



In This Issue

Page

Clinicians' Corner

- Trauma in the New Era: Pharmacotherapy and Psychotherapy in the Treatment of PTSD 2
Joshana K. Goga & Anita O. Solomon

Perspectives

- The Age of Aquarius 12
Patrick Deleon
- A Funny Thing Happened on the Way to the State House 16
Michael R. Butz

- Chart** — Common Liver Function Tests 18

President's Podium

- Thanks to All Who Have Given Their Time, Energy, and Talents to Division 55 19
Glenn Ally

Legislative Updates

- Explaining Oregon's Psychologist Prescription Bill HB 3523/SB 228 21
Robin Henderson
- In Brief—Hawaii 23
Jill Oliveira Gray
- In Brief—Tennessee 24
C. Keith Hulse

From the Editors

- We Need Your Leadership 25
James D. Calvert, Editor
- Publishing in The Tablet 28
Nicholas Patapis, Associate Editor

Clinicians' Corner

Trauma in the New Era: Pharmacotherapy and Psychotherapy in the Treatment of Post-Traumatic Stress Disorder

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Post-Traumatic Stress Disorder (PTSD) is a painful condition that often goes diagnosed. PTSD may be seen in victims of violent assault, persons involved in natural or man-made disasters (e.g., recent tsunami and nuclear crisis in Japan), first responders to traumatic events (e.g., EMS, police), and military personnel. Not surprisingly, PTSD is especially prevalent among those in careers which demand exposure to potentially traumatic events, such as first-responders to traumatic events (e.g., EMS and firefighters at the terrorist attack on the Twin Towers) and combat personnel (e.g., soldiers in war and military operations). In-

creasingly, clinicians are becoming aware of the disproportionate incidence of PTSD among soldiers returning to America from combat abroad. The rates of PTSD among non-military persons is significant (see below), and the increased rates among military personnel further highlights the need for effective interventions for PTSD.

The lifetime prevalence rate for non-military PTSD appears to be in the range of 7% to 12% (Breslau, Davis, Andreski, & Peterson, 1992; Kessler, Donnegan, Bromet, Hughes, & Nelson, 1995; Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993). This psychiatric diagnosis carries high co-morbidity, with a six-fold increased risk, compared with the community, of major depression, a three-fold increased risk of alcoholism or substance abuse, and approximately four-fold increased risk of panic disorder or agoraphobia. PTSD typically presents as a chronic illness, with a median time to recovery in the range of 3-5 years (Breslau, Davis, Andreski, & Peterson, 1992). The illness is burdened with high levels of health-related problems, disability and overall poor quality of life. Recent studies show greater levels of use of welfare, use of prescription medication and healthcare visits, as well as work impairment, to as much as four days per month (Amaya-Jackson et al., 1999). Most alarming is an estimated suicide attempt rate of 20% (Davidson, Hughes, Blazer, & George, 1991).

Symptomatology and Diagnosis of PTSD

The essential feature of PTSD is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders: DSM-IV-TR., 2000). The person's response to the event must involve intense fear, helplessness, or horror (or in children, the response must involve disorganized or agitated behavior). The characteristic symptoms resulting from the exposure to the extreme trauma include: intrusive symptoms, avoidance symptoms, and arousal symptoms. *Intrusive symptoms* are experiences that interrupt and interfere with a person's normal life. They include: flashbacks, sleep disorders, such as nightmares, and intense distress when there is mention of the original event. *Avoidance symptoms* involve attempts by the patient to refrain from dealing with the original event. They include, trying to avoid thinking or feeling anything about the trauma, inability to remember the event, loss of ability to feel and express emotions, and a sense that the past is approaching very quickly. *Arousal symptoms* are obvious changes in a person's mental state. They include: problems falling asleep, sudden and extreme reactions to unexpected noises, memory problems, concentration problems, moodiness and violence.

Pathophysiology of PTSD

Neuroimaging studies have demonstrated significant neurobiological differences between patients with PTSD and persons without PTSD. There appear to be three areas of the brain that are different in patients with PTSD compared with those in control subjects: the hippocampus, the amygdala, and the medial frontal cortex (Nutt & Malizia, 2004). Positron emission tomography studies show that veterans with PTSD demonstrate increased right amygdala activity when exposed to combat movies (Rauch, van der Kolk, Fislir, & Alpert, 1996). However, these retrospective studies do not rule out pre-trauma differences in these brain regions which may have made these veterans to have an increased vulnerability for the development of PTSD. More recently, the U.S. Department of Defense (DOD) has begun funding university-based neuro-imaging and neuropsychological testing of soldiers, and this data is expected to be highly-informative of changes that occur in the brains of soldier with PTSD with more conclusive evidence that the identified changes occurred at some point in time between the pre- and post-combat testing.

The Hippocampus, Amygdala, and Medial Frontal Cortex appear to differ between persons with PTSD and those without PTSD

In addition to neuroimaging studies, research suggests that increased release of nor-adrenaline and increased autonomic activity may cause postsynaptic down-regulation of adrenergic receptors for serotonin and norepinephrine. The amino acid transmitters, glutamate and gamma-aminobutyric acid (GABA) are involved in the process of factual memory registration, and research suggests that amine neurotransmitters, such as norepinephrine and serotonin, are involved in encoding emotional memory. The dopamine system may also demonstrate sensitization in PTSD. Symptoms of hypervigilance and even paranoia are likely to be mediated by the dopamine system, similar to the use of cocaine (Stein & Seedat, 2000).

Pharmacological Treatment of PTSD

Although pharmacological treatment of PTSD is considered to be an adjunctive treatment strategy to psychotherapy, studies have indicated that medications can be helpful in managing certain symptoms. Controlled double-blind trials with selective serotonin reuptake inhibitors (SSRIs) have shown to be advantageous over placebo in the management of PTSD symptoms. SSRIs are effective across all PTSD symptom clusters and improve the overall quality of life thus are recommended as first-line therapy for PTSD (Ballenger, Davidson, Lecrubier, Nutt, & Marshall, 2004). Paroxetine and sertraline are currently FDA-approved for the management of PTSD, but it appears that all of the currently available SSRIs show similar beneficial effects for patients with PTSD.

SSRIs are recommended as first-line pharmacotherapy for PTSD

Acute Efficacy Studies:

Fluoxetine. Three randomized, double blind, placebo controlled trials have confirmed a significantly higher response in patients with PTSD receiving fluoxetine versus placebo for up to 3 months. In a 5-week study comparing fluoxetine at up to 60 mg per day (N= 33) versus placebo (N=31), fluoxetine significantly reduced overall PTSD symptoms assessed using the CAPS-2 ($p=.01$) (van der Kolk, Dreyfuss, & Michaels, 1994). A 12 week trial comparing fluoxetine up to 60 mg per day (N=27) versus placebo (N=27) revealed that fluoxetine was more effective on most measures using the Duke Global Rating for PTSD and the Structured Interview PTSD measure at week 12 (Connor, Sutherland, & Tupler, 1999). In a large scale, 12-week study comparing fluoxetine at 20 mg to 80 mg per day (N=226) and placebo (N=75), fluoxetine was associated with a greater improvement from baseline in TOP-8 scale total score versus placebo at week 12 ($p=.006$) (Martenyi, Brown, & Zhang, 2002).

