated.

The result of the press attention and managed or manipulated media gave rise to the real scientific controversy. Since then, the power of subliminal messages to influence behavior has been admitted by some of the people who were the most outspoken while defending CBS' position. Even the *Skeptical Enquirer*, a science journal with a history of dismissing many things later proven to be true, admits evidence for behavior changes because of subliminal stimuli (Epley, Savitsky, & Kachelski, 1999), although the journal had published many articles supposedly debunking subliminal influence during and following the Judas Priest trial. The definitive work of Robert Bornstein and his meta-analysis approach shows clearly that a properly delivered (signal strength) psychoactive message (affirmation) can and does influence behavior (Bornstein & Masling, 1998). Bornstein posits that the effects of subliminal stimuli on humans, including behavior, is robust in the literature.

The literature contains hundreds of research findings suggesting the efficacy of subliminal messages; yet a literature review is not the only support for this theory. Personal experience shows no doubt that subliminal information is processed and acted upon. The author's research on InnerTalk, an audio dichotically-presented subliminal method, includes more than a dozen double-blind studies conducted by independent researchers at leading institutions throughout the world and on several domains ranging from attention deficit hyperactive disorder to examination anxiety. The model is simple and was first put forward by Albert Ellis (1988).

The A-B-C model, as it is called, is graphically depicted as follows, where *A* is the *activating event*, *B* is the *belief* that *A* leads to, and *C* is the *consequence* of *B* in emotional and behavioral terms:

A——————> B——————> C

An activating event, stimulus, or verbal affirmation affects belief, which equals emotional and behavioral consequences. It is easy to see this rather linear in-and-out when looking at the negative input in our lives, and it works more or less in the same way with respect to the positive. Ellis coined a term for negative self-talk that is best known as ANTS—automatic negative thoughts.

During the Judas Priest trial, the author was asked if he had ever conducted a research design that indicated a person would kill himself as a result of a subliminal message. "Of course not," had to be the answer. It is hoped that no scientist would even consider doing such a thing. Then an idea came: What if a person received a subliminal message of danger?

A pilot study was arranged through a science project at a local high school. Group A listened to ocean sounds with three subliminal information deliveries spaced approximately one minute apart. The messages were "Danger, danger, watch out!—Ah-h-h-g-h! Danger!" The messages were recorded and delivered simultaneously in both forward and reversed speech. Group B listened to the same ocean track with the message "People are walking" delivered subliminally.

Both groups listened to the tapes for four minutes, with earphones, while their body responses were monitored for changes in breathing, blood pressure, the electrical resistance of their skin, and the moisture

at the end of their fingers. A four-needle polygraph, commonly known as a lie detector, recorded these responses.

After the 4-minute trial, each subject responded to a questionnaire that included a request to report any particular reverie, feelings, or thoughts that occurred during the trials. Only then did an assistant reveal to the subject which group he or she was in.

All five of those in Group A responded with gross reactions or changes in the measurements of their body functions coinciding with the delivery of the subliminal *danger* message. Those in Group B had no such response. This suggests that the participants in Group A recognized the danger stimulus. The subjects' bodies in Group A responded as though an actual danger existed, as did their minds. Three of the five participants in Group A reported reveries of killing or being killed. A fourth person reported feeling extremely upset. The fifth said she was too occupied by what the experimenters were doing to notice her thoughts, although the experimenters were doing little.

Psychological theory has categories of fantasy formation. Our response to danger, the fight-or-flight response, can generate compelling fantasies. When a person feels threatened, his or her fight-or-flight response gives rise to thoughts of this nature. Killing is fight oriented, and death may be flight oriented. Many deal with fear, in fantasy, by neutralizing the source of the fear—even if it means killing. Dying, on the other hand, means escape to many. Of five normal, healthy teenagers, four had thoughts of killing or dying. The fifth apparently *blanked out*. This came from listening, in a pleasant and sober state, to a few repetitions of a single, simple, subliminal message for a few minutes.

Those who heard the message *people are walking* had reveries similar to "I was at a sunny beach, and there were a lot of people."

This study has been posted, together with all needed materials, including downloadable sound files, as an academic challenge at www.progressiveawareness.org. No one has run the study with a different outcome.

Today, the science of subliminal communication is still poorly understood by many, but it is a true science with valid merits. It can assist in enabling individuals to overcome the doubt, fear, and negative input that all too often create self-imposed limitations. It is a powerful take-home modality that the therapist can add to his or her resources. Many clinicians do just that. My office has received many reports from health-care providers attesting to this. One doctor reported increased improvement with patients dealing with many different health-care issues when using a subliminal audio program as a take-home care modality. In his words, "Basically my patients get better faster when they use InnerTalk in addition to the rest of their treatments as compared with similar patients who use only 'traditional' treatment methods" (Taylor, 2007).

Conclusion

There are many potential applications where the use of subliminal technology could be beneficial. A quick review of the literature suggests that this technology can be helpful in areas as diverse as learning something to oncology care (Taylor, Bey, & Sadana, 2000). The research designs often provide very good models to follow and as often suggest possible improvements. For example, some treat an audio message as though it were a written message; therefore, it is not subject to the qualities expected in meaningful voice delivery, such as inflection, tone, sincerity, and so forth. In other words, a computer-generated voice is thought by some to be as effective as a real human voice. The answer to this and many other questions is unknown because the research has not yet been done.

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By Irene Rosenberg-Javors, MED, LMHC,
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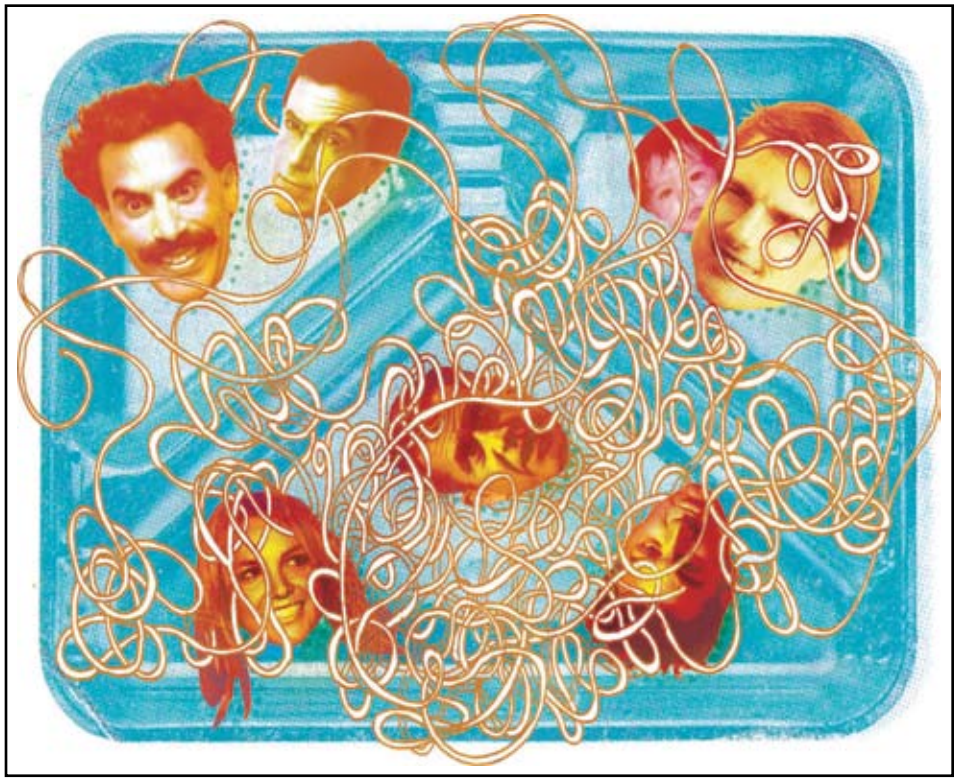
Bigotry: Cause for Therapy?

MCT Illustration by Michael Hogue/The Dallas Morning News



I teach a graduate class in counseling techniques at a local university. During a recent discussion, a student brought up the topic of "celebrity rehab," referring to the bizarre outbursts of such performers as **Mel Gibson**; Seinfeld's Kramer, **Michael Richards**; and Grey's Anatomy's **Isaiah Washington**. My student raised the issue of whether the verbally abusive statements made by these celebrities reflected mental disturbance or outright bias and prejudice.

After class, I continued to mull over this question. Gibson, Richards, and Washington engaged in verbally abusive tirades against Jews, women, Blacks, and gays. Yet, their reprehensible behavior was reframed as symptomatic of an illness that required rehabilitation. They were victims of a sickness, and the cure involved residential treatment, consciousness raising, anger management, etc.

Is prejudice an illness? Is a rehabilitation facility the place to "treat" the "suffering bigot?" What is going on when a culture pathologizes hate and reframes bigotry as a medical problem? Are hatemongers *not responsible* for their words and deeds? Or, do we just give them medication, have them attend 12-step programs, and then have them interviewed on a talk show where they confess the error of their ways?

I am dismayed by the way such unacceptable behavior is processed by celebrity-saturated media coverage. As a society, we seem so obsessed with our entertainers that we grant them a status above the law. We make excuses for them. We *understand* them to the point that we absolve them of any serious responsibility for their actions.

