Cultural and Ethical Issues for
Psychological Interventions of the Future

By John Caccavale. Ph.D.

Note: This is an essay that expresses my opinion. It is not designed to appear as a scientific article with the traditional citations. The opinions I express, however, for the most part, are supportable by our current knowledge base.

Trying to see the future can be an exercise in futility given the difficulties involved in foreseeing the dynamics of change. These difficulties, however, don’t seem to impair our quest to want to know the future. When I was teaching psychology, a very long time ago, I would tell my students, “If we were able to go back in time and talk with Aristotle about present day mathematics, there wouldn’t be much of a conversation. The mathematics of the ancient Greeks is not the mathematics of today.” At the same time, if we were to talk with Plato about human behavior, little would be lost. Human behavior, has remained fairly constant over time. Purpose, motives, likes, dislikes, anxieties, depression, haven’t really changed that much. What has changed is the ways in which we view them.

Society, as it progresses, may present different issues to which we must respond, but how we respond typically is similar irrespective of the time period in question. Human needs and wants also show a similar pattern. That being said, for psychologists, both psychological interventions and the cultures of the patients we treat have changed. For the most part, psychodynamic therapy is less popular than other cognitive approaches today. Behavior therapy has also lost its sheen. For many patients, medications have become the first line of treatment and, in some cases, psychotherapy is not even considered. Moreover, we can expect greater changes as psychologists lose more and more control over the types of people we treat and the bureaucratic forces that control how we treat. In essence, the changing mix of patients who will be the patients of the future and the dynamics of mental health policy will present both providers and patients with serious ethical challenges and choices.

The Cultural Challenges

In the past, the patient mix comprising the average practice was rather narrow. Typically, when a patient sought out a psychologist, the choice was likely to boil down to a middle-aged, English speaking male. The patient, on the other hand, would likely be a female. I don’t think that we need to dwell too much on why this was because we know why. Caucasian males dominated psychology with little change over time. Today, things are different. There are demonstrably more female psychologists and more males are seen in therapy. Moreover, we now see many more patients who are not English speaking, although the number of psychologists who can communicate with these patients in their native tongue remains limited. In the case of Spanish-speaking patients the number
The Challenges of Race

Racial discrimination in American society remains a major challenge and psychology and psychologists are not immune to racism. African-American and Latino patients continue to experience and suffer race-related stressors rising out of racial discrimination. It is not hyperbole to suggest that our neatly bundled system of diagnosis is without much merit and courage when presented by the harms on how racial discrimination affects people of color. How many therapists are comfortable in providing an abuse of power of one race over another as the predominant cause of one’s anxieties, mood disorders, and mental status? I suspect few.

The reason for this is that most of us are uncomfortable and because we have no real discernable diagnostic category that reads, “Chronic exposure to years of racial discrimination.” For example, Feminist therapists are justified and have little difficulty pointing out to their patients, male or female, that many of their presenting issues are a product of the long standing imbalance in the power of males over females. I think we may need to adopt a similar approach when confronting racial discrimination. This is not to suggest that we are insensitive or lack compassion or understanding. I cannot see how one

of psychologists who speak fluent enough Spanish remains a challenge. Added to the linguistic deficit of Spanish-speaking therapists is the growing numbers of patients of Asian, Middle-Eastern, and other cultural and ethnic backgrounds who are hard pressed to find a therapist. In contrast, these patients have little difficulty finding medical practitioners who can communicate with them. It’s understandable then that psychologists will probably lose these populations of patients as medications become their only option because few of us can communicate in the primary language of these patients.

Language, in and of itself, is not the only challenge for providers. Even when a patient seems to possess adequate communication skill in English, understanding the patient within a cultural context presents additional challenges. In the case of the Latino population in particular, Spanish is not monolithic. That is, in most Spanish-speaking countries, local idioms and customs can differ significantly. Clearly there is a core Spanish language, but unless one really knows the specific cultural context from where the patient originates, communication can become a challenge since psychotherapy is a “talk” dominated therapy.

Cognitive-behavioral interventions can be difficult when there is a lack of real communication, and impossible if one is psychodynamically oriented. So, as the number of cultures becoming integrated into American society increases, so the challenges to providers and patients will multiply. How we as a profession deal with this issue is one thing. How we as individual providers deal with this raises many ethical issues. Even though the various divisions of psychology's professional organizations have tried to address these issues, cultural competency, more or less, remains an academic issue. As for progress in diversity, the one achievement that has been met is that psychology has attracted and trained a significant and growing number of female practitioners.