Paroxetine. A 12-week study comparing paroxetine 20-50 mg per day (N=151) and placebo (N=156) showed significantly greater improvement in CAPS-2 total score from baseline beginning at week 4 ($p< .05$ vs

placebo), with significantly greater proportions of paroxetine-treated patients achieving a response ($p < .001$ vs. placebo) and remission ($p = .008$) by week 12 on the Clinical Global Impressions-Improvement scale (Tucker, Zaninelli, & Yehuda, 2001). In another 12-week study comparing paroxetine 20 mg per day ($N = 183$), 40 mg per day ($N = 182$), and placebo ($N = 186$), paroxetine-treated patients in both dose groups showed significantly greater improvement on the CAPS-3 ($p < .001$) (Marshall, Beebe, & Oldham, 2001).

Sertraline. A 12 week study with sertraline at 50 to 200 mg per day ($N = 94$) versus placebo ($N = 93$) demonstrated that sertraline produced a significantly greater improvement from baseline at endpoint in CAPS-2 total score ($p = .02$) (Brady, Perlstein, & Asnis, 2000). A second 12-week study with sertraline 50-200mg per day ($N = 100$) or placebo ($N = 108$), sertraline was shown to have greater benefit over placebo on most measures (Davidson, Rothbaum, & van der Kolk, 2001).

Long-Term Efficacy Studies:

The onset of SSRI action may be rapid with quick peak plasma concentrations; however, the complete remission of PTSD requires long term therapy. The majority of SSRI efficacy trials in PTSD have been of 3 months' duration or less. These trials have shown short-term therapy has shortcomings in remission and full recovery may not be seen until after 6 to 9 months of treatment. In an open-label continuation phase of a 12 week acute study, patients treated with sertraline showed continued improvement up to 9 months. The mean CAPS-2 score was reduced from 45 (representing mild PTSD) at 3 months to 20 (equivalent to minimal or no PTSD symptoms) at 9 months (Londborg, Hegel, & Goldstein, 2001).

Other Treatment Options:

Other agents beyond the SSRIs have also shown efficacy in the treatment of PTSD. Mirtazapine and venlafaxine, both antidepressants, have demonstrated efficacy in PTSD with their noradrenergic and serotonergic activity (Davidson, Weisler, & Butterfield, 2003; Davidson, Lipschitz, & Musgnung, 2004).

Mirtazapine and venlafaxine, both antidepressants, have demonstrated efficacy in PTSD

Mood stabilizers, such as lamotrigine, carbamazepine and divalproic acid may also be useful in managing varying symptoms (Hertzberg, Butterfield, & Feldman, 1999; Tucker, 2005). There is growing literature on the use of atypical antipsychotics, specifically olanzapine and risperidone, as adjunctive therapy for the management of PTSD symptoms (Bartzokis, Lu, & Turner, 2005; Stein, Kline, & Matloff, 2002). However, there are many limitations to the study design in these trials such as the small number of patients included thus we have seen conflicting results. Therefore, these agents are not considered first line therapy in the management of PTSD.

Limitations to pharmacological treatments

Most randomized controlled trials (RCTs) with combat (mostly Vietnam) veterans showed less treat-


ment efficacy with medications than RCT with non-veterans whose PTSD was related to other traumatic experiences (e.g., sexual assaults, accidents, natural disasters). Differences in population response accounts for the varying approved indications within in the class of SSRIs. However, Expert Consensus guidelines recommend the use of any SSRI for the treatment of PTSD since SSRIs are closely related in their chemical structure and their effects on neurochemicals (Ballenger, Davidson, & Lecrubier, 2000). Due to this disconnect, some professionals may hesitate to treat combat veterans with PTSD since they may be less responsive to treatment than survivors of other traumas. The difference between veterans and other PTSD patients may be related to the greater severity and chronicity of their PTSD rather than to the differences inherent to combat traumas. Since most treatment studies have included either military veterans or female adult survivors of sexual assault, there is a gap in the current knowledge about treatment efficacy with people who have been traumatized more than once instead of the soldier who has been assigned for the first time. Although lifetime prevalence rates of PTSD were twice as high for women as for men (10.4% vs 5%) and women are four times more likely to develop PTSD when exposed to the same trauma, gender differences in response to treatment have not been studied systematically. (Breslau et al., 1992; Kessler et al., 1995; Resnick et al., 1993). Furthermore, 20-40% of patients fail to achieve complete remission with SSRI therapy and approximately 50% of people discontinue drug therapy due to side effects (Ballenger et al., 2004).

50% of people discontinue drug therapy due to side effects

Psychotherapy as Treatment of PTSD

Psychotherapy is considered a first-line treatment approach for PTSD. Psychotherapeutic approaches commonly used to treat PTSD involve a multitude of styles, of which we will highlight a few approaches that have been used successfully with PTSD.

Cognitive-behavioral therapy (CBT) involves concentration on cognition in order to change emotions, thoughts, and behaviors. CBT conditions learning skills for coping with anxiety (such as breathing retraining or biofeedback) and negative thoughts (cognitive restructuring). Cognitive restructuring is a process of changing subconscious thoughts. The goal is to help people overcome faulty thinking errors by bringing them to a level of conscious awareness of their incorrect programming. Exposure in a safe, controlled environment helps the victim face and gain control of the fear and distress that was overwhelming during the trauma. In some cases, trauma memories or reminders can be confronted all at once (“flooding”). For other individuals or traumas, it is preferable to work up to the most severe trauma gradually by using relaxation techniques and by starting with less upsetting life stresses or by taking the trauma one piece at a time (“desensitization”) (*National Center for PTSD, U.S. Department of Veterans Affairs*2006). The Institute of Med-



icine (2008) evaluated the evidence on PTSD treatment and indicates that the most significant treatment for PTSD is cognitive-behavioral therapy that includes psychoeducation, anxiety management, exposure, and cognitive restructuring, with exposure and cognitive restructuring being the two most important components of treatment.

Exposure and Cognitive Restructuring appear to be the most important components of CBT in the treatment of PTSD

Another approach is Eye Movement Desensitization and Reprocessing (EMDR). This is a treatment for traumatic memories that involves elements of exposure therapy, and cognitive-behavioral therapy combined with techniques (eye movements, hand taps, sounds) that create an alternation of attention back and forth across the person's midline. Several research studies show that "attentional alternation," may facilitate the accessing and processing of traumatic material (Beck, 1976; Beck, 1986).