We *therapize*, rather than hold people accountable for their words and deeds. Bigotry and prejudice are not diagnostic categories; rather, they involve issues of ethics, morality, and civil discourse. When a celebrity mouths biased speech, that person is not having an anxiety attack, he or she is having a hatefest. Drinking or drugging does not make someone become a bigot; the biased distortions were learned long before the individual ever resorted to a drink or narcotic. Yet, "demon rum" or poor anger-management skills are pointed to as the cause of all the bad thinking.

What is this saying to our young people? One of my adolescent clients told me that, "if you have lots of money and you are famous, no one can touch you—you can say and do whatever you want." She further pointed out that life is about, "what you can get away with." Indeed, she is quite accurately expressing the cynical realities of our overly materialistic times.

How we have dealt with these terrible, celebrity outbursts reveals more about us, as a society, than it does about Gibson, or Richards, or Washington. Bigotry is not a medical problem that can be cured with a pill. Hate and prejudice are societal problems. As a culture, we need to deal with our racism, sexism, anti-Semitism, and homophobia as failures of our democracy. The cure for bigotry is good citizenship, not therapy!

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By Daniel Reidenberg, PsyD, FAPA, CRS, MTAPA

Tips for a Successful Therapy Practice

As a consultant to therapists, I am often asked for tips on how to make a practice successful. When I ask therapists how they define success, many tell me they want to make more money, and many say they want to feel less overwhelmed with the realities of a practice. When they tell me they are overwhelmed because their caseloads are booked and they are making referrals to others in the community, I tell them they are already successful. Nevertheless, here are some ways to be more successful and reduce stress (in no particular order).

Tip 1: Understand that Your Practice *is* a Business

All businesses exist to provide a service or sell a product and to make money. And just like other businesses, you have hours of operation and overhead expenses; a successful business provides you with the means to earn a living. Most of us went into the health-care profession to help others. This is noble and honorable, though, as most of us would agree, not necessarily wise financially, especially if you had hoped to work a normal 8-5 job and retire at 62 with a permanent pension fund and lifetime benefits paid by someone else. At times, being a business means you are "closed" for the day. At times it means you have other customers. Still other times it means that you have documents that need signatures and approvals. By keeping in mind that you, too, run a business just like all the other businesses that you frequent, you will better serve your clients.

Tip 2: Aim for Cash Only

As soon as you are able to do so, work toward making your practice 'cash only'—pay at the time of service. Until then, inch in that direction, but always keep thinking that way. Just like other businesses, the sooner you are paid for what you have done (or sold), the sooner that money is in your bank account. Every day that it is not, the actual value of that dollar you earned drops. Until you can be cash only, I recommend you work toward a 60/40 (insurance reimbursement/cash) split. Being tied to insurance company contracts and networks keeps you at their mercy. If you owned a hardware store and one of your suppliers was late bringing you nuts and bolts, for example, how long would you stay with that supplier? Not long, because nuts and bolts are part of your staple products as a hardware store owner. The same thinking applies to our field. Remember you have a business to run and this means not being held hostage by an insurance company, waiting for reimbursement or for referrals. You need to be in control. When you can demand cash for services provided, everyone will be better off.

Tip 3: Watch the Clock

Time truly is money for you. Part of your job is to set boundaries, model certain behaviors, and establish healthier behavior patterns for your client. One of the most problematic issues for therapists is getting behind hour after hour. The more you can watch the clock and stick to the time your client has paid for, the better off you and your day will be. Many therapists think that clients are actually paying for 60 minutes of service, and they are right! However, what they do not realize is that in the case of insurance, the insurance company is paying for a 50-minute therapy session and 10 minutes for charting, phone calls, and other paperwork. They are not paying for 60 minutes of therapy plus 10 minutes for the other things. Stick to your clock and keep your day on track. On a related note, assist your clients in self-training to be more thoughtful and productive with their time with you. Establish at the beginning and remind them early in therapy that you have 50 minutes to spend with them and they need to work with you to help determine how that time will be spent. If they cannot, you can help them by structuring their hour (important issues, less relevant issues, etc.). Too often, clients control when they tell you things during the hour and, as we all know, it is usually right before their time is up. Help them learn how to manage their time, present concerns, reflect on things, and use the hour as a "mini-practice round" for outside of the office.

Tip 4: Always Offer a Free Consultation

Everyone likes to get something for free, and a first session is the best we can do in our business without giving the business away. Chances are, if someone comes to you to see if you can work with them, they will stay with you. Count how many free sessions you have offered, and then count how many free sessions turned into regular sessions with paying clients. You will quickly see the value of spending an hour with a prospective client for free—it will go a long way for your practice.

Tip 5: Do Good Work

This may seem like a no-brainer, but it really is not. The average client is seen 4–6 times. This might be hard to believe, but it is actually true. Many clients are seen longer/more, others just once or twice. The better job you do with a client, helping them sooner rather than later, the more likely you are to get referrals from them. The majority of your clients do not want to be in therapy, and your clients do not want to be in therapy forever. Our world moves faster and faster, and so should you. Rather than spending 3–4 sessions determining their diagnosis, help

them with the issue that brought them in to see you in the first place. The sooner you can offer them ways to change or feel differently, the happier they will be. Keeping a client in therapy longer than they really need to be is not only unethical, it is also not helpful to the client.

Tip 6: Do Not Work Harder Than Your Clients

In consultation groups, one often hears how frustrated a therapist is because they feel they are offering great suggestions, insights, and interventions, however, their client(s) are not improving (which is why these clients are often brought up in consultation groups). When you realize you are working harder than your client, it is time to change something. Change can mean a referral to another therapist, as well as a straight-forward check-in with your client. I often tell therapists to pull out the treatment plan and go through it with the client. Discuss the progress and see how you both feel about it; make the necessary adjustments to the plan and/or consider termination and/or referral, whichever might be the best for the client. Also remember this: the more time you spend talking about a client outside of the paid hour you are with them, the less the value for the dollar they paid you. Consultation is sometimes needed and helpful, but check-in with yourself first and figure out if you are working harder than your client is, then determine how much more time is needed.

Tip 7: Do More Than Just Therapy

Do not do just one thing. Flexibility, diversity, and opportunity should be something in all therapists' vocabularies. To have a successful practice often means doing more than just therapy 8–12 hours a day. Be open to ideas such as writing, lecturing, community presentations, working with another therapist, etc. Consider volunteering some of your time at a free clinic or hospital. Diversifying your practice grows your skills and talents and offers you a chance to give back, do other things, and keep a fresh perspective.

Tip 8: Be a "General Specialist"

The health-care profession has swung from the days of old where most (medical) doctors were family practice doctors and they treated a range of illnesses, and only few were specialists brought in solely on cases when they were desperately needed. Today, the reverse seems to be true—we have a health-care system full of specialists and few generalists. If you can see anyone, you are more likely to have a range of clients. This diversity in your client base will keep you more present and interested throughout your day. I have a colleague/friend who is an OCD specialist, and that is how he is known in our community. When a therapist is seeing a client with OCD and cannot help the client adequately, he or she makes a referral to my friend. It is good for him to have this reputation; however it is also a detriment to his practice. If I have a full caseload and I cannot take on another client (who does not have OCD), my first inclination is not to send the client to my OCD-specialist friend. While I know that he can see clients of all types and with all issues, he is really a specialist. Most often my client needs a generalist. So, be a generalist that is also really good at something (or two things), rather than a specialist willing to see all clients.

Tip 9: Be Intentional When Locating Your Practice

Locate your practice in a building with other therapists and, if possible, medical providers. Clients will see other therapists on the marquee when you share a building, and they will not feel the shame of seeing a therapist because they know others are coming to the same building for similar reasons. More importantly, as you network throughout your building, you will become acquainted with the other therapists and medical doctors. The other therapists will refer their clients to you when their caseloads are full and the medical doctors will have someone close by to whom they can refer their patients.

Tip 10: Do Not Focus on the Diagnosis

Most clients want to know what their diagnosis is, but diagnosis is primarily done for us—it provides a way that we can communicate, with labels and terms, expressing a generally understood set of symptoms or characterological traits, especially for insurance purposes. In the end, however, a diagnosis does little more for a client than give them something to hold on to. How good do you feel when you bring your car in for service and the mechanics tell you they know what the problem is? Most of you would probably agree that you do not feel much better until you actually have it fixed. Therefore, if you can give your client(s) things to do as a result of the diagnosis, they will be far happier with you than just being glad you were able to figure out what the problem was.

Extra Tip: Work Fast

Help your clients return to their optimal level of functioning as quickly as possible. In today's world of fast food, fast oil changes, and fast fixes from a medical doctor, most clients expect the same to be true of psychotherapy. We lose credibility with our clients when we see them week after week and they do not feel like they are getting any better. Further, when their family, friends, and co-workers, ask them (and they do!) how therapy is going, if your clients tell them they have been seeing you for a couple of months, the first thought the other person has is, "what in the world is taking so long?!" While many of us would like to go back to the days of seeing clients for 1, 2, or more years, and really working intensely with them on developmental and other dynamic traits and issues, know it and recall it fondly, then help your client get back to feeling well quickly. They will appreciate it, and their appreciation will reflect well on your practice.

About the Author

See Daniel J. Reidenberg's bio on page 38.