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can be a therapist and not have these qualities.

The problem is that psychological interventions are based on having the individual accept that the maladaptive behaviors we are treating are a result of something in the individual. In essence, implicitly, the patient is the problem and the solver for the response and for the change. We do not like blaming society for individual ills. Clearly, we cannot order a societal change as a treatment. We can, however, put into perspective that, while the individual must make changes to survive, the impact of institutional racism is the cause. I believe that patients need to know that they are not wholly defective and that the response to racial discrimination is not an illness even if does require an individual to learn healthier coping mechanisms. Psychologists who are able to articulate and place racial discrimination into perspective will be meeting this challenge.

The Challenge of Sexual Orientation

In the past, sexual orientation was more clear cut than today or as it will be in the future. Slowly, society is changing to adopt more flexible definitions of sexuality and gender orientation. How psychologists and our interventions adapt to these changes is likely to challenge our personal perspectives and attitudes toward sexuality and sexual orientation. It is also likely that these issues may cease to be a focus of therapy. As people become more flexible in their sexuality and identification and societal concerns no longer are at issue, patients who sought therapy because of personal crisis related to sexual orientation is likely to wane.

The Ethical Challenge of Evidence-based Therapies

I must admit that while I support any objective analysis that demonstrates efficacy in psychological treatment, I believe there are significant ethical problems associated with our quest for evidence-based therapies. First, I do not think that anyone has demonstrated that a particular treatment has proven efficacy. The term “evidence” is not really a scientific term. It is a legal term meaning related to proof. The only “proof” offered with passes for evidence-based is statistical and not really convincing. For example, when a provider provides a treatment to a patient declaring that the treatment is evidence-based, it implies to the patient that they are receiving the best scientifically determined treatment available for his or her particular issue.

Factually, the whole issue about evidenced-based therapies is more related to reimbursement than to real science. Without any opposing data, it is well established in psychology that the variable that most accounts for success in treatment is the perspective of how the patient evaluates the therapist. Is the therapist likeable? Does the patient trust the therapist? Does the patient have confidence in the therapist? The therapist variable accounts, according to all prior research, for 70% of the success in treatment. How then will we explain to patients that we are only able to provide treatments that have been recognized and authorized by our associations and state boards as meeting the criteria of being “evidence-based?”

Ethically, we are required to provide informed consent to patients. How can we provide informed consent about the efficacy of manualized treatment simply because it met the .05 level of statistical significance? Will we be violating our ethical principles if we do not tell them that manualized treatment appears to be effective because it is so disassociated with the therapeutic interaction that patients report significant improvement just to not have it any longer? I have found no studies investigating or explaining that cognitive dissonance may be the main explanatory variable in manualized treatment. Likewise, there are a host of studies declaring one treatment or another as being “evidence-based.”

Clearly, we must all seek to provide the best and most appropriate treatment available. It may very well be that the most appropriate treatment will be psychodynamically based, although this approach will be difficult to be included in the evidence-based category. This is just one example of an ethical dilemma that will become more readily apparent in the future as insurers dictate how and what we can treat while using data from academia as justification for their decisions. Is it ethical to not disclose that the data underlying these studies were based upon a homogeneous sample of college students and written to support an academic promotion?

These are real issues that professional psychologists must address and resolve. There are significant ethical considerations as we narrow patient treatment options to only those therapies that have achieved statistical significance so providers can be reimbursed. There has been a creeping tide toward cost savings as healthcare
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is looked at from the perspective of insurers, utilization review managers, and accountants. Psychological treatment, in my opinion, should not be subjected to an industrial model based on producing mouthwash, for example.

Yes, we need to assess efficacy. Yes, we need to look at cost effectiveness. These issues are different in psychology, because efficacy and cost effectiveness cannot be evaluated as a function of a quantity of therapy. It takes time to see results given the level of issues and problems that psychologists have to deal with in therapy. Moreover, given the complexity and quantity of stressors in modern society that are likely to produce even greater stress in the future, having access to a professional who can sit with someone to talk out their issues is important and needed. The real ethical violation is to deny people that right.