Group psychotherapy can aid trauma survivors in sharing traumatic material within the safety, cohesion, and empathy provided by other survivors (Solomon, 1975; Solomon, 2003). Solomon (second author of the current article) teaches creative problem solving as proposed by E. Paul Torrance (Torrance, 1966). As discussed by Crevar (2001), teaching divergent thinking leads to many different types of solutions where there are no right or wrong answers. In this technique, patients take responsibility for making up the endings to their stories, with the understanding that they will reach positive conclusions and structure optimistic solutions. As group members achieve greater understanding and resolution of their trauma, they feel more confident and able to trust. As they discuss and share how they cope with trauma-related shame, guilt, rage, fear, doubt, and self-condemnation, they prepare themselves to focus on the present rather than the past. Telling one's story (the "trauma narrative") and directly facing the grief, anxiety, and guilt related to trauma enables many survivors to cope with their symptoms, memories, and other aspects of their lives.

Brief psychodynamic psychotherapy focuses on the emotional conflicts caused by the traumatic event, particularly as they relate to early life experiences. Throughout the retelling of the traumatic event to a calm, empathetic, compassionate, and nonjudgmental therapist, the survivor achieves a greater sense of self esteem, develops effective ways of thinking and coping, and learns to deal more successfully with intense emotions. The therapist helps the victim to identify current life situations that set off traumatic memories and worsen PTSD symptoms.

Complex PTSD trauma from extreme stress often includes depression, alcohol/substance abuse, panic

disorder, and other anxiety disorders and if found among individuals who have been exposed to prolonged traumatic circumstances, especially during childhood, i.e. childhood sexual abuse. Developmental research reveals that many brain and hormonal changes occur as a result of early, prolonged trauma. These difficulties may “contribute to difficulties with memory, learning and regulating impulses and emotions.” (Davidson et al., 1991)

Management Strategy

Expert Consensus guidelines support the use of psychotherapy for mild PTSD and a combination of psychotherapy and drug therapy for more severe PTSD (Ballenger et al., 2000). Immediately following exposure to trauma, education should be provided to victims. During the first two weeks after trauma, victims should participate in one or two counseling sessions to be aware of their distress and need for specialized interventions (Ballenger et al., 2004). Guidelines recommend the consideration of starting treatment with any SSRI three weeks after exposure to a traumatic experience in those patients with no improvement in their acute stress response. Low dose SSRI should be initiated with a gradual titration period to maintenance doses used in the management of depression. An appropriate trial of initial drug therapy is three months. If there is not substantial response to treatment, the most appropriate form of management is referral to a specialist. Effective pharmacotherapy should be continued for twelve months or longer, depending on the severity and duration of illness.

Once an SSRI has shown effectiveness, it should be continued for 12 months or longer

Psychotherapy should be continued for 6 months, with follow up therapy as necessary. For patients who need special consideration and for patients who fail these current evidence-based treatments of cognitive behavioral-cognitive processing and prolonged exposure, there are alternate strategies of engagement (Van der Kolk, Dreyfuss, & Michaels, 1994). These alternate strategies combine flexible applications of manualized treatments from different treatment approaches (Hamblen, Schnurr, Rosenberg, & Eftekhari, 2010).

Hamblin and colleagues also note the increased use of virtual reality therapies (Hamblin et al., 2010). Virtual reality therapies utilizing “computer generated simulation during exposure exercises to enhance activation of trauma memories and related emotions” are beginning to be studied in the treatment of PTSD (Difede et al., 2007). Difede and colleagues also indicate that treatment may be enhanced through use of the internet whereby “patients access therapeutic materials on-line while receiving assignments and feedback

from a therapist via a computer” (Difede et al., 2007). Use of the internet appears to be particularly effective for patients living in remote areas, those with limited mobility, and those who are shy of seeking treatment (Knaevelsrud & Maercker, 2007). Freuh and colleagues further highlight the potential effectiveness of video-conferencing delivered through live video feeds as the therapist and patient communicate with each other (Freuh, et al., 2007). The study of the efficacy and effectiveness, not to mention confidentiality and other ethical issues, of these newer technologies are in their infancy, but these approaches offer the promise of new tools in the management of PTSD.

Newer technologies, such as psychotherapy through video-conferencing, may provide needed help for persons living in remote areas or with limited mobility

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*And while we're on the subject of medication, you always need to look at risk versus benefit – Temple Grandin, Ph.D., author of *The Way I See It* and well known adult with autism*

Do you have a clinical review or grand-round case presentation? If so, we would like to consider it for publication in THE TABLET. Please contact Jim Calvert, Tablet editor, at jcalvert@calvertpartners.com to discuss your ideas.

Perspectives

The Age of Aquarius

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Pat Deleon

“When the moon is in the Seventh House, and Jupiter aligns with Mars (2012).” As President Obama’s landmark healthcare reform legislation, the Patient Protection and Affordable Care Act [PPACA], is steadily implemented over the next five to ten years, it will become increasingly clear that the States have considerable flexibility in designing their own approaches to meeting the underlying federal policy objectives. As the extensive Congressional debate was coming to a close, the Administration: **“(S)trongly supports House passage of health insurance reform legislation. This legislation makes significant improvements that will help to give American families and small business owners more control of their own health care. It makes important changes – ending the worst practices of insurance companies... bringing down the cost of health care for families and businesses while also reducing the Federal budget deficits. This legislation provides the necessary health reforms that the Administration seeks – affordable, quality care within reach for the tens of millions of Americans who do not have it today....”**

Under the President’s vision, priority will be given to ensuring timely access to quality primary care, provided by a wide range of healthcare providers, with an emphasis upon encouraging healthy lifestyles, health promotion and disease prevention. The unprecedented advances occurring almost daily within the communications and technology fields will finally have a direct and lasting impact upon the healthcare environment (i.e., telehealth and health information technology [HIT]). Psychology must come to appreciate that integrated, patient-centered interdisciplinary care will become the norm, as Katherine Nordal has emphasized during her APA State Leadership conferences. And, that those who remain rooted in the past will soon become history, like the dinosaurs they have become.

From a policy frame of reference, it is important to appreciate that any of the healthcare professions that wish to thrive in the 21st century must continuously expand their knowledge base, including through interactive CE experiences, in yet to be determined ways. For psychology, prescriptive authority (RxP) would seem to be a most productive venue. Rob McGrath estimates that there are 1500 colleagues who have al-

ready completed their advanced psychopharmacological training. As of last Fall, 276 graduates had been admitted to take the PEP examination, which historically has a first-time passing rate of nearly 71%. Deborah Baker reports that over the years, approximately 37 State Associations have established task forces to coordinate RxP activities, with 24 States having introduced relevant legislation since 1985.

An Historical Perspective: On January 7, 2005 Mario Marquez applied for his conditional certification as a “prescribing psychologist” on the first day the New Mexico implementing rules went into effect. On January 20, 2005 John Bolter became the first medical psychologist to prescribe in Louisiana. By the end of 2008, Glenn Ally estimated that he and his colleagues in Louisiana had written more than 200,000 psychotropic medication orders, including refills, orders in hospitals, patients on multiple medications, and orders to reduce, consolidate, and/or discontinue medications. And, by October 2010 Jim Quillin estimated that there were 51 medi-


Dr. Mario Marquez applied for his conditional certification as a prescribing psychologist on the first day New Mexico implemented its prescribing psychologist rules

Dr. John Bolter became the first psychologist to prescribe psychotropic medication in Louisiana

cal psychologists practicing in Louisiana and 26 licensed prescribing psychologists in New Mexico. Utilizing the most up-to-date interactive technology, Steve Tulkin reports that with the next CSPP at Alliant International University psychopharmacology graduating class, there will be eight additional Louisiana psychologists eligible

for prescriptive authority, as well as an additional four specially trained psychologists currently working in the Indian Health Service (IHS). Over all, since 1999 Steve’s program has graduated 390 colleagues, representing approximately 40 states plus Guam, and providing training for several international students. The program has 83 students currently enrolled, and the next cohort will begin in September 2011. It will feature live, interactive classes over the Internet. The 21st century has arrived.