By Anne D. Gooding, PhD, LCSW,
Diplomate of the American Psychotherapy Association

Coaching Niches: Part 3

Niches are specialized areas of coaching that a life coach offers and markets to a particular group. My niche is in coaching adolescents and adults diagnosed with **Attention Deficit Disorder/Attention Deficit Hyperactive Disorder, (ADD/ADHD)**. Statistically, 2 out of 3 children with ADHD will go on to become adults with ADHD. Additionally, 80% of the adults with this disorder are undiagnosed and untreated.

There are a variety of methods by which ADD/ADHD clients contact me for coaching services. Aside from the traditional marketing referrals, there are other less traditional routes—I have gotten referrals while sipping coffee, attending a physical therapy session, and even while waiting to have my auto serviced! A third party contacted me recently because her friend had heard me speak at IONA College in New York during Women's History Month 4 years ago. This kind of referral is central to my practice.

It is relevant to recall that ADHD coaching, unlike more traditional psychotherapy, is not focused on the past or on feelings, and is not initially "insight-oriented." The major struggles, concerns, and tasks for the ADHD client are focused on how to negotiate their lives on a daily basis, taking one day at a time. An ADHD coach addresses the symptoms of the disorder, along with the consequential impact of these symptoms on the client's daily functioning.

Along with the ADHD diagnosis are the co-morbid factors, of which anxiety, bipolar disorders, oppositional defiant disorder, and depression are the most prevalent. Because other DSM-IV conditions may be present as well, most ADD clients are prescribed two or more medications.

Frequently, medication compliance becomes another issue that must be addressed. It has been my experience that this is especially problematic with the 18–25 year-old college/graduate student population. It is not unusual for the student to sell their stimulant medication to non-ADD students. Local newspapers have published stories about parents of high school juniors and seniors who manage to obtain meds for their non-ADD children with the expectation that this will increase their children's scores when taking the SAT and ACT exams. These issues must also be addressed in ADHD coaching.

An ADHD coach addresses problems in the multiple environments of a client's life, including work, home, school, social outings, and other environments. Many clients struggle with particular aspects of functioning in specific environments. The following are brief illustrations of ADHD issues and the clients who hire me to coach them around their ADD crisis. These brief illustrations highlight problems that generally underlie the variety of issues ADD/ADHD clients face on a daily basis, though each client is different and his or her specific struggle will be different from any other client's.

Disorganization or an inability to locate frequently used items.

Carol, a 38-year-old visiting nurse, complained of being unable to document her chart notes in a timely manner. She could not complete her notes during the time she was on-duty, so she would go in on her days off in order to complete each week's documentation. She responded well to coaching interventions and is now using a notebook computer to immediately document her legally required data, rather than taking her personal time to do so.

Lack of time management skills and an inability to prioritize tasks.

This is a primary issue with each college/graduate student I've coached. ADD students most often do not plan, prioritize, or consider the repercussions of not adhering to the requirements of educational institutions. They usually begin preparing for exams the day or night before the scheduled exam. As part of my contract with them, I request the syllabus for each course that they are registered to take, and plan a study and preparation schedule for exams, presentations, and required reports. Students ususally do not permit their parents to intervene at this level, but they must agree to this level of activity or I will not coach them. Coaching students is especially labor intensive and my background in teaching is extremely helpful.

Poor or ineffective stress-management techniques.

This is a problem for most of my ADD clients. Interestingly, a majority of my ADD adult clients have only been diagnosed within the past 2–3 years. Clients have told me that until they were diagnosed, they felt that they were "stupid, lazy, or crazy," and these emotions were enhanced by poor job performances. They were unable to manage the stress of school or work at an appropriate level, and their distress at being unable to manage stress well, and knowing it, just added additional stress. Clients are quite relieved to know that there is a legitimate reason for their inability to function and receptive to learning stress management techniques.

About the Author

Anne D. Gooding, PhD, LCSW, is

a Diplomate of the American Psychotherapy Association and has been a member since 1999. She works as a therapist and personal coach and maintains a dual therapy/coaching practice in Westchester County, New York. For more information on coaching, visit www.adgsms.com. She can be reached at dranne@adgsms.com

By Daniel Reidenberg, PsyD, FAPA, CRS,
Diplomate of the American Psychotherapy Association

Our Association

About 2 months ago my mom was reading a copy of *Annals* and saw the advertisement for logo products that members can purchase from APA. She asked me, "Why is your picture on the ID card?" Before I could offer an explanation, she asked, "Why in the world would they want to use your picture? You're no model."

"No, Mom, I'm not a model." That said—I do hope that I am a model for all of you, the APA members, of who we are, and who we want to be.

I joined this organization 10 years ago, when it was in its infancy. When I heard about it, I was immediately impressed with the vision of both **Dr. O'Block** and my predecessor and mentor, **Dr. Bear**: to create an organization for all psychotherapists that would truly be dedicated to the profession.

The concept was brilliant: create a professional organization motivated to providing leadership to its membership in the areas members felt were most important; bring together therapists of various disciplines and share current scholarship from experts in the various fields; create opportunities for members to advance themselves in their field through certification and recognition programs.

What I heard then, and what I believe remains true today, was that APA would be a member-driven organization, not a business-driven organization. Unlike other professional associations, we are not in the business just to make money. Of course, we need and appreciate your membership (financial) support, but our dues are not outlandish. Our course fees are not exorbitant. Our conferences are not cost-prohibitive. And our products are sold at a reasonable rate. We do not spend a lot on overhead and duplication of staff; years ago, Dr. O'Block wisely saw that having several organizations under one roof would save money and make better use of member dues to give back to programs.

In December 2006, I testified before an FDA panel on the use of antidepressant medications in adults. At the hearing, there were two camps: one, a scientific camp, and the other, an advocacy/personal survivor camp. Leading scientists, experts, and lobbyists testified for all of the major organizations from across the country. It was a long and emotionally exhausting day of listening to families talk about the pain, suffering, and grief caused by the loss of their parents, children, and spouses to suicide. They believed pharmaceutical companies, the FDA, and, ultimately, antidepressants had caused the deaths of their loved ones. Having worked in this field for 20 years and as the current executive director of a suicide prevention agency, I assure you, there is no single cause of suicide. Suicide is a multifaceted and complex problem—and a public-health crisis.

However, one moment in particular has stayed with me since last December: it was when I was asked about "our APA." Actually, it was more like *what is the difference between your APA and other associations?* I felt good knowing that I had a clear answer. Our APA is just that: it is *ours*.

We, the members, help determine where the annual conference will be held and what topics will be offered. We, the members, determine which certification programs we promote based on what members say will be of greatest benefit. We, the members, contribute articles for our professional journal and we make publication a realistic option for therapists who choose to write. The membership also determines what issues we collectively pursue in terms of advocacy on a national basis. All of these things make our APA unlike other associations; all these things make me proud to be part of something unique.

As I write this, I'm sitting on a plane wearing an APA shirt I bought at a conference several years ago. How many of you do the same thing? As Chair of the Advisory Board, I offer you this challenge: become involved in *your* APA. Tell us what you want to see, what you want to read, what you want to learn, how you want to be involved, how you want to grow as a professional, how you want to be connected to the thousands of therapists who also want something different than just paying annual dues and getting a journal in the mail. This is *your* APA and I encourage you to jump in, to get involved, and to help us continue to define the future of the field of psychotherapy. Consider buying a shirt or wearing an APA name badge with your picture on it—go ahead, make your mom ask about your picture too!

"The concept was brilliant: create a professional organization motivated to providing leadership to its membership in the areas members felt were most important; bring together therapists of various disciplines and share current scholarship from experts in the various fields; create opportunities for members to advance themselves in their field through certification and recognition programs."

About the Author

Daniel J. Reidenberg, PsyD, FAPA, CRS, MTAPA, is the chair of American Psychotherapy Association's Executive Advisory Board and has been a member since 1997. He is a Fellow and Master Therapist of the American Psychotherapy Association, the chair of the Certified Relationship Specialist, CRS, Advisory Board, and executive director of Suicide Awareness Voices of Education (SAVE) in Minneapolis, Minnesota. Contact him with your thoughts at dreidenberg@save.org.

By Bruce Gross, PhD, JD, MBA, FACFEI, DABPS, DABFE, DABFM,
Diplomate of the American Psychotherapy Association

Life Sentence: Co-Victims of Homicide

Defined as the "willful (non-negligent) killing of one human being by another," criminal homicide generally represents the smallest proportion of all violent crimes (Bureau of Justice Statistics [BJS], 2005; Federal Bureau of Investigation [FBI], 2006). According to both the FBI and the National Center for Health Statistics, approximately 16,500 murders were committed in the United States each year from 2003 to 2006 (FBI, 2004, 2005, 2006, 2007; Minino, Heron, & Smith, 2006). Beyond that tragic number, it has been estimated that for every victim there are anywhere from 6–10 close relatives who become secondary- or co-victims of homicide (Kilpatrick & Acierno, 2003; Vessier-Batchen & Douglas, 2006). That represents anywhere from 99,000 to 165,000 people each year, just from 2003 to 2006, and does not include significant others, friends, or co-workers who are left to mourn as well.

As with "natural" death, the impact of homicide on survivors is influenced by the circumstances of the murder. Both natural and unnatural deaths can occur suddenly or slowly, with more or less pain, and to someone of any age. As compared to many natural deaths, with murder there is no chance to prepare, no opportunity to make amends or to say good-bye, and (for most of society) no developmental frame of reference for understanding this unique loss. Most notably, unlike natural deaths, homicide, by definition, involves an intentional act of violence by another person, someone either unknown by the victim or a loved one of the victim and/or survivor(s) (see Table 1). Finally, the impact of homicide on survivors is further shaped by the context in which it occurs, be it during a sexual assault, an argument, an act of arson, the result of torture, drunk-driving, or a "romantic triangle."