The Ethical Challenges of Medicalized Mental Health

As a psychologist, I would invite any person or entity promoting evidence-based treatment to apply that same standard to psychotropic medications. As definitive research into the lack of evidence supporting the efficacy of these drugs mounts, in my opinion, it is unethical to not disclose to patients the potential harm and ineffectiveness of anti-depressants, anxiolytics, off-label prescribing, polypharmacy and the stark paucity of training in mental health of the physicians who treat them as compared to that received by professional psychologists. The growing use of psychotropic medications with patients of all ages is completely devoid of objective analysis. Unlike psychotherapy, which is not that easy to evaluate in the short run, it is relatively easy to evaluate the efficacy and harm related to psychotropic medications.

There are studies available that illustrate the placebo effect of medications, which explains most of the improvement reported by some patients. The problem is not so much the placebo effect itself, as it is the severity and potential side effects that regularly accompany psychotropic medication treatment. This is in contrast to psychotherapy in the hands of a competent professional, for which there are few risks or harm to patients. As medications have become and will likely continue to be a first line treatment for emotional, mental, and behavioral disorders, psychologists and other mental health professionals will be ethically challenged to refrain from providing this information to patients. Moreover, as legal cases against physicians also are likely to increase over the inappropriate use of psychotropics, mental health professionals are also likely to incur liability if we remain silent.

In conclusion, the challenges to psychotherapy in the future will not be much different than they are today. However, they will become more prevalent and demanding. Psychology boards and the public must be educated and re-educated about many of these issues. My guess is that many psychologists will also require re-education. As professionals we must be courageous to stand firm against this major issue of the inappropriate medicalization of mental health. Drugs do have a place in treatment but they have proven to be both generally ineffective and harmful. Psychologists need to make the case that it is unethical to withhold or delay psychotherapy in favor of unproven medication strategies. It will not be easy, but failing to do so will result in the continuing decline of psychotherapy as a real option for patients.

Board certification for healthcare providers

American Board of Behavioral Healthcare Practice

Board certification by ABBHP is an indication to both patients and providers that you are a specialist in providing behavioral healthcare diagnoses and treatments. Our board certification, the first of its kind, tells the public and your referral sources that you are a specialist and partner in the primary care of patients.

See our website to find out if you qualify

http://abbhp.org/
Having conducted a highly successful private practice for nearly 40 years, with experience and research I learned the keys to effective and efficient private practice marketing:

1. **Think like a business person.**

Most mental health providers never had a course in business, management, or marketing. In fact, most mental health practitioners dislike business and abhor marketing. This negative view of business and marketing is the prime reason for the high failure rate of private practices.

A private mental health practice is a business—albeit a service business—in every sense of the term. The lifeblood of any business is a consistent flow of new and returning customers. This can only occur through effective marketing. You may be the most skilled therapist in the county, but if only you, your mother, and your administrative assistant know this, you will fail in practice and clients will not be able to avail themselves of your service. To be successful in today’s competitive private practice environment, you must conduct your practice as a business and spend the time and energy to promote it.

2. **Identify and promote your niche(s).**

Ask a mental health provider “What do you do?” and the typical response is general in nature. For example, “I see kids and families.” This generic answer will not garner many clients. The following specific statements, on the other hand, will be far more productive: “I work with children with bipolar disorder” or “I help couples whom are struggling with a betrayal—like an affair.” It may seem counter-intuitive, but the more narrow your niche, the more effective your marketing becomes.

You likely have more than one niche (I certainly did) but you should not promote all of them at the same time. Recently I saw an ad on TV in which a local attorney touted an array of services—personal injury, divorce, wills, business transactions, etc. As is often said in the marketing world, if you say you can do everything, you are also saying you’re an expert in nothing.

3. **Identify your marketing target and determine the best approach to connect with it.**

Most mental health providers view marketing as spending a day dropping in on a few physicians in a nearby medical building. While this is better than doing nothing, it is not very effective and certainly is inefficient.

When I decided to pursue my niche in the personal injury (PI) arena 25 years ago, I arranged with the Arizona Bar Association to present, “Recognizing and Managing PTSD in the PI Client.” Approximately 45 PI attorneys attended that workshop. That 90-minute presentation resulted in one of the most significant facets of my practice. It clearly was effective and efficient.

A therapist who consulted with me wanted to enhance her practice and see more children. She had met with her child’s pediatrician and had spoken to parents at her child’s private school, with modest results. After some discussion, I recommended she contact the local pediatric society and offer a relevant presentation. Four months later she presented to 35 pediatricians on the psychological and behavioral management of ADHD. Her practice took off.

4. **Speak—become the expert.**

Speaking to the right audience not only is effective and efficient marketing, it also marks the presenter as an expert. Speaking to professional groups, associations, schools, religious organizations, health clubs, etc. will establish you as an expert. Clients with managed care insurance will pay cash to see you if they perceive you as a specialist.