Colleagues within the Department of Defense (DoD) and the Indian Health Service (IHS) continue to demonstrate impressive psychopharmacological expertise in addressing some of society’s most pressing needs. Clearly, psychologists can learn to competently and safely prescribe. We are not “public health hazards,” as organized medicine continues to claim. With the States possessing considerable flexibility over the next decade under the President’s plan, it is absolutely essential that our profession increase its efforts to enact prescriptive authority legislation at the State level. Last year in his veto message, the Governor of Oregon called for “a pilot program that would generate data on which to inform and guide solutions that give greater access to broader mental and physical healthcare.” Hawaii, with its 2007 veto, has a new Democratic Governor. Sallie Hildebrandt, the newly elected President of the California Psychological Association (CPA), will be establishing a Presidential RxP Task Force; hopefully again, revitalizing the RxP movement in that visionary state, which also has a new Governor. And, at CSPP’s RxP graduation ceremonies last Summer Juan Rapadas, who will be the first prescribing psychologist in Guam, indicated that they will soon be imple-




menting their 1998 legislation as he fulfills his clinical practicum.

A Practice-Oriented Approach: The Institute of Medicine (IOM) recently released its report Redesigning The Clinical Effectiveness Research Paradigm: Innovation and Practice-Based Approaches, providing an exciting insight into the probable future of our nation's healthcare system over the next decade. The underlying goal is to have 90% of clinical decisions supported by the best available evidence by the year 2020. The care provided should be the most appropriate for the individual patient, emphasizing prevention and health promotion, delivering the most value, adding to learning throughout the delivery of care, and leading to improvements in the nation's health.

“To the greatest extent possible, the decisions that shape the health and health care of Americans – by patients, providers, payers, and policy makers alike – will be grounded on a reliable evidence base, will account appropriately for individual variation in patient needs, and will support the generation of new insights on clinical effectiveness.” - IOM

Throughout the IOM report is the clear theme: “(I)n the emerging era of tailored treatments and rapidly evolving practice, ensuring the translation of scientific discovery into improved health outcomes requires a new approach to clinical evaluation.” There is the call for a paradigm shift; one that supports a continual learning process about what works best for individual patients. One which takes advantage not only of the rigor of traditional trials, but also one which incorporates other methods (including clinician observations) that might bring insights relevant to clinical care and endeavors to match the right method to the question at hand. There is the distinct declaration that clinicians and scientists must work collaboratively and increasingly focus upon what matters on a day-to-day basis. Fortunately for psychology this is not a new message. Over the past several years our APA Presidents have issued very similar challenges to our membership, urging our scientists and practitioners to work together.

The President's Economic Stimulus legislation, which was enacted in February 2009, provided significant federal funding in support of this clinical research evolution, as well as the increased utilization of HIT. However, several underlying questions remain: How can the APA and other national associations become more actively involved on behalf of their members? And equally importantly, How can individual psychologists more directly participate in shaping our nation's evolving healthcare system? Interdisciplinary and cross-disciplinary efforts are clearly critical, as is appreciating the magnitude of change that is coming. Are our training institutions and State Psychological Associations up to the inherent challenges?



Clinical effectiveness research (CER) is seen as the bridge between the development of innovative treatments and therapies and their productive application to improve human health, including mental health. Historically limited resources is one element to be considered, with less than 0.1% of the nation's more than \$2 trillion investment in healthcare being allocated to evaluating the relative effectiveness of the various diagnostics, procedures, and interventions in clinical practice. Beyond increasing resources, however, what is really needed is a more practical and reliable clinical effectiveness research paradigm. Given the growing capacity of information technology to capture, store, and use vastly larger amounts of clinically rich data and the importance of improving our understanding of an intervention's effect in real-world practice, the advantages and necessity of indentifying and advancing methods and strategies that draw research closer to practice become even clearer.

The common themes which surfaced during the IOM workshop are: * Address current limitations in applicability of research results; * Counter inefficiencies in timeliness, costs, and volume; * Define a more strategic use to the clinical experimental model; * Provide stimulus to new research designs, tools, and analysis; * Encourage innovation in clinical effectiveness research conducted; * Promote the notion of effectiveness research as a routine part of practice; * Improve access and use of clinical data as a knowledge resource; * Foster the transformational research potential of information technology; * Engage patients as full partners in the learning culture; * and, Build toward continuous learning in all aspects of care.

Given the long-term importance of this (r)evolution for all elements of psychology, we were particularly pleased that during his Presidential year visionary James Bray represented APA before the IOM, as it crafted its recommendations for CER priorities for the Administration. As Stephen Ragusea has been urging over the years, in this most recent report the IOM called for a multifaceted, practice-oriented approach to clinical effectiveness research. “The critically central question for clinical effectiveness research is what works best in clinical care for the individual patient at the time the care is needed. Answering this type of question will require the transformation of current approaches to a system that combines point-of-care focus with an electronic health record (EHR) data system coupled to systems for assembling evidence in a variety of ways.” The underlying goal is to turn evidence into action. Clinicians know that what is right for one person does not necessarily work for the next person.

“The critically central question for clinical effectiveness research is what works best in clinical care for the individual patient at the time the care is needed.” - IOM

Those of our colleagues interested in the RxP movement should be particularly intrigued, if not gratified, by the IOM finding that: “(T)here is a paucity of evidence to help guide clinical, purchasing, and policy decisions regarding antipsychotic medications.” There is much that psychology can contribute to this debate,

including assisting in defining the appropriate utilization of psychotropic medications. Modifying financial incentives and actively engaging consumers are critical next steps. The current research paradigm, infrastructure, funding approaches and policies – some of which are more than 50 years old – are seen as being in need of significant overhaul and emendation. “(D)espite the custom of referring to ‘our healthcare system,’ the research community in practice functions as a diverse set of elements that often seem to connect productively only by happenstance.” Psychology is no different. In our judgment, for us to collectively fail to obtain prescriptive authority (RxP) would be to fall progressively farther and farther behind in an ever-changing and dynamic healthcare environment. We would point out that this would be at a time when our colleagues in nursing and clinical pharmacy are aggressively and appropriately expanding their educational and clinical frontiers, including within what psychology would consider the traditional mental health arena. “Let the sun shine in. The sun shine in.” *Aloha, Pat DeLeon*

A Funny Thing Happened on the Way to the State House

Michael R. Butz, Ph.D.