The process of grieving a loss through homicide is distinguished by the traumatic nature of violent death. The survivors must not only find their way through the process of "normal" bereavement, but must also resolve the emotional and physical consequences inherent in learning a loved one suffered (to some degree) from intentionally inflicted emotional and/or physical violence. Like all survivors of loss, co-victims of homicide struggle with the range of normal reactions to grief, such as denial, shock, confusion, anger, guilt, powerlessness, depression, and a desperate search for understanding and meaning. Surrounding this normal pattern of grieving, homicide survivors are confronted with intense and often paralyzing feelings of fear, as well as near-consuming thoughts of revenge.

The Aftermath of Horror

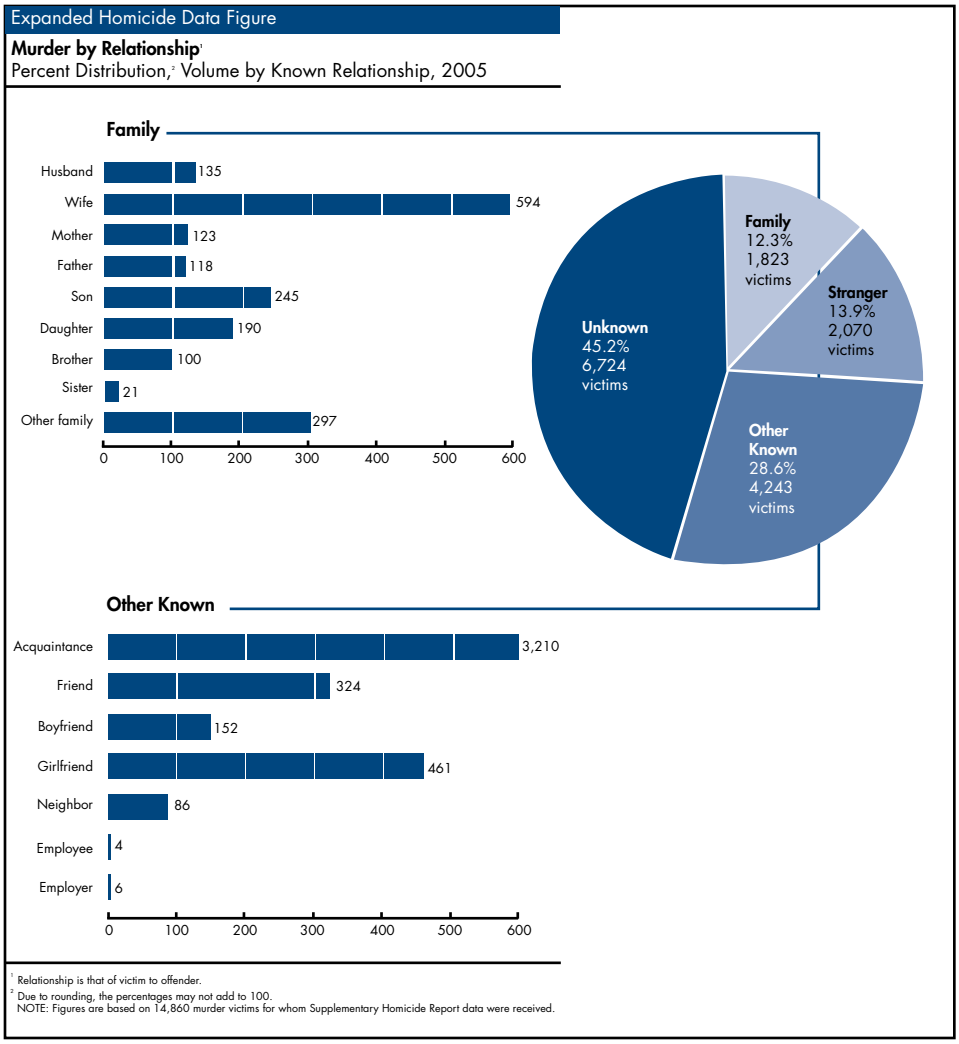
The event of unpredictable, intentional violence gives rise to a sort of primal fear and horror that can be overwhelming for those surviving the victims of homicide. This fear is virtually impossible to comprehend, contain, or explain with words. Survivors are apt to vacillate between a state of *psychic-separation* (characterized by numbness, denial, and disbelief) and *over-connectedness* (during which they are painfully aware of the presence of the event in every thought, image, and emotion).

Subsequent to the loss of a loved one through homicide, it is not uncommon for survivors to become pervasively distrustful and hyper-vigilant and to develop an exaggerated startle response. Fear and panic may quickly evolve into a diagnosable anxiety disorder, especially post-traumatic stress disorder. Survivors are apt to manifest profound feelings of helplessness, emotional liability, extreme irritability, cognitive disturbances (especially in concentration and decision-making), and impaired functioning in all social roles. Survivors may struggle with a loss of faith and feel as if their very core and connection to the world is lost. The magnitude of these feelings can easily develop into a diagnosable depressive disorder.

Most co-victims of homicide are plagued by questions regarding the specifics of the murder. In fact, the need to know every little detail can take on obsessive and compulsive qualities. Depending on the circumstances, survivors may become angry with the victim and even blame the victim for his or her own death. Where answers are unavailable or incomplete, and especially in the case of sexual or sadistic murder, survivors will likely create their own highly detailed *murder-story*. They over-identify with the victim, replaying in their minds what they imagine their loved one experienced, suffered, thought, and felt up to the very moment of death. These *reenactment fantasies* quickly become intrusive, repetitive flashbacks during the day, and recurring nightmares during sleep. For most, these murder-stories tend to subside spontaneously over time; for others, they increase in frequency and exact a heavy emotional toll on survivors.

If the murder was intra-familial, survivors may develop reenactment fantasies for both the victim and the perpetrator. Depending on the nature of the pre-existing relationships, survivors may actually identify more with the perpetrator than the victim, even to the point of questioning whether they, too, might commit murder some day. These thoughts can be acutely disturbing for survivors and result in an exacerbation of their fear and anxiety. It is not uncommon for surviving family members

Table 1: [From: FBI. (2006). Crime in the United States, 2005. (Expanded Homicide Data)]



to have divided loyalties, resulting in even greater turmoil for the individual survivors. In addition, the very family members who would generally be a source of support for survivors may be emotionally unavailable because of their own grief and/or survivor-directed anger due to torn loyalties.

Along with re-enactment fantasies, survivors of homicide are apt to experience intense and vivid fantasies of revenge. These seemingly uncontrollable fantasies may be extremely frightening to survivors, especially to those who have not previously known themselves to be vengeful. This may be the first time the individual has harbored such violent thoughts and feelings. The associated fear, shame, and self-disgust may be worsened if the perpetrator at the center of the fantasies is a family member.

Depending on the timing, location, and nature of the murder, survivors may be confronted by the media. Some survivors may view media involvement as a beneficial opportunity for public assistance and support. Other survivors may experience media involvement as a thoughtless, intrusive violation of their privacy and grief.

At this time of total devastation, survivors may find themselves feeling isolated and even betrayed by their friends. Friends whom survivors thought would be there for them, may not be; however, others may come forward to provide unexpected support and solace. Many people are unable to cope with loss and pull away; others fall victim to the unfortunate stigma that surrounds murder and remove themselves from its shadow. Friendships are seldom tested as significantly as when one friend has lost a loved one to homicide. This, in itself, can be a source of terrible sadness and additional loss for survivors.

The homicide of a loved one may result in a sudden role change for survivors. In the midst of crisis, survivors may be required to take on the role of the *bread-winner*, or become the primary care-taker of dependents. These types of change can be inordinately stressful, even at the best of times.

How survivors or co-victims of homicide adjust depends, in part, on their pre-existing emotional and physical relationship and financial status. Prior exposure to trauma and violence may have either a positive or negative effect on survivors' immediate and long-term ability to absorb and adjust to the loss at hand. The recentness and nature of the prior exposure(s) informs survivors' emotional foundation for recovery, as does how, and how well, the prior traumas were resolved.

Therapeutic Intervention

There are a number of support groups throughout the nation for survivors of homicide. For many, being and sharing with others who have been through a similar type of loss is very helpful and healing. For others, such groups can be overwhelming and actually exacerbate the survivor's symptoms of trauma. For these survivors, individual therapy is the treatment of choice, allowing the sufferer a private, anonymous, and safe environment in which to explore and process his or her loss.