5. **Write.**

Writing articles on topics related to your niche(s) and having them published is another excellent way to become known and recognized as an expert.
Articles can be published—and re-purposed—in many places—local newspaper and/or magazines, health club newsletter, place of worship newsletter, community newspaper, etc.

Nearly every mental health provider, I submit, has at least one book within them and they should write it. Nothing contributes more to the perception of your expertise than authoring a book. There are numerous methods today to put out a book—self-publish, e-book, audio-book, print-on-demand, Amazon publishing, etc. In addition to promoting your name, niche, and expertise, writing a book fosters a sense of accomplishment and can provide needed passive income.

6. Use the media and social media.

Another sure-proof way to become recognized as an expert is to get on a local TV news show or a talk radio program. It is surprisingly easy to do. What is necessary is a “hook”—a specific topic that relates to a current event, the calendar (such as New Year’s or Valentine’s Day), or an “evergreen” (always relevant) subject, such parenting or marital communication. A five-minute appearance on a TV spot or on a 30-minute radio show could reach several hundred prospective clients.

With regard to social media, you should copy your articles, or chapters in your book, onto your professional Face Book page and your website. If you can develop a substantial following, you can hone the perception as an expert. You may even be asked to allow advertising on your pages, which will increase your passive stream of income.

By using these six key marketing strategies on a regular basis, you will soon develop a consistent stream of cash-pay clients.

Featured Products...For Sleep

Chinese Medicine defines pain as an imbalance between Qi (energy) and Blood. TCM does not differentiate between physical and emotional pain.

**Evergreen Calm (ES)**

Calm (ES)* is an updated Traditional Chinese Formula to regulate Liver qi, calm the Shen (spirit) and tranquilize the Heart. It is designed to relieve insomnia with disturbed sleep and night awakenings and to help with stress reflected in poor appetite, headache, tension and insomnia. It is used as an adjunctive formula for depression.

**Evergreen Calm ZZZ**

Calm ZZZ is designed to treat those who are under constant stress but also have a deficient constitution. This is one of the best formulas to treat Shen disturbance both during the day and at night. Shen disturbance during the day can manifest as stress, anxiety and emotional instability. Shen (spirit) disturbance at night manifests as insomnia with difficulty falling asleep and/or staying asleep.

**Evergreen Schisandra ZZZ**

Schisandra ZZZ* is used with excessive worries and dreams, fatigue, pensiveness, and poor appetite. Applications include insomnia, difficulty falling asleep and staying asleep, poor memory, dizziness, weakness, constant fatigue, and postpartum depression due to anemia. It is formulated to nourish the Spleen and the Heart, tranquilize the Shen and tonify qi and blood.

Why Evergreen? Evergreen Herbs use the best of modern technology to bring the essence of traditional Chinese herbology to mainstream America. Evergreen pharmaceutical-grade, full-spectrum extracts are your assurance of correct species and maximum potency. Evergreen’s herbs are tested with HPLC for qualitative and quantitative analysis.

Statements contained herein have not been evaluated by the Food and Drug Administration. These products are not intended to diagnose, treat and cure or prevent disease. Information provided by CHS is not intended to replace a one-on-one relationship with a qualified health care professional and is not intended as medical advice.
The Safety, Tolerability and Risks Associated with the Use of Newer Generation Antidepressant Drugs: A Critical Review of the Literature

Newer generation antidepressant drugs (ADs) are widely used as the first line of treatment for major depressive disorders and are considered to be safer than tricyclic agents. In this critical review, we evaluated the literature on adverse events, tolerability and safety of selective serotonin reuptake inhibitors, serotonin noradrenaline reuptake inhibitors, bupropion, mirtazapine, trazodone, agomelatine, vilazodone, levomilnacipran and vortioxetine.