President, Montana Psychological Association

The following is an excerpt from Dr. Butz’s introductory remarks for a breakout session of the conference for Division 55 and the State Leadership Conference on March 13, 2011.



Michael Butz

First of all thank you are in order, to the American Psychological Association and Division 55 for putting on this breakout session amid the many important topics that are being addressed at SLC. We thank you for this opportunity.

You know, as the title of this session describes, a series of ‘funny things’ really did happen as the prescription privileges movement for psychologists made its way to the State Houses of our nation. Not only on their way to, but in their way through, these State Houses. While our preverbal oil was being checked by the arguments of the opponents to this movement, our reasons for taking up this initiative were challenged to their very core. It is one thing to argue matters in theory, and through the literature. It is quite another to do so on a podium, in a State House, and in an adversarial environment.

Recently other psychologists, and even supportive physicians, new to this process in Montana were shocked and appalled at how rancorous this process can become. Like these Montanans, in turn, many involved in the movement paused and reflected and found their central reasons for becoming involved, and



staying involved, with the movement. That reflective process, however, has taken a while to evolve.

Early on, and I can recall this like yesterday, I was sitting in a Board Meeting for what was then the Yellowstone Valley Psychological Association in 1992. A member, who shall remain nameless — had he had the words or the benefit of the commercial in recent years — would have said he would have been ready to prescribe because he stayed at Holiday Inn Express the night before. Well, perhaps, in a few weekends across six months he felt he would be ready to prescribe as the very least. Though stunning to consider now, that is how the movement was perceived by a number of psychologists in 1992.

On the other hand, some of us felt that it (prescribing) may well be psychology's version of Jurassic Park. But, since that time, much has changed:

- APA put forward its Postdoctoral Education and Training Program in 1996
- Institutions began offering this curriculum
- The Psychopharmacology Examination for Psychologists began development in 1998, and was put into practice in 2000
- Model language was developed by the American Psychological Association for legislation in 2009, *and*
- Across the seventeen years that psychologists have been prescribing now in the Armed Services, New Mexico, Louisiana and the Indian Health Service—and there have been no substantiated complaints or malpractice suits.

These are all important accomplishments, in-and-of-themselves. Rigors that other disciplines have not engaged in when it comes to matters such as, for example, (licensing for) the use of psychological assessment. Psychologists, instead, did their groundwork and those efforts are now bearing fruit.

Still, even with these accomplishments a question lingered in the mind of many a psychologists following this movement – Would psychologists remain psychologists? Would psychologists hold to the multiple therapeutic modalities that they have been trained in? Would they hold to their roots in assessment, with this newly developed skill? The short answer is yes, they have indeed.

There is no better exemplar than the model they are holding to in New Mexico. So stalwart in these efforts are they that our colleague, Dr. Mario Marquez, has strongly advocated for accepting no funds from pharmaceutical companies, or the like. And, Dr. Elaine Levine and her colleagues are busy re-coining the phrase Psycho-bio-social...

The power to prescribe, is the power to un-prescribe - as a colleague of mine from Wyoming and I had many

a long and intense a discussion about. Indeed, the power to un-prescribe allows psychologists to make use of other therapeutic modalities that are more effective in many instances. In reflecting on the utility, and the drawbacks, of pharmacotherapy as but one modality, it is my belief that psychologists have found themselves again through a Hegelian process and ultimately redefined the breadth of what it is to practice as a psychologist.

In my view, that's the funny, and fortunate "thing", that has happened on the way to the State House.

Nothing great in the world has ever been accomplished without passion – Georg Wilhelm Friedrich Hegel

From time to time we will include clinically useful tables and charts. We begin with liver function tests.

| COMMON LIVER FUNCTION TESTS | | | | |
|--|-------------------------------|------------------|--------------------|--|
| Test | Reference Ranges ¹ | | | Possible concerns for abnormal findings |
| | Male | Female | Child ² | |
| Alanine Transaminase (ALT) □ aka: alanine aminotransferase (ALT or ALAT) or serum glutamic pyruvate transaminase (SGPT) | 7-46 IU/L | 5-35 IU/L | 3-37 IU/L | Most liver disease shows a higher elevation on ALT than AST. The exception is for alcohol abuse and cirrhosis, where AST higher than ALT, often at a 2:1 ratio. Acute elevation of ALT, which is often many times the upper limits of the reference ranges, can indicate viral hepatitis or overdose of hepatotoxic drugs such as acetaminophen. |
| Aspartate Transaminase (AST) □ aka: aspartate aminotransferase (AST or ASAT) or serum glutamic oxaloacetic transaminase (SGOT) | 8-26 IU/L | 8-20 IU/L | 19-28 IU/L | |
| Gamma-glutamyl Transferase (GGT) | 10-39 IU/L | 6-29 IU/L | 0-23 IU/L | GGT elevations may indicate ingestion of alcohol or other hepatotoxic drugs. High levels of both GGT and AP often indicate bile duct blockage. |
| Alkaline Phosphatase (AP or ALP) | 98-251 IU/L | 81-196 IU/L | 85-400 IU/L | |
| Total Bilirubin (TBIL) | 0.2-1.2 mg/dl | 0.2-1.2 mg/dl | 0-1.5 mg/dl | Increased TBIL will present as jaundice, which can be caused by factors such as cirrhosis, hepatitis, anemia, and bile duct obstruction. Elevated conjugated can indicate sepsis (bacteria in blood), liver or bile duct disease. If TBIL is elevated but conjugated is not, consider hemolytic anemia, cirrhosis, or hepatitis. If TBIL and conjugated are both elevated, consider bile duct obstruction or cancer. |
| Conjugated Bilirubin (direct bilirubin) | 0-0.3 mg/dl | 0-0.3 mg/dl | 0-0.5 mg/dl | |

¹Normal reference ranges vary depending on source and specific lab testing. These ranges should be used as a general reference only.

²These child reference ranges generally apply to children ages 2 to 16.

President's Podium

Thanks to All Who Have Given Their Time, Energy, and Talents to Division 55

Glenn Ally, Psy.D., MP


President, APA Division 55



Glenn Ally

As happens each year, some of the members of our Board are changing. I'd like to take this opportunity to acknowledge those members who have given of their time, energy, and talents to help this division move forward, and who are rotating off of the Division 55 Board. First, our APAGS Representative, Audra Shulman is leaving the Board and our new Representative will be Katherine Barteck. Dr. Laura Holcomb will be leaving us. She has done an incredible job as editor of the *Tablet*. Dr. Holcomb made sure that articles were secured in time and that articles were always interesting and informative. Dr. Earl Sutherland, our Member at Large, has helped pave the way for medical psychologists in Indian Health Services... simply amazing work. Also rotating off of the board is Dr. Mark Skrade, our Treasurer. Dr. Skrade has been tireless in his stewardship of our financial resources and has managed the division's funds with incredible dedication. Leaving the Board is one of our two Council Representatives, Dr. Elaine LeVine. As many of you know, Dr. LeVine has demonstrated unparalleled dedication to this division. She has served as the division's President-Elect, President, Past-President and most recently our Council Representative. She has not only served the division well, Dr. LeVine has represented the RxP movement on Council and while serving on CAPP. We are indeed very fortunate to have Dr. LeVine as an ambassador for Medical Psychology. Dr. Morgan Sammons has completed his tenure as Past President and is rotating off of the Board. He is an imposing figure among us and he is an imposing worker in our movement. His guidance of this Division has been truly inspiring.