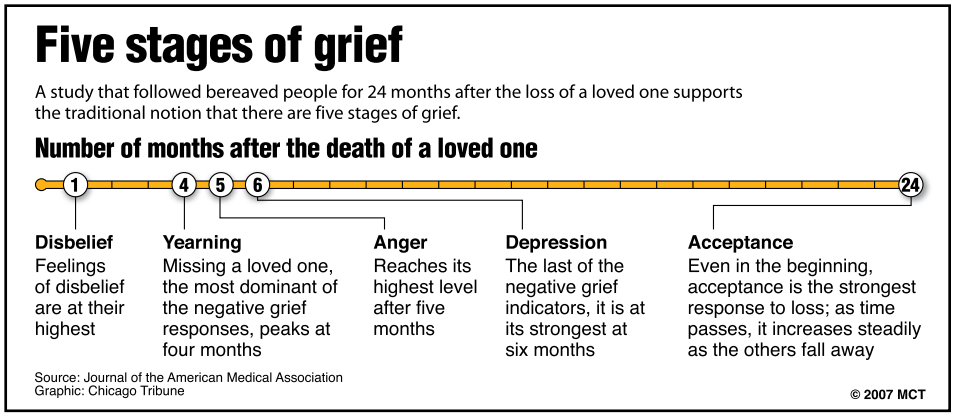
When working with co-victims of homicide, treating the effects and symptoms of trauma takes precedence over treating issues related to the loss (or any pre-existing issues). Keeping therapy focused on the trauma tends to decrease the hold of denial, which, in turn, allows for more rapid recovery. Sometimes co-victims enter therapy with prior trauma that must be resolved before they can move on to the current one. If co-victims push to focus on other issues, assess whether the underlying theme is the same as that in the trauma at hand (e.g., helplessness, intense violation, disruption of security, etc.). If it is the

same, focusing on and resolving that issue may make it possible or easier for the co-victim to move on to the present loss.

When working with survivors of homicide it is especially important not to be overly empathetic, running the risk of adding perceived *emotional weight* to what the co-victim already carries. Therapists (who may have their own issues around death and homicide) should be careful to avoid offering platitudes, using disempowering statements, and suggesting rationales (especially religious) for their loss. In addition, therapists should never set up expectations or be overly optimistic with the survivor-client about their recovery.

Early on, therapists need to identify the survivor-client's typical/historical positive and negative defense mechanisms and coping strategies. How the co-victim has coped in the past may be inadequate to manage the complexity of the internal and external demands of homicide. Positive approaches may need to be reinforced, and negative ones replaced with those that are more effective. Normalizing the horrendous fear the co-victim feels is an important first step in treatment. Eventually they will need to learn how to separate or distance themselves from the known or imagined experience of the victim and move from sympathy to empathy. In addition to reinforcing patience with one's own healing, survivor-clients will need to learn how to calm themselves in the face of overwhelming fear.

Along the same lines, therapists need to identify the survivor-client's support system, as well as the client's ability to enlist their aid. It might prove worthwhile to include one or more of those persons in a session (only with the client's consent) in order to enhance the support they provide. Therapists should determine those persons to whom the survivor-client is typically a source of support, especially in the case of intra-familial homicide. It may be necessary for the therapist to help the client find other or additional resources for those persons during this time of trauma.



As described above, co-victims are apt to come to therapy with vivid fantasies of violence toward the perpetrator. Survivor-clients need to verbalize their fantasies, as well as their reaction to those very thoughts. To work effectively with co-victims, therapists must be able to listen to oftentimes horrendously violent fantasies—without reaction—and normalize the violent thinking. Therapists must be able to differentiate a co-victim's "revenge fantasy" from the survivor posing a possible or probable threat of harm to themselves or others. For those co-victims for whom forgiveness is a value, they may need reassurance that thoughts of revenge are not inconsistent with the process of forgiveness.

Most co-victims want to understand the perpetrator's motive for killing their loved one. In intra-familial homicides this natural line of thinking can lead to tremendous feelings of guilt (towards both victim and offender) and responsibility. When the homicide victim is a child, the feelings of guilt, personal failure, and self-blame (for not having protected the child) can be crushing. Beyond motive, most survivors search for meaning in the traumatic and violent loss of their loved one. This is especially so for those survivor-clients who have an ingrained and practiced spiritual and/or religious belief system. Therapists should respectfully explore the survivor's thoughts and beliefs about death, as well as the impact the homicide had on their spiritual beliefs. In many cases, survivors begin to question the existence of their identified higher-power or the existence of that higher-power's goodness; both of which can result in intense anger and a profound sense of isolation and disorientation.

The recovery process of many survivor-clients is affected by "unfinished business" from their relationship with the homicide victim. The survivor and victim's last interaction may have been an angry one, which can exacerbate their anguish at not being able to make amends, reconcile, or say good-bye. If the survivor and victim had a long-standing bad or abusive relationship, the survivor might actually feel relief with the victim's death. Having responded with relief may ultimately lead to guilt at having that initial reaction. Where the relationship between the survivor and victim had been good and loving, the co-victim may suffer from *survivor guilt* (especially when the victim was a child). *Survivor guilt* is also common in co-victims who were present at the time of the homicide, but escaped death.

How the trauma of homicide affects the survivor's employment, marriage, friendships, and other social roles and responsibilities depends, in part, on their prior functioning and level of stability. Each of those areas should be intermittently assessed and enhanced as needed. Over time, hopefully, co-victims will be able to accept life without their loved one. Survivors should be alerted to the possibility of the re-emergence of symptoms in the future, triggered by certain dates, special occasions, or other events the survivor associates with

the victim. Often, especially in the case of intra-familial homicide, the survivor may need to create new rituals around holidays and significant daily routines.

Overall, co-victims of homicide need a safe opportunity to ventilate, a calm and supportive presence or authority, the restoration of a sense of control and security, and guidance in preparing for life-after-homicide. Within that process, survivors may need referrals to appropriate adjunctive therapies, including medication for anxiety and/or depression. Therapy is often enhanced by providing check-in phone calls (if desired by the client) between sessions during the initial stage of therapy.

Special Concerns

Unlike most cases of natural death, unnatural death or homicide brings the survivors into contact with the criminal justice system, which begins with notification of the loved one's death. While the process varies slightly between jurisdictions, notification is usually made by two trained officers, at least one of whom is in uniform. The officers will transport the survivor (or arrange transportation) to the morgue for identification of the body if necessary. They ensure that someone is with the survivor after notification, leave their contact information, and make a follow-up call the next day.

In addition to their natural, automatic reaction to the notification, survivors may find the experience itself a negative one. Depending on the specifics of the crime, the survivors may need to be ruled out as suspects, a task which may not have been achieved prior to notification. In that event, the officers may initially talk to the survivors separately and may not be as forthcoming as they would be otherwise or as the survivors might like or expect. Even the thought of being considered a suspect can leave the survivor feeling insulted, incensed, embarrassed, or afraid they may end up being falsely accused.

After death, the victim's property may take on special significance to survivors. In many cases, that property becomes evidence and might not be returned to the survivors until the case is over. This necessary, but frustrating, fact may add to survivors' feelings of loss of control.

Survivors should be referred to the Crime Victims Compensation or Victim/Witness Assistance program if the police or prosecutors have not made them aware of those services. While program specifics may vary between jurisdictions, and most have an upper limit, survivors may be eligible for financial reimbursement for funeral expenses, loss of income, and counseling. In addition, funds may be available for necessary crime-scene clean up if the homicide occurred in the home.

At some point in the process, most survivors find themselves feeling impatient and frustrated with the criminal justice system. While survivors may consider police and prosecutors their allies (which to some degree they are), they may not always (or ever) be a source of support. At some point, law enforcement officers may seemingly "give up" on a case, when all reasonable efforts to find the perpetrator fail. While all parties want to see "justice served," survivors and prosecutors may be operating from a different set of definitions and criteria. Prosecutors and the defendant may negotiate a plea-bargain, which serves the purpose of the legal system, but not the needs of the survivors.

In a 2004 study by King, the emotional reactions of the families of murder victims were compared with those of the families of death row inmates. King found that both groups suffered "distorted" patterns of grieving that were very similar. Both groups experienced emotional, physical, and social difficulties, and both struggled with fears and concerns regarding their personal safety and security. Of note, both groups perceived those who worked in the justice system as lacking in compassion and having little understanding of normal grief reactions. Both groups complained their phone calls went unreturned, that personnel were not accessible, and that they were given incomplete and/or untruthful information (2004). It may be helpful to explain to survivors that the perceived insensitivity of some within the justice system may simply be the cognitive-emotional barriers they develop to protect against the pain and ugliness they see and hear on a daily basis.

If the case goes to trial, survivors may have conflicted emotions regarding whether to attend the trial. Survivors are typically instructed not to show any emotion in the presence of the jury in order to avoid influencing them in any way. This can be extremely difficult and taxing for survivors, especially if they see the defendant socializing with attorneys and/or family members during breaks in the proceedings. If the survivor is a witness for either side, they may be barred from attending the rest of the trial. It is not unheard of for defense attorneys to add family members to their witness list expressly to keep them out of the courtroom and away from the jury.

It is around the trial that most survivors are confronted with the reality of the judicial system's obligation to protect the rights of the accused. This may be experienced by survivors as a violation of their rights and only accentuate the loss of their loved one. It is important to help survivor-clients anticipate all possible outcomes, including a plea-bargain. While some jurisdictions allow survivors to give input in possible plea-bargains, many do not. If a plea-bargain is negotiated (especially without or despite their input), the survivors may feel cheated of their right to justice. Murder cases are not often tried quickly, especially those in which the prosecution is seeking the death penalty. With each delay and continuation, survivors may feel deflated, re-wounded, and increasingly frustrated.