Several side effects are transient and may disappear after a few weeks following treatment initiation, but potentially serious adverse events may persist or ensue later. They encompass gastrointestinal symptoms (nausea, diarrhea, gastric bleeding, dyspepsia), hepatotoxicity, weight gain and metabolic abnormalities, cardiovascular disturbances (heart rate, QT interval prolongation, hypertension, orthostatic hypotension), genitourinary symptoms (urinary retention, incontinence), sexual dysfunction, hyponatremia, osteoporosis and risk of fractures, bleeding, central nervous system disturbances (lowering of seizure threshold, extrapyramidal side effects, cognitive disturbances), sweating, sleep disturbances, affective disturbances (apathy, switches, paradoxical effects), ophthalmic manifestations (glaucoma, cataract) and hyperprolactinemia. At times, such adverse events may persist after drug discontinuation, yielding iatrogenic comorbidity. Other areas of concern involve suicidality, safety in overdose, discontinuation syndromes, risks during pregnancy and breast feeding, as well as risk of malignancies. Thus, the rational selection of ADs should consider the potential benefits and risks, likelihood of responsiveness to the treatment option and vulnerability to adverse events. The findings of this review should alert the physician to carefully review the appropriateness of AD prescription on an individual basis and to consider alternative treatments if available. The findings of this review suggest that long-term treatment with new generation ADs should be avoided if alternative treatments are available.

Psychother Psychosom 2016;85:270-288

Ed: This pretty much sums it up.

Pharmaceutical Industry–Sponsored Meals and Physician Prescribing Patterns for Medicare Beneficiaries

The association between industry payments to physicians and prescribing rates of the brand-name medications that are being promoted is controversial. In the United States, industry payment data and Medicare prescribing records recently became publicly available.

To study the association between physicians’ receipt of industry-sponsored meals, which account for roughly 80% of the total number of industry payments, and rates of prescribing the promoted drug to Medicare beneficiaries, a cross-sectional analysis of industry payment data from the federal Open Payments Program for August 1 through December 31, 2013, and prescribing data for individual physicians from Medicare Part D, for all of 2013 was conducted.

Participants were physicians who wrote Medicare prescriptions in any of 4 drug classes: statins, cardioselective β-blockers, angiotensin-converting enzyme inhibitors and angiotensin-receptor blockers (ACE inhibitors and ARBs), and selective serotonin and serotonin-norepinephrine reuptake inhibitors (SSRIs and SNRIs). We identified physicians who received industry-sponsored meals promoting the most-prescribed brand-name drug in each class (rosuvastatin, nebivolol, olmesartan, and desvenlafaxine, respectively). Data analysis was performed from August 20, 2015, to December 15, 2015.

Prescribing rates of promoted drugs were compared with alternatives in the same class, after adjustment for physician prescribing volume, demographic characteristics, specialty, and practice setting.

A total of 279669 physicians received 63524 payments associated with the 4 target drugs. Ninety-five percent of payments were meals, with a mean value of less than $20. Rosuvastatin represented 8.8% (SD, 9.9%) of statin prescriptions; nebivolol represented 3.3% (7.4%) of cardioselective β-blocker prescriptions; olmesartan represented 1.6% (3.9%) of ACE inhibitor and ARB prescriptions; and desvenlafaxine represented 0.6% (2.6%) of SSRI and SNRI prescriptions. Physicians who received a single meal promoting the drug of interest had higher rates of prescribing rosuvastatin over other statins (odds ratio [OR], 1.18; 95% CI, 1.17-1.18), nebivolol over other β-blockers (OR, 1.70; 95% CI, 1.69-1.72), olmesartan over other ACE inhibitors and...
Science Notes- Drugs

ARBs (OR, 1.52; 95% CI, 1.51-1.53), and desvenlafaxine over other SSRIs and SNRIs (OR, 2.18; 95% CI, 2.13-2.23). Receipt of additional meals and receipt of meals costing more than $20 were associated with higher relative prescribing rates.

Conclusions: Receipt of industry-sponsored meals was associated with an increased rate of prescribing the brand-name medication that was being promoted.


Ed: The lead author explained, “Most Doctors Take Money From Drug, Device Companies. Nationally, about three quarters of doctors across five common medical specialties received at least one payment from a company in 2014. In Nevada, that number was over 90 percent. In Vermont, it was less than 24 percent. (family medicine, internal medicine, cardiovascular disease, psychiatry and ophthalmology.)” ProPublica, Dolars for Doctors https://www.propublica.org

Antipsychotic use and risk of hospitalisation or death due to pneumonia in persons with and without Alzheimer’s disease

Antipsychotics have been associated with increased pneumonia risk, but although persons with dementia are particularly susceptible to pneumonia, only one small study assessed the risk of pneumonia in relation to antipsychotic use among persons with Alzheimer’s disease (AD).