Though not rotating off the Board, Dr. Owen Nichols has completed his tenure as President and will become the Past President. There are some who believe that "leadership" means you must have your face and name before the membership at every opportunity. Dr. Nichols has been what I consider to be a true leader who knows that a high profile is not necessarily how one leads. He knows how to find the right person for the right job and how to guide that person and the team to do their job in getting tasks accom-



plished. Personally, I look forward to my continued work with Dr. Nichols on behalf of this Division. Coming onto the Board this year will be Dr. Kathleen McNamara as Member at Large, Dr. Bob McGrath as Council Representative, Dr. Mary-Kathryn Black as Treasurer, and Dr. Kevin McGuinness as President-Elect. Dr. Jim Calvert will be taking over as Editor of the *Tablet*. I look forward to working with this group of very talented folks in continuing the progress of the Division. I would also like to acknowledge the hard work done by our committee Chairs. I will be recognizing them in future columns, but please note that there are many folks who are busy on your behalf behind the scenes.

It has been my privilege to serve you on the Board through several distinguished Presidents: (in no particular order) Dr. Mario Marquez, Dr. Bob McGrath, Dr. Elaine LeVine, Dr. Beth Rom-Rymer, Dr. Morgan Sammons, and Dr. Owen Nichols. All outstanding leaders and I have learned much from each of them. Although each may have differed slightly in the details of their mission, the common thread throughout has been to promote psychopharmacology and to promote prescriptive authority for specifically trained psychologists. My Presidential mission will be no different.

As many of you know through my postings on the list, I firmly believe and have no doubt whatsoever that passing RxP legislation is a state by state issue. Though we may have differing opinions on other issues related to RxP, I think I can safely say that most, if not all, in this Division would like to see additional states pass RxP legislation.

Can your national organization help? Absolutely! As economic times become more difficult for APA and as other health care issues move to the political front burner, I'm asking the APAPO to reaffirm its enthusiasm and commitment for RxP and to renew its vigorous support for moving the RxP agenda forward. Division 55 stands ready to assist in any way that we can. Several states will be introducing legislation this year. I would ask you to be as generous as you can in assisting these states.

Though economic times are difficult from most organizations, I pledge to you that Division 55 will continue to support efforts that are aimed at driving the RxP agenda forward on state and national levels. Division 55 has a wealth of talented professionals who have tremendous knowledge and expertise. Making those who have this experience available to other states pursuing an RxP agenda and supporting state legislative agendas will be one of the Division's top priorities.

Everyone has wonderful, creative ideas and a strong desire to help when it comes to RxP. Your ideas and suggestions are more than welcomed. But, we need more than ideas! We also need those who will be willing to give time and money. During the Louisiana legislative effort to pass our first statute, Dr. Jim Quillin kept the drive and motivation alive more than 10 years to get a prescriptive authority bill passed. His montra was, "If we do not quit, we will win." It was true then and it is true now. We can pass another statute if we

do not get sidetracked. Please join us in this continuing journey. We definitely need you.

Finally, our Mid-Winter Conference was a spectacular event this year. For the first time, it was held in conjunction with the State Leadership Conference. Since the conference was finishing just as this issue of The Tablet was going to press, I will update everyone on what came out of the conference in the next issue of The Tablet, including some of my irresistible Cajun jokes!!

I (JC, your intrepid editor) don't have one of Glenn's Cajun jokes for you, but I did go to LSU, so here's a good one:

Boudreaux spotted Thibodeaux walking down the levee the other day, carrying a sack over his shoulder. Of course, curiosity got the best of Boudreaux, and he asked Thibodeaux, "Hey, Mon Homme, what you got in dat sack ?" Thibodeaux says, "Well, I got me some chickens in dat sack." Boudreaux says, "If I can guess how many chickens you got in dat sack, can I have one of dem ?" Thibodeaux replies, "Well, my fren, if you can guess how many I got, you can have both of dem!"

Legislative Updates

Explaining Oregon's Psychologist Prescription Bill HB 3523/SB 228

Robin Henderson, Psy.D.


RxP Chair, Oregon



Robin Henderson

The Oregon Legislature is in Session, and the Oregon Psychological Association will be putting forward a bill for consideration that would give specially trained psychologists the ability to prescribe psychotropic medications. There are a few minor changes to this bill from the 2010 version, but the bill remains substantially the product of the 2009 Oregon workgroup between physicians and psychologists.

The bill establishes a Committee on Prescribing Psychologists that resides within the Oregon Medical Board. This Committee is comprised of:

- 
- Four licensed psychologists, at least one of whom is a member of the Oregon Board of Psychologist Examiners
 - Three licensed physicians, at least one of whom is a psychiatrist

Each member serves for three years at the pleasure of the appointing authority. One of the members of the committee must have expertise in the treatment of children. The Chair is elected by the members from one of the licensed psychologists.

All of the Committees actions are reported to the Oregon Medical Board and required the concurrence of the Oregon Board of Psychologist Examiners. Duties include:

- Reviewing and making recommendations on clinical training programs proposed by applicants seeking a conditional certificate of prescriptive authority;
- Reviewing and making recommendations on applications submitted for certificates of prescriptive authority;
- Developing and making recommendations regarding the prescribing psychologist formulary and annual revisions to the formulary;
- Developing and making recommendations regarding standards, examinations and continuing education for prescribing psychologists; and
- Reporting on the use of prescriptive authority by prescribing psychologists.

The bill also establishes the conditions within which the Oregon Medical Board may issue a conditional certificate of prescriptive authority to a licensed psychologist. This conditional certificate allows the psychologist to prescribe under the supervision of a physician. These include:

- Post doctoral Master's degree in clinical psychopharmacology, including training in physical assessment, pathophysiology, psychopharmacology and clinical management from an institution accredited by a regional accreditation organization recognized by the US Department of Education; or
- Has successfully completed the US Department of Defense Psychopharmacology Demonstration project (or its equivalent); and
- Has proposed a clinical training program that has been accepted by the Committee. This clinical training program consists of 24 months of training in conjunction with a longitudinal outpatient experience that:
 - Is completed under the contracted residency supervision of at least one psychiatrist and includes the following:
 - Two months of clinical experience in a mental health setting in direct collaboration with a psychiatrist;
 - One year of clinical experience in a general medical health setting;
 - If the psychologist intends to practice with a specialized population, at least three months of clinical experience in that specialized setting (ie: pediatric, geriatric, etc.)

A full certificate of prescriptive authority may be issued when:

- The psychologist completes the clinical training program previously approved by the Board; and
- Passes the national certification exam in psychopharmacology.