If the case attracts the media, most survivors will benefit from guidance in how to deal with this often-intrusive involvement

in their loss (many support groups offer help in this area). While publicity may help draw attention to the case, that is not media's bottom-line purpose or goal. Media attention can be extremely unsettling to survivors. While journalists and reporters may appear sympathetic and sincere, it is not uncommon for the information the survivor provides to end up twisted in some way. False or highly personal information about the victim or the circumstances of the crime may be revealed. Unfortunately, survivors have no say and receive no guarantee as to how their interview information will be used. Some survivors may learn about new developments in the case from the media, rather than from an appropriate authority, although efforts are made to prevent this from happening.

It can be very beneficial to explore (well in advance) the survivor-client's expectations regarding the outcome of trial, including their feelings about capital punishment (if relevant). There may be a significant difference between what the survivor hopes for and expects, and what are actual sentencing options. Survivors may find themselves unfathomably angry if the defendant is acquitted or receives a sentence that seems too soft. Many survivors become singularly focused on the trial, believing they will feel better when it's over and justice prevails. Therapists should help survivor-clients separate healing and moving-on from the process and outcome of trial.

Most states allow oral and/or written "victim impact statements" during the penalty or sentencing phase of trial. The purpose of these statements is to refocus attention on the "human cost" of the defendant's crime. For most survivors, this is the only opportunity they will have to speak on behalf of the victim, and to demonstrate to the judge or jury the depth of suffering the defendant caused in their lives. A study conducted by the National Center for Victims of Crime found that for 80% of over 1,300 subjects, the ability to make a "victim impact statement" at sentencing (and/or during parole hearings, where they are also allowed) to be "very important" (Alexander & Lord, 1994).

There are some survivors of homicide who want to communicate or meet with the convicted murderer. The motive for such a meeting, as well as the pros and cons, should be carefully explored. Whether the meeting takes place is ultimately the inmate's decision. Survivors may ask to be notified of and present at the convicted murderer's parole hearings. Similarly, they may request notification of the convict's release (should that happen). To receive these notifications, some states require written request and others use a state-specific request form. Survivors are responsible for ensuring that the Department of Corrections in their state has their current phone number and address. In capital cases, some states allow survivors the right to witness the execution, a possibility that should, obviously, be very carefully explored.

Ending Thoughts

Certainly not all grief is the same, and that of survivors of homicide is extremely complicated. Survivor-clients can be a very rewarding, but challenging, population with which to work. It requires a range of therapeutic skills and specialized knowledge, including familiarity with everything from the process of arranging funerals to the specifics of witnessing an execution. If not doing so already, therapists should incorporate questions regarding loss-through-homicide in all client intakes. Therapists who wish to work with co-victims should be sure they have adequate preparation, training, and supervision; those who do not should have qualified referrals at the ready.

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By Ronald Hixson, MBA, PhD, LPC, LMFT,
Diplomate of the American Psychotherapy Association

But Do We Want To?

Health-care is a risky business. The workplace is full of shadowy demands for accountability and legal responsibility with inadequate revenues and resources to build strong firewalls. We are exposed to a whole group of nasty diseases and viruses, over-powering emotional energies, and impossible problems to solve.

It seems like everyone has an opinion as to "the problem" of health-care. Employers say they cannot afford to provide the coverage they did 10 years ago. Managed care organizations (MCOs) and health maintenance organizations (HMOs) say they are offering benefit packages that employers want. They will argue that they were born out of the need for cost control. Politicians stand on a teeter-totter trying to keep a balance between providing health coverage for the very young and the chronically ill patients (which is morally right) and cutting property taxes (which is politically popular). Economists, journalists, talk show hosts, educators, and a few physicians have also contributed to the discourse, but only a few of these have ever practiced medicine or mental health. Some of the problems being discussed include the control of overhead expenses of a practice, reimbursement rates, access, delivery, resources to finance, quality of care, quantity of services, reform legislation, state and federal budgets, and setting priorities.

We entered this profession to make a difference. We have stayed in this field because we have developed treatment techniques that have assisted those who have chosen to learn better coping skills and more effective problem-solving techniques. However, we encounter self-doubt and fear—fear of not completing progress notes to the satisfaction of auditors, fear of not making payroll, fear of not having enough time to meet the needs of our patients. Frustrated by our lack of energy from increasing demands for a paper trail of accountability without adequate reimbursement, our internal motivation is weakened, consuming the drive needed to work additional days or more evenings. Many therapists complain of feeling alone, of not having enough support from colleagues, or the financial inability to hire adequate staff and legal and accounting services. For these reasons, and perhaps many others, private practitioners find themselves cutting back in their practices and refusing to accept new patients with Medicaid, Medicare, MCOs, HMOs, etc. Others are retiring, some are choosing another career, and a few are only accepting cash-paying patients.

We saw the lack of adequate numbers of experienced health-care providers when a 160 mph tornado hit Rosita Valley Elementary School, destroying 250 houses and killing seven people in Eagle Pass, Texas, in April, 2007. The Red Cross arrived with volunteers hailing from all parts of Texas and neighboring states. My patients said the Red Cross was great for handing out water, roof covers, and helping identify those needing help, but none of the individuals needing help were directed to local health-care providers. Secondly, patients reported that they were instructed to "suck it up" or offered platitudes as ways of taking their minds off the nightmares and flashbacks from the death and destruction. FEMA had limited mental and medical health providers too, and neither of these organizations approached any local professional providers of medical or mental health.

Considering the shortage of health-care providers, is it not time to band together in some way to rescue our industry from the clutches of outsiders? Doing this will take time, money, and compromises. We must break down turf issues, and we must become a larger, better-organized group in order to be heard and recognized by the powers in both federal and state halls of legislation. While there are arguably a number of options we can take, the first question might be "where do we start?" To begin with, we must decide our perimeters. For example, we can create a list of options, but how do we judge the priority of each? How can we select one idea as better than another, discern which is stronger politically, or determine which is the more time and cost effective? You may be developing a frustration headache just thinking about this process. Maybe the question, then, is: Do we want to?

There are a number of ways to combat fatigue, burnout, or a simple lack of energy to continue fighting back. Joining a professional organization like the **American Psychotherapy Association, APA,** (www.americanpsychotherapy.com), is a good first step for a number of reasons. Associations like APA can give you a place to share your ideas, to ask questions, and to actually get a reply from another therapist. The annual conference has proven to be a valuable resource for networking and an invaluable source of strength as pertains to your sense of purpose and to the reinforcement of your self-esteem. We may operate independently of other psychotherapists, but at the conference we gain a different perspective of our varying roles in our communities. We gain tools and techniques we can use in our practices, and we hear how others are dealing with practice obstacles, often the same ones you are dealing with.

Quarterly journals also help reinforce the learning and re-learning process. *Annals* is professionally produced and the articles address the current and relevant issues we frequently face. Discounted continuing education courses keep more money in our pockets. Join an association that gives you an opportunity to be an active member (organizational boards, special projects,

giving seminar presentations, and writing journal articles). The American Psychotherapy Association has had the foresight to anticipate future needs and has opened enrollment and programs designed for special interests in the field of therapy. One is the **American College of Forensic Examiners, ACFEI**, (www.acfei.com), which encourages those with a special interest in working in a special niche. Members from a multitude of specialties actively promote the dissemination of forensic information. Those interested in homeland security programs can become **Certified in Homeland Security, CHS,** (www.acfei.com/chs/index.php). This program also has a diverse membership of highly qualified professionals, including active and retired military personnel, law enforcement officers, security experts, and firefighters, as well as others who are first responders in emergency situations.

The American Association of Integrative Medicine, AAIM, (www.aaimedicine.com)**,** advocates for a broader treatment awareness and support. This association promotes the wellness of patients not only with the use of traditional programs, but also by using alternative treatments.

More recently, the **American Board of Professional Counselors, ABPC,** (www.americanpsychotherapy.com/abpc.php), is attracting counselors who have at minimum a master's degree in a related area and three years experience as a counselor. The purpose is to assist those who practice family or individual psychotherapy. During the grandfathering phase, professionals working in schools, in law, and in governmental and civil agencies are being given an opportunity for recognition of their efforts, affirmation that, until now, was not otherwise possible. Thousands of people have been working with children and families, and, although these people may not work in the structured therapeutic arena that many of us work in, they are still doing a job that is both needful and helpful for many, reaching communities and populations many of us cannot reach. Now they have an opportunity to join with us, to learn from us, and to return home with something that they could not get anywhere else: support from a professional community of care-givers. This gives everyone hope.

The second step is to form or join a local group of psychotherapists in your community. The American Psychological Association, the American Marriage and Family Therapy Association (AMFTA), and the American Mental Health Alliance (AMHA) are a few who support, in some way, the organization and development of local groups of therapists. In addition, the American Psychotherapy Association, offers therapists a webpage post advertising their credentials, services, and contact information. These professional sites can be valuable for referrals and for the validation of your practice.

A third step is to keep on top of the latest health-care news, especially news that affects your practice. As part of a global economy, we have news from around the world available for use 24/7. The power of this information is that anyone can use it to sell a concept, support an argument, or generate national or international awareness. You can stay informed with the Internet easier and faster than reading newspapers or watching news programs.

Not enough has been written about the risks and liabilities of practicing in today's marketplace. There are enormous risks in light of how the balance of power has swung over to the managed care organizations (MCOs) and health maintenance organizations (HMOs). They are the kings of the nation's health-care services because they control pre-authorizations, reimbursement rates, those that make the medical necessity decisions, and the payments to providers. Regardless of license or discipline, providers are discovering the need to spend more time protecting their businesses from legal and financial liabilities. One way we can fight back is to grow in numbers. The more people who know of our concerns, the more places we have advocates, the more efficacious our communication will be. To those organizations that are in a position to control our practices, numbers mean everything!