We investigated whether incident antipsychotic use, or specific antipsychotics are related to higher risk of hospitalisation or death due to pneumonia in the MEDALZ cohort. The cohort includes all persons with AD who received a clinically verified AD diagnosis in Finland in 2005-2011 (N=60,584, n with incident pneumonia 12,225). A matched comparison cohort without AD (N=60,584, n with incident pneumonia 6,195) was used to compare the magnitude of risk. Results were adjusted for a propensity score derived from comorbidities, concomitant medications and sociodemographic characteristics. Sensitivity analyses with case-crossover design were conducted.

Antipsychotic use was associated with higher pneumonia risk (adjusted hazard ratio, 95% confidence interval (CI) 2.01, 1.90-2.13) in the AD cohort and somewhat higher risk in the non-AD cohort (3.43, 2.99-3.93). Similar results were observed with case-crossover analyses (odds ratio 2.02, 95% CI 1.75-2.34 in the AD cohort, 2.59, 1.77-3.79 in the non-AD cohort). The three most commonly used antipsychotics (quetiapine, risperidone, haloperidol) had similar associations with pneumonia risk.

Conclusions: Regardless of applied study design, treatment duration, or the choice of drug, antipsychotic use was associated with higher risk of pneumonia. With observational data we cannot fully rule out a shared causality between pneumonia and antipsychotic use, but the risk-benefit balance should be considered when antipsychotics are prescribed.

Chest, 2016; DOI: 10.1016/j.chest.2016.06.004

Ed: Agitation is the most common symptom for which antipsychotics are given to the elderly (and to all ages). Non-drug interventions, including caregiver training and good nursing practices, have proven far more effective and safer than drugging these people.

In reporting the study, authors also found “The findings indicate that antipsychotic use is linked to a higher pneumonia risk regardless of age, applied study design, treatment duration, choice of medication or comorbidities. In addition, the study only included cases of pneumonia leading to hospitalization or death, which means that the actual risk increase may be even higher. Consequently, the risk-benefit balance should be carefully considered when antipsychotics are prescribed, and the treatment period should be as short as clinically possible.”

Effects of first-generation antipsychotics versus second-generation antipsychotics on quality of life in schizophrenia: a double-blind, randomised study.

Whether or not second-generation antipsychotics (SGAs) represent an advantage over first-generation antipsychotics (FGAs) in the treatment of schizophrenia is not certain. Effectiveness studies published in the past 10 years have not unequivocally confirmed the superiority of SGAs over FGAs. We aimed to compare quality of life in patients with schizophrenia on an FGA strategy with those on an SGA strategy.

In the multicentre, randomised, double-blind Neuroleptic Strategy Study (NeSSy), we recruited participants (aged 18-65 years) with schizophrenia (ICD-10: F20.X) who required treatment initiation or a change
in treatment, from 14 psychiatric university hospitals and state hospitals in Germany. Double randomisation allowed for restricted selection of a treatment within each antipsychotic drug group (FGA or SGA) for an individual patient: first, patients were assigned with a random number table to two of six possible drug pairs, each pair consisting of an FGA (haloperidol [3-6 mg] or flupentixol [6-12 mg]) given orally and an SGA (aripiprazole [10-20 mg], olanzapine [10-20 mg], or quetiapine [400-800 mg]) given orally, and the investigator then selected which pair was best suited to the patient; a second, double-blind random assignment allocated either the FGA or the SGA from the investigator-chosen pair to the patient. Treatment duration was 24 weeks. Primary outcomes were change from baseline to week 24 in quality of life (SF-36) and clinical global impression (CGI-I), analysed in all randomly assigned patients who received at least one dose of the study drug. Safety was assessed in a safety set, consisting of all randomly assigned patients who received at least one dose of the study drug, coinciding with the set of the efficacy analyses.

Between April 1, 2010, and May 31, 2013, 149 patients were randomly assigned, 69 to FGA treatment and 80 to SGA treatment. 136 patients received at least one dose of study drug (63 in the FGA group, 73 in the SGA group). Mean area under the curve (AUC) values of SF-36 were significantly higher in the SGA group than in the FGA group (85.1 [SD 14.7] vs 79.7 [17.3], p=0.0112). Mean AUC values for CGI-I scores decreased in both groups, but were not significantly different between the two groups (3.39 [SD 0.89] in the FGA group vs 3.26 [0.92] in the SGA group, p=0.3423). 30 (48%) of 63 patients given FGAs had at least one adverse event compared with 42 (57%) of 73 patients given an SGA (p=0.3019); the most common were nervous system disorders (18 [60%] of 30 in the FGA group vs 19 [45%] of 42 in the SGA group) and psychiatric disorders (ten [33%] vs 16 [38%]). One patient died after cessation of study drug (olanzapine), most likely as a result of an illicit drug overdose. The increase in body-mass index (BMI) was significantly higher in the SGA group than in the FGA group (p=0.0021 at week 6 and p=0.0041 at week 24).