Both certificates expire every two years and must be renewed as per the rules drafted by the Committee. Prescribing psychologists in Oregon will also be required to document and maintain ongoing collaboration with the primary healthcare professional overseeing the patient's medical care, and discuss any significant changes in the patient's medical or psychological condition. The bill also sets forward stringent timelines for the Oregon Medical Board and the Committee to move things forward, along with guidelines for contested cases, and for suspending, limiting or revoking the certificate of prescriptive authority and how to handle complaints.


A few key points to remember about Oregon's bill:

- Prescribing psychologists must maintain an active Oregon license as a psychologist in order to have a certificate of prescriptive authority;
- Discipline related to any issue impacting the license of the psychologist is handled by the Oregon Board of Psychologist Examiners; the Oregon Medical Board only has authority over the certificate to prescribe, which is unrelated to the license;
- Prescribing psychologists will be able to practice and prescribe during the conditional certification period;
- All recommendations of the Committee on Prescribing Psychologists are enacted by the authority of the Oregon Medical Board, which must act in concurrence with the Oregon Board of Psychologist Examiners. This allows the Boards to legally collaborate without issuing a joint decision (which is not allowed under Oregon law).

Oregon needs the support of the members of Division 55 as we pursue legislation this year. We welcome letters of support to our Legislators as we continue to pursue this important legislation. If you have questions, please contact Robin Henderson, RxP Chair at rhenderson@stcharleshealthcare.org.

Legislative Updates—In Brief

Hawaii—The Hawaii Psychological Association (HPA) is working with legislators to advance this year's prescriptive authority bill. SB 597 was introduced in the Senate and passed through the Health and Commerce and Consumer Protection Committees with amendments. On March 8, 2011, SB 597 SD2 passed the third reading on the Senate floor with a vote of 18 ayes, 3 with reservation, and 4 no. SB 597 has crossed over to



the House and is awaiting a hearing to be scheduled in the House Health Committee.

SB 597 calls for a 5-year pilot study with the first 2 years occurring at one of Hawai'i's Community Health Centers followed by expansion to other CHC's in subsequent years. In year 4, a report will be conducted and submitted to the legislature on the impact and outcomes of the pilot project that will be used to inform and broaden future legislation. Additional information regarding SB 597 SD2 and its status can be accessed via www.capitol.hawaii.gov.— Jill Oliveira Gray, Ph.D., immediate Past President, Hawaii Psychological Association

Tennessee—In Tennessee, we have spent the past two years planning for anticipated Republican majorities in both houses. Indeed, after this year's election, Republicans "own" the House, Senate, and Governorship for the first time since Reconstruction. This upset established alliances for both sides on the RxP front. But TPA has worked hard to build new ones, and wishes to thank APAPO and CAPP for their generous support in assisting us in this effort. Our RxP bill was heard first this year in the Senate General Welfare committee, on 3/2. The hearing lasted two hours, and our allies on the committee soundly negated our opponents' testimony. Unfortunately, a number of amendments, some friendly, some not, were introduced, and consequently it was necessary to "roll" (postpone) the committee vote to have time to address these amendments. Stay tuned.— C. Keith Hulse, Ph.D., MSCP, D,ABSM, Director of State Legislative Affairs, Tennessee Psychological Association

Things may come to those who wait...but only the things left by those who hustle – Abraham Lincoln

Do you have a legislative update regarding RxP? If so, please send it to Jim Calvert, Tablet editor, at jcalvert@calvertpartners.com

From the Editors

We Need Your Leadership

James D. Calvert, Ph.D., MSCP

Editor, *The Tablet*



Jim Calvert


Let me start off my first issue as editor of *The Tablet* by thanking Laura Holcomb for her insight and support from the moment I threw my hat into the ring to be editor. Laura guided *The Tablet* for two years and culminated her editorship with a special double issue focusing on RxP in the Indian Health Service. A very special thanks to Laura for her stewardship of *The Tablet* through two outstanding years.

Laura already introduced me to you in the last issue of *The Tablet*. But let me give you a quick update, and then I thought I would briefly discuss my path to being a prescribing psychologist. I also want to talk a bit about the midwinter conference, which ended just a day before I wrote this column, and discuss changes in *The Tablet*.

As Laura mentioned in the last issue, I am a graduate of Clemson University and received my Ph.D. in clinical psychology from Louisiana State University. Having spent many years in Louisiana, I have a few good Cajun jokes just like Glenn Ally. Of course, not being Cajun myself, I don't have that Cajun flare for storytelling that Glenn does. However, I did marry a Cajun, so I can always hear good stories and eat good food (nothin' like crawfish, gumbo, etouffee, and jambalaya to make you happy).

Over the years I have been clinical director of a psychiatric hospital, training director at APA-approved internships, and director of non-profit organizations. I am currently a lecturer at Southern Methodist University and run a small continuing education and program evaluation consulting firm, Calvert Partners. I am married to Stacey, a labor and employment attorney with an aerospace firm, and we have two children, Max and Lily. We live in Cedar Hill, TX, which is about 15 miles southwest of downtown Dallas.

My interest in psychopharmacology training didn't start with a burning desire to prescribe. It started with a need for cheap CE. In the early 1990s, I believe it was 1993, I had just moved to start a new job when I received a letter from the Prescribing Psychologists' Register (PPR) offering 16 hours of CE credit for \$25. Having little extra money but needing CE credit, that sounded like a great deal, so I did the home study. The



home study was okay, but what really peaked my interest was the workshop PPR was doing in Orlando. I grew up in Florida, and Disney World has always been one of my favorite destinations. I cobbled together the cash for both the PPR workshop and Disney's Epcot Center (going to Disney's Magic Kingdom seemed just a tad too creepy for a man by himself—at least I could enjoy the world of food and adult drink at Epcot). The PPR workshop was on cellular biology. As a onetime zoology major, I actually enjoyed the topic. But what made it a great workshop was that it was taught by Dr. John Preston. It is still the single best workshop I have ever been to because of Dr. Preston's skill at presenting the material. I was hooked, at least as far as taking the workshops. Over the next seven or so years I completed 17 workshops with PPR.


While attending the PPR workshops I met many psychologists who attended for reasons similar to mine—the information was interesting and seemed important to know. Indeed, during the time I was doing the PPR workshops I started a private practice. I began getting calls from pediatricians in town because there were no child psychiatrists in the city. The pediatricians would ask me what medications I recommended, and I always told them that I could not prescribe. They would usually respond with something like, “Yeh, yeh, but what do you think would work best?” After about a year a child psychiatrist moved into town, and for about four months I got no more calls from pediatricians about medications. However, after patients began seeing this psychiatrist regularly, I began getting calls again.

As I said, I continued to attend the workshops on psychotropic medications because the information was interesting and important to my practice. At the time, many psychologists attending the PPR workshops had much more zeal for obtaining prescription privileges. Some even seemed a little angry about it. I usually tried not to look the angry ones in the eyes and backed away slowly. Although I'm still not what most would consider zealous, my thoughts about RxP changed in the late '90s.