Many of us have learned the value of having other professionals we can go to for second opinions, advice, guidance, and discussion of both clinical issues and therapies that might be more effective. When we communicate across professional relationship lines, we close a gap that often interferes with the patient getting adequate care. We need information about developing cost-effective practices, not only for controlling costs, but also for developing more effective treatment plans and better documentation. Communicating across the professional lines also helps us face the challenge of developing collaboration with community resources, partnerships that will enhance our practices. This is the challenge of the next decade. To save the future today, we must be part of that future now. But do we want to?

About the Author

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By Harpriya A. (Sonya) Bhagar, MBBS and Alan D. Schmetzer, MD, Fellow of the American Psychotherapy Association, and Master Therapist

Smoking Cessation Pharmacology

This 1-credit continuing education opportunity is co-sponsored by the American College of Forensic Examiners International (ACFEI) and the American Psychotherapy Association. ACFEI maintains responsibility for all continuing education accreditations. This article is approved by the following for 1 continuing education credit:

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Approximately 400,000 Americans die each year from the effects or consequences of cigarette smoking. Smoking increases the risk of lung cancer 22 times in men and 12 times in women. Between 1960 and 1990, deaths from lung cancer in women increased 400%, and by the mid-1980s they surpassed deaths from breast cancer in women. Further, exposure to second-hand smoke causes an estimated 3,000 deaths annually (Centers for Disease Control and Prevention, 2006). Despite these alarming trends, the national prevalence of smoking in 2004 still averaged about 22% percent of the population (United Health Foundation, 2006). What is the mystery behind this highly prevalent and dangerous addiction? Like all addictions, there are certain biological, psychological, and social reinforcements. Hence, successful treatment must address all of these aspects.

From a pharmacological perspective, Nicotine Replacement Therapies (NRTs) and bupropion, a nicotine-free alternative, are considered first-line smoking cessation therapies. Other nicotine-free alternatives, like nortriptyline and clonidine, are considered second-line treatment options (Fiore et al., 2000). In 2006, the U.S. Food and Drug Administration approved varenicline tartrate, also a nicotine-free medication, for smoking cessation (Anthenelli, 2007). Further, non-pharmacological measures are equally important in assisting with abstinence from smoking. Recently, a 4-month health-promotion/health-protection intervention of smoking cessation at a labor union apprenticeship program demonstrated a 19.4% post-intervention quit-rate at 1 month among baseline smokers (Barbeau et al., 2006). In addition, social and political influences like banning smoking in public places are efforts to minimize exposure to second-hand smoking.

In a study comparing the efficacy of NRTs, bupropion, and nortriptyline, NRTs were the most successful monotherapies, with an efficacy rate of 50% (Flora, Emiliano, & Coelho, 2005). An NRT is used to gradually wean the patient from the influence of nicotine. The cost is about the same or less than that of cigarettes. NRTs are available as patches, gums, inhalers, and nasal (nose) sprays. Nicotine patches are usually dispensed as 14–21 mg/day for 4 weeks, and then as 7–14 mg/day for 4 weeks. The patch is changed daily, and the application site should be rotated to reduce skin irritation. Nicotine gum is available in strengths of 2 mg or 4 mg and it should be chewed for 1–2 hours over a period of 1–3 months for best results. The gum may cause hiccups, stomach upset, or sore jaw (American Academy of Family Physicians, 2007). NicotrolTM inhaler is a cartridge system that can be orally inhaled when there is a craving to smoke. It may satisfy some of the oral fixation occurring with cigarette use, as well as the nicotine addiction. Not more than 16 cartridges a day should be used and the length of treatment should be held to no more than 12 weeks. It can irritate the mouth and throat and cause cough (American Academy of Family Physicians, 2007). Nicotine nasal spray is applied as 1–2 sprays to each nostril. One spray to each nostril constitutes a "dose." The Agency for Health Care Policy and Research recommends a maximum of 5 doses per hour, or 40 doses per day. It can cause nasal irritation, diarrhea, and tachycardia.

Patients should not smoke while using NRTs. Cases of death from cardiac failure have been reported with multiple doses of nicotine patches, along with concomitant smoking and alcohol consumption ("Nicotine patch," 2007). In case of pregnancy or cardiac or blood vessel disease, a consultation with a physician regarding risks-

versus-benefits should be conducted prior to using an NRT (American Academy of Family Physicians, 2007).

Bupropion has been used as an anti-depressant since 1989. It was licensed for use in smoking cessation in 1997 and marketed under the trade name of ZybanTM (bupropion sustained release) at 150 mg. Its main mechanism is believed to be via dopamine and noradrenaline reuptake inhibition. This formulation has been extensively evaluated for smoking cessation and has shown continuous abstinence rates of 20% at 1 year across many clinical groups. It is well tolerated, but does have side-effects like insomnia, headache, dry mouth, dizziness, and nausea. It is a cytochrome P450 2D6 inhibitor and care must be taken when co-prescribing other medicines that are metabolized by this enzymatic pathway (Wilkes, 2006). It is contra-indicated in people who have seizure disorders and current or past history of bulimia or anorexia (Kline, 2007).

Varenicline (ChantixTM) is a partial nicotinic acetylcholine receptor agonist. It is dosed as 0.5 mg daily for 3 days, then 0.5 mg twice daily for 4 days, then 1 mg twice daily for 11 weeks. It is strongly recommended that patients identify a target "quit date" to coincide with the initiation of the 1 mg twice-a-day-dose. Patients who are successful are continued on Chantix for another 12 weeks to reduce relapse. Nausea, vomiting, constipation, flatulence, and sleep disturbance are reported as common side effects (Anthenelli, 2007). Four placebo-controlled trials showed that after 12 weeks of treatment with varenicline, 22% of the patients remained abstinent at 1 year, versus 8% of those who were treated with a placebo ("Varenicline," 2006). Varenicline was also associated with higher short- and long-term abstinence rates compared with bupropion SR, although in one study, the comparison with bupropion SR was not statistically significant for weeks 9 through 52 (Anthenelli). Currently, no comparison studies between varenicline and NRTs are available ("Varenicline"). However, clinicians feel that varenicline might have a better long-term quit-rate and a more tolerable side-effect profile than NRTs.

To summarize, several medications are available for smoking cessation. First-line drugs, NRTs and bupropion, have an efficacy rate of 50% (Flora et al., 2005) and 20% (Wilkes, 2006) respectively, and in combination the success rate increases to 60% (Flora et al.). In addition, varenicline has recently been approved for smoking cessation (Fiore et al., 2000). Further, newer products are under development, like nicotine vaccines, dopamine receptor antagonists, and inhibitors of nicotine metabolism (Siu & Tyndale, 2007).

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ARTICLE 1 (PAGE 12) LEARNING OBJECTIVES

HELPING CLIENTS CREATE THE PARTNERS THEY WANT

After studying this article, participants should be better able to do the following:
1. Recognize moments in therapy when cultural conditioning may be a source of discord with client couples.
2. Offer psychoeducational tools to help couples further understand each other and diffuse conflict.
3. Utilize specific assignments for couples to help them attain their goals.

1. Appropriate items for clients to list on their love lists include all but:
- a. Spontaneous hugs and kisses
- b. A warm welcome when one returns home
- c. Making contact during the day
- d. Being more loving

2. A positive startup refers to a conversation between spouses beginning:
- a. Without criticism
- b. Neutrally
- c. With honest praise
- d. With a manipulative ploy

3. When a wife asks her husband to do something she most likely:
- a. Wants him to do it
- b. Wants him to get to it eventually
- c. Wants him to do it and do it wholeheartedly
- d. Wants him to do something else

4. The best way for a spouse to get what he or she wants from his/her partner is to:
- a. Negotiate
- b. Compromise
- c. Take turns
- d. Make it good for the partner to deliver it

5. "Aiming short" refers to a man:
- a. Not reaching his target
- b. Attempting less to avoid failure
- c. Asking for less than he wants
- d. Declining an offer

6. Dr. Gottman's "Four Horsemen of the Apocalypse," which forcast the demise of a marriage, include all but:
- a. Criticism
- b. Contempt
- c. Lying
- d. Defensiveness

Article 1 Evaluation: (1-3 rating section) Circle one (1=Poor 2=Satisfactory 3= Excellent)

1. The author presented material clearly. 1 2 3
2. Learning objective 1 was met. 1 2 3
3. Learning objective 2 was met. 1 2 3
4. Learning objective 3 was met. 1 2 3
5. New knowledge or technique was gained. 1 2 3
6. Comments:

ARTICLE 2 (PAGE 28) LEARNING OBJECTIVES

SUBLIMINAL INFORMATION THEORY

After studying this article, participants should be better able to do the following:
1. Evaluate the information and disinformation surrounding subliminal information processing.
2. Recognize the potential application(s) of subliminal tools as a take home care modality in therapeutic programs.
3. Identify the potential research opportunities available for working with information processing without awareness.