Conclusion: Improvement of patient-reported quality of life was significantly higher in patients with schizophrenia given SGAs than in those given FGAs, when treatment selection was individualised. This advantage, however, has to be weighed against the potential metabolic adverse effects of some SGAs.


Ed: I find the “Interpretation” of superiority of the SGAs troubling. “Mean AUC values for CGI-I scores decreased in both groups, but were not significantly different between the two groups.” “30 (48%) of 63 patients given FGAs had at least one adverse event compared with 42 (57%) of 73 patients given an SGA.” “The increase in body-mass index (BMI) was significantly higher in the SGA group than in the FGA group (p=0.0021 at week 6 and p=0.0041 at week 24).”

Proton Pump Inhibitors Accelerate Endothelial Senescence

Proton pump inhibitors (PPIs), such as esomeprazole (Nexium), are widely used drugs for the treatment of gastroesophageal reflux disease. In the United States, these drugs are sold over the counter, and thus, medical supervision is not required. Although these agents are effective, they were never approved by regulatory authorities for long-term use. Furthermore, evidence suggests that ~70% of PPI use may be inappropriate. Recent large and well-controlled epidemiological and retrospective studies have found associations between the use of PPIs and an increased prevalence of myocardial infarction, renal failure, and dementia. However, in the absence of a mechanism and without evidence of causality, global regulatory authorities have not restricted the use of PPIs.

In this study, we provide evidence that chronic exposure to proton pump inhibition accelerates senescence in human endothelial cells (ECs), a unifying mechanism that may explain the association of adverse cardiovascular, renal, and neurological effects with the use of PPIs.

The salient findings of this study are that long-term exposure to proton pump inhibition (1) impairs lysosomal acidification and enzyme activity, in association with protein aggregate accumulation; (2) increases the generation of reactive oxygen species and impairs the NO synthase pathway; (3) accelerates telomere erosion in association with reduced expression of the shelterin complex; and (4) speeds endothelial aging as manifested by impaired cell proliferation and angiogenesis, together with histological markers of senescence and
EndoMT.

Vascular senescence would provide a mechanistic explanation for the accumulating evidence that PPIs increase the risk of cardiovascular morbidity and mortality, renal failure, and dementia. In the presence of consistent epidemiological evidence of harm and a unifying mechanism for the disparate disorders linked to PPI use and with the knowledge that PPIs are being used by millions of people for indications and durations that were never tested or approved, it is time for the pharmaceutical industry and regulatory agencies to revisit the specificity and the safety of these agents.

Conclusions: Unless otherwise indicated, physicians should consider proton pump inhibitors only for short term use of relief of symptoms of GERD.

http://dx.doi.org/10.1161/CIRCRESAHA.116.308807

Ed: Add to this, “Previous and current gastric acid inhibitor use was significantly associated with the presence of vitamin B12 deficiency. These findings should be considered when balancing the risks and benefits of using these medications. Vitamin B12 deficiency is relatively common, especially among older adults; it has potentially serious medical complications if undiagnosed. Left untreated, vitamin B12 deficiency can lead to dementia, neurologic damage, anemia, and other complications, which may be irreversible.” (Proton Pump Inhibitor and Histamine 2 Receptor Antagonist Use and Vitamin B12 Deficiency, JAMA 2013)

Alternative Approaches

Childhood interleukin-6, C-reactive protein and atopic disorders as risk factors for hypomanic symptoms in young adulthood: a longitudinal birth cohort study

This study examined if childhood: (1) serum interleukin-6 (IL-6) and C-reactive protein (CRP); and (2) asthma and/or eczema are associated with features of hypomania in young adulthood.

Participants in the Avon Longitudinal Study of Parents and Children, a prospective general population UK birth cohort, had non-fasting blood samples for IL-6 and CRP measurement at the age of 9 years (n = 4645), and parents answered a question about doctor-diagnosed atopic illness before the age of 10 years (n = 7809). These participants completed the Hypomania Checklist at age 22 years (n = 3361).