I was presenting about drug metabolism at a workshop attended by physicians. One of the psychiatrists mentioned after the session that I had presented more in-depth information on P450 enzymes than he had heard at any psychiatry workshop he had been to before. It was then that it dawned on me that it was only a practical reality that psychologists with advanced training should prescribe. The need was there. Psychologist's doctoral training already gives us the most important skill for treating any person — the ability to accurately diagnose psychiatric problems. And advanced training was giving us the necessary knowledge about psychotropic medication.

When Louisiana was developing its RxP licensing law (I have been licensed as a psychologist in Louisiana since 1990), I realized that I needed to get my postdoctoral Masters degree, so I enrolled in Fairleigh Dickinson University, received my MSCP, and was licensed as a medical psychologist in Louisiana.

So that's my story of how I became a prescribing psychologist. I am interested in hearing your story about working towards prescription privileges. Were you one of the early prophets of the need for psychologists to prescribe? Perhaps you were like me and the need to know more about medications was born of a



general interest and necessity. Any initiative such as RxP needs dedicated, motivated, and energetic people in order to get it done. But that dedication may be born of fervent belief or practical need or a thirst for knowledge. Although we can't publish everyone's story, I hope to highlight some of your journeys.

One idea that I took from the Division 55 midwinter conference fits with the differing paths that each us takes toward prescribing authority. Dr. David Satcher, 16th Surgeon General of the U.S., pointed out that leadership comes from what you do, not your position in life. That reminded me of a story a business professor told our class about when he was at Woodstock in 1969. I suspect the story was apocryphal, but it impressed me. My professor said that he went to the porta-potty and a guy was whistling a merry tune as he cleaned the toilet. When asked what he was smoking to be so happy cleaning such a disgusting toilet, the guy replied that he wasn't smoking anything. He was just happy he could do something helpful to make everyone's concert enjoyable.

I am sure that Dr. Satcher would be thrilled to know that I was thinking of porta-potties at Woodstock while he was talking. But it does highlight how many ways we can all pitch in and support. Not everyone can be president of the division. Probably only a few psychologists can afford to give thousands of dollars to state associations to help with RxP. Many probably don't feel comfortable giving speeches or presenting information to state legislatures. If you can give large sums of money (or even small sums) or have the presence to stand up in front of legislators and talk about RxP, then please do so. However, there are so many others ways you can help. Do you know a congressperson in your state? Perhaps you could take one out to lunch and discuss RxP. Are you good at collecting and organizing data? If so, you could help organize information for others to present to state legislatures. Do you write well? Perhaps you could write a compelling argument for RxP that others could use when talking about RxP. Use your strength and capability to further RxP. We need your leadership.

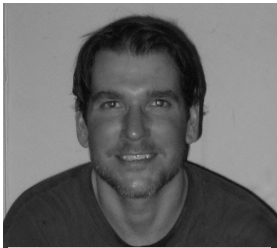
Finally, let's talk about *The Tablet*. You have probably already noticed the change in format. I have just never been good at reading stories that jump from page 1 to page 8 to page 22. So I have changed it so that you read one article all of the way through before starting the next article. I hope this works as well for you as it does for me personally and editorially. This year we also have two of us editing. Nick Patapis (see his article next) is the first associate editor we have had at *The Tablet*. This let's us have two eyes on every article so we can better help you with any article you submit. Nick has already done a great job editing articles for this issue. Nick and I look forward to working together to bring you timely information on psychopharmacology and RxP. But we need your help.

And that brings me to submissions for *The Tablet*. I want to encourage you to submit clinical reviews (brief and focused), case examples (especially grand round formats), perspectives on RxP, and legislative updates. If you want to talk about an idea for an article, please give me a call at 972-293-8787 or e-mail me at jcalvert@calvertpartners.com. I look forward to hearing from you.

Publishing in The Tablet

Nicholas Patapis, Psy.D., MACJ, MSCP

Associate Editor, The Tablet



Nick Patapis

It is my honor and pleasure to be working with Jim Calvert as the first Associate Editor of *The Tablet*. This is my first time writing from an editorial position and I must say it is liberating to not need a citation behind every statement. I guess the questions to address in my introduction to *The Tablet's* readership are "Who are you?" and "Why are you here?" I'll jump straight to the latter question and leave space for a final sentence to address the former.

I'm here mainly as an advocate that every person with a mental illness have full-access to any and all possible relief from the extreme pain and suffering of their mental illness. As a clinical psychologist I can provide such care. However, my toolbox contains only so many tools and each one has its limitations. Fortunately for me, I work very closely with a psychiatrist who shares my desire to alleviate suffering. Between the two of us, we can provide a spectrum of care from brief phone calls to patients just to check-in, to long-term psycho and pharmacotherapy, and finally admissions to one of the many excellent hospitals in Philadelphia. You would think in a great city such as this that there would be an abundance of colleagues like mine. However, my patients generally report 8-week waits for appointments with psychiatrists. Others that come to me are often under-medicated by prescribers who lack psychiatric training, who avoid entire classes of medications (e.g., antipsychotics), and who never exceed FDA recommended dosages. This practice of defensive-medicine is understandable in a city where civil juries provide among the largest plaintiff awards for medical malpractice in the entire country. While this practice is understandable, it is not acceptable.

In terms of credentials, like many ASAP members I have a post-doctoral MS in clinical psychopharmacology (FDU, '09). This give me a degree of "street credit" if it happens to come up in my consultations. But perhaps more importantly is my background as a clinical researcher working with a team of prolific publishers. When I graduated with my PsyD and MA in Criminal Justice in '02 I was awarded a NIDA-funded Clinical research Fellowship in Substance Abuse and Addictions at the University of Pennsylvania's Treatment Research Center. During this two-year formal post-doc and six additional years in the Law & Ethics Research Division of The Treatment Research Institute, I was surrounded by dedicated empiricists with exceedingly high standards. Every literature review included only the most recent and state of the art citations. Every study was conducted with the highest level of scientific integrity whether it was conducted in a sterile lab with fMRI imaging or in a real-world, high-volume urban Drug Court. During this time I was fortunate to have a co-author on many publications, some in top-tier journals and other in seminal textbooks.

The point to me including this in my introduction is that some people do not know the extensive training required to earn an accredited MS in psychopharmacology—some may not care. However, whether I'm working with a disruptive juvenile, an opioid addict or a law-maker, I have a publication I can send them ahead of our conversation that tells them to take me seriously. Whether I am first or 8th author, regardless of whether the publication was an invited chapter, an encyclopedia entry, or even if all I can come up with is someone else's work in which I am referenced, my foot is in their door.

The Tablet need not be a top-tier journal; it need not even require peer-review. However, it is my hope that over time *The Tablet* can become a forum for ASAP members to publish meaningful works that directly and indirectly address all the questions and concerns about who we are and what we do. I hope to see brief and concise case studies, recently presented posters or papers from national conferences, and other works that can be disseminated to our medical colleagues and to decision-makers at all levels of government which can serve as a definitive statement that says we are part of the answer to the problems of alleviating suffering.

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