1. The nature of the controversy surrounding subliminal information theory is not due to:
- a. Poor research designs
- b. Intentional dis-information
- c. Hyped claims by retail sellers of subliminal tapes
- d. Good science

2. The A-B-C model designed by Albert Ellis states:
- a. Actual beliefs cause behavior
- b. Activating beginnings cure false memories
- c. Arousal builds calming effects
- d. Activating events impact belief, which produces consequence.

3. The "danger" message fails to illustrate:
- a. A linear-in linear-out processing of subliminal stimuli
- b. The direct physiological response to a subliminal stimuli
- c. The influence of a subliminal stimuli on a reverie
- d. Conscious inhibition of unconscious mechanisms

4. For a stimuli to meet the minimum criteria as a subliminal stimuli it must be:
- a. Below the level of registration
- b. Flashed at zero candle power on a background of 500 candle power
- c. Mixed in audio at minus 200 decibels
- d. Generally undetected, but above the level of registration

5. Meta-analysis of the subliminal research indicates:
- a. Robust data suggesting that subliminal information is both processed and acted upon.
- b. A weak but general statistical data set suggesting subliminal information is processed and acted upon.
- c. A weak statistical data set suggesting subliminal information is not generally processing in a meaningful manner, nor is it acted upon.
- d. A weak statistical data set suggesting subliminal information is processed, but not acted upon.

6. The Judas Priest, Reno, Nevada trial sought to prove that
- a. Lyrics in music could be dangerous to one's mental health.
- b. Heavy metal music caused violent and uncontrollable arousal in some
- c. The graphic portrayal on the album cover of a man blowing his head off was a subliminal suggestion
- d. A subliminal message could link with congruent self-destructive drives and produce a behavioral response.

Article 2 Evaluation: (1-3 rating section) Circle one (1=Poor 2=Satisfactory 3= Excellent)

1. The author presented material clearly. 1 2 3
2. Learning objective 1 was met. 1 2 3
3. Learning objective 2 was met. 1 2 3
4. Learning objective 3 was met. 1 2 3
5. New knowledge or technique was gained. 1 2 3
6. Comments:

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ARTICLE 3 (PAGE 46) LEARNING OBJECTIVES

SMOKING CESSATION PHARMACOLOGY

After studying this article, participants should be better able to do the following:
1. Identify medicines used first-line for smoking cessation.
2. Name a new medication approved for smoking cessation.
3. Identify four different forms Nicotine Replacement Therapies (NRTs) can take.

1. Which of the following statements is correct:
- a. Each year 100,000 Americans die from cigarette smoking and 1,000 die from second hand smoking.
- b. Each year 200,000 Americans die from cigarette smoking and 2,000 die from second hand smoking.
- c. Each year 300,000 Americans die from cigarette smoking and 2,000 die from second hand smoking.
- d. Each year 400,000 Americans die from cigarette smoking and 3,000 die from second hand smoking.

2. All of the following are available Nicotine Replacement Therapies except:
- a. Nicotine Patch
- b. Nicotine Ointment
- c. Nicotine Inhaler
- d. Nicotine Gum

3. Which of the following statement about bupropion is false?
- a. It is used for the treatment of seizure disorder
- b. It is used for the treatment of depression
- c. It is used for smoking cessation
- d. It is contra-indicated in seizure disorder

4. The most effective monotherapy for smoking cessation is:
- a. NRT
- b. Bupropion
- c. Nortriptiline

5. Varenicline's mechanism of action is as a:
- a. Nicotine vaccine
- b. Dopamine receptor antagonist
- c. Partial nicotinic acetylcholine receptor agonist
- d. Nicotine metabolism inhibitor

6. Medicines used first-line for smoking cessation are:
- a. NRTs and Bupropion
- b. Varenicline
- c. Nortriptyline
- d. Clonidine

Article 3 Evaluation: (1-3 rating section) Circle one (1=Poor 2=Satisfactory 3= Excellent)

1. The author presented material clearly. 1 2 3
2. Learning objective 1 was met. 1 2 3
3. Learning objective 2 was met. 1 2 3
4. Learning objective 3 was met. 1 2 3
5. New knowledge or technique was gained. 1 2 3
6. Comments:

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The Jekyll and Hyde Syndrome

By Beverly Engel

Beverly Engel

In ***The Jekyll and Hyde Syndrome***, Engel explains, for the first time, what this syndrome is and how to cope with the Jekyll and Hydes, those people with unpredictable or abusive mood swings of a more dramatic nature than what people normally experience. The book is both accessible to nonprofessionals and useful for professionals in the field, and identifies the seven types of Jekyll and Hydes—the abusive, the unpredictable, the classic, the addict, the imposter, the all-good and all-bad, and the I'm-fine-as-long-as-you-don't-cross-me. The author further discusses the specific psychological conditions and childhood experiences that can create Jekyll-and-Hyde personalities.

Engel does not avoid the hard topics, dealing with, among other things, personality disorders, relationships with Jekyll and Hydes, cyclical patterns of involvement with Jekyll-and-Hyde personalities, confronting abusive behavior, and what to do if you are a Jekyll and Hyde. She explores the damage the syndrome can inflict on those who are close to a sufferer, effects such as loss of self-esteem, confusion and disorientation, and the stress of "walking on eggshells" to avoid conflict. With the help of questionnaires and real stories both from her life and her psychotherapy practice, she offers specific information and techniques to assist the reader in recognizing the syndrome and dealing with someone who has a Jekyll and Hyde personality.

A section of the book addresses those who believe they are suffering from the Jekyll and Hyde syndrome. She offers specific counsel for those trying to overcome the syndrome, those who have personality disorders, and those who are abusive, including ways to discover the causes of abusive behavior and ways to change. The final chapter of *The Jekyll and Hyde Syndrome* suggests that everyone has a little Jekyll and Hyde in them, and explores a few of the ways the reader will benefit from an enhanced understanding of a syndrome that affects so many lives in as many different ways and by varying degrees.

Beverly Engel is a Diplomate of the American Psychotherapy Association and will be presenting a workshop on "The Jekyll and Hyde Syndrome" at the National Conference in Kansas City, MO, October 5–6. Engel, an internationally recognized expert on emotional abuse and a licensed marriage and family therapist for 30 years, is the author of numerous books, including such successful titles as *Healing Your Emotional Self*, *The Emotionally Abusive Relationship*, and *Loving Him without Losing You*. Engel conducts professional training programs and workshops throughout the United States and Canada. She has appeared on many nationally televised shows, including *Oprah*, *Starting Over*, *Donahue*, *Ricki Lake*, and *Sally Jessy Raphael,* and her work is frequently featured in print media.

Help for the Helper: Self-Care Strategies for Managing Burnout and Stress

By Babette Rothschild with **Marjorie Rand**

Marjorie Rand

Therapist burnout is a pressing issue and self-care is possible only when therapists actively help themselves. ***Help for the Helper*** takes a frank assessment of the risks involved in psychotherapy, risks such a compassion fatigue and vicarious traumatization, and challenges current thinking about the ways in which therapists are affected by their clients. The result is a new outlook on the therapeutic process that yields concrete strategies for mental health professionals who want to maintain their own mental health and overall well-being while maximizing their competency with clients.

Based on the latest neurobiological research and drawing from the literature in both the fields of social psychology and folk psychology, the authors identify three major processes that can, when left unchecked, pose enormous risks to a professional's well-being. The first and most unexplored of these processes is empathy, a—if not *the*—major tool of the helping professions. The second process is the regulation of arousal in the professional. The third process draws heavily on neuroscience and is defined by the authors as the process(es) that maintain the ability to think clearly, even in the most stressful of helping situations. Throughout each chapter, case illustrations, supervision transcripts, and easy-to-follow exercises equip the reader with the necessary tools for identifying and mediating their own individual risk factors for compassion fatigue, vicarious traumatization, and burnout, risks no mental health professional can afford to ignore.

Help for the Helper is an essential resource for all helping professionals who want to assist their clients while managing their exposure to burnout and stress.

Marjorie Rand is a member of the American Psychotherapy Association.

Parenting

Sneak Preview—Spring *Annals* 2008

The excerpt that follows is just a taste of the Child and Child Therapy issue of *Annals* to come out in the Spring. You can submit CE articles, case studies, and columns on this topic for publication to *Annals*, 2750 E. Sunshine, Springfield, MO 65804. All articles must be approved for publication by December 26, 2007. The approval process may take 3 weeks or longer, so submit your articles early!

By Michael A. Baer, PhD, ScD, Chair Emeritus

We have had a fractured infrastructure in the parenting process for several generations. We now have young parents who have lost the skills of child rearing. Parents no longer have an extended family to assist them or close neighbors to play a vital role. We lack incidental learning on how to parent. As many parents of the last few generations were reared by television sets and absent parents, the art of childrearing is now lost to most young adults. That community of family and friend who used to assist with modeling childrearing is no longer available to young couples. Children are now reared by their friends, electronic devices, television, movies, and peers. Parents, schools, churches, and other institutions formerly involved in childrearing have been substantially marginalized or lost. Children have gained power over their parents. They no longer obey, listen, heed, or feel the necessity to respect their parents. Schools have been reduced to places where children are babysat. Schools must defend themselves not only against the children, but also the angry parents who show up to support their deviant children. Yes, we may have gone overboard in our legitimate attempt to protect children against parental abuse. This has sadly resulted in an unwanted shift in power from parents to children. . . .

Be sure to read Dr. Baer's essay in its entirety in the Spring 2008 issue of *Annals*.

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