After adjusting for age, sex, ethnicity, socio-economic status, past psychological and behavioural problems, body mass index and maternal postnatal depression, participants in the top third of IL-6 values at 9 years, compared with the bottom third, had an increased risk of hypomanic symptoms by age 22 years [adjusted odds ratio 1.77, 95% confidence interval (CI) 1.10–2.85, p < 0.001]. Higher IL-6 levels in childhood were associated with adult hypomania features in a dose–response fashion. After further adjustment for depression at the age of 18 years this association remained (adjusted odds ratio 1.70, 95% CI 1.03–2.81, p = 0.038). There was no evidence of an association of hypomanic symptoms with CRP levels, asthma or eczema in childhood.

Conclusions: Higher levels of systemic inflammatory marker IL-6 in childhood were associated with hypomanic symptoms in young adulthood, suggesting that inflammation may play a role in the pathophysiology of mania. Inflammatory pathways may be suitable targets for the prevention and intervention for bipolar disorder.

Psychological Medicine 01 August 2016

Ed: Either the patients had “Bipolar Disorder” or they had significant inflammation which had hypomanic behaviors as a symptom. All available evidence points to “Bipolar Disorder” being a physical disorder, not a psychiatric one. It comes with a host of psychological issues which can only be treated with therapy. In my opinion there is no “comorbidity.” See the next four study abstracts, below.

Medical Comorbidity in a Bipolar Outpatient Clinical Population

The presence of medical illnesses among inpatients with bipolar disorder is known to complicate treatment and lengthen hospital stay. However, except for a few specific diseases, little is known about prevalence of medical illnesses in bipolar outpatients and the effect it may have on treatment. The authors sought to assess the presence of medical illnesses in a large outpatient clinical sample of bipolar patients, and the effect that medical illnesses may have on the clinical assessment and treatment of the underlying bipolar disorder. Us-
Alternative Approaches

ing the Duke University Medical Center clinical database, the authors categorized the medical diagnoses of 1379 patients who were treated with bipolar disorder from 2001 to 2002 through outpatient psychiatric clinics. The prevalence of medical comorbidities was examined, as well as the effect their presence had on the clinician’s assessment of disease severity and time to improvement. As expected, medical comorbidities increased with age. The most common systemic illnesses in bipolar outpatients were Endocrine and Metabolic Diseases (13.6% of the sample), Diseases of the Circulatory System (13.0%), and Diseases of the Nervous System and Sense Organs (10.7%). Significant specific diseases included cardiovascular diseases/hypertension (10.7%), COPD/asthma (6.1%), diabetes (4.3%), HIV infection (2.8%), and hepatitis C infection (1.9%). Clinicians assessed greater severity of illness in patients with increasing numbers of comorbid conditions; however, the time to recovery was not significantly affected by the presence of medical comorbidity. In conclusion, comorbid medical illnesses are common in bipolar outpatients, increasing with age. HIV rates may be increased relative to population norms. Their presence compounds the severity of the illness at time of presentation.

Neuropsychopharmacology (2005) 30, 401–404

Elevated serum levels of C-reactive protein are associated with mania symptoms in outpatients with bipolar disorder.

We investigated the association between serum levels of C-reactive protein (CRP), a marker of inflammation, and the severity of psychopathology in outpatients with bipolar disorder. We also compared the levels of CRP in the bipolar disorder individuals with those of a non-psychiatric control group.

We measured the level of CRP in N=122 outpatients with bipolar disorder and N=165 control individuals and evaluated the symptom severity of the bipolar disorder patients with the Young Mania Rating Scale (YMRS) and the Hamilton Depression Scale (Ham-D).

Within the bipolar disorder sample, CRP was significantly associated with the YMRS score (r=.306, p<.006), age of onset, gender, and race. CRP was not significantly associated with the Ham-D score or other clinical or demographic variables. In a multivariate analysis of covariance, CRP was the only independent predictor of YMRS score (F=11.7, p=.0009). The CRP levels of the n=41 individuals with YMRS >6 were significantly greater than the levels of the n=81 individuals with YMRS <or=6 (F=7.94, <.006). The CRP levels of the group with YMRS >6 were also significantly greater than the levels of the control group (p=.033) while the CRP levels of the group with YMRS <or=6 did not differ from that of controls (p>.05).

Conclusions: Our results suggest that outpatients with bipolar disorder with mania symptoms have increased levels of CRP as compared to those without mania symptoms and compared to individuals without psychiatric disorders. The long-term consequences of CRP in bipolar disorder should be the subject of future studies.


The British Neuropsychiatry Association 26th Annual General Meeting 7th–8th February 2013 Institute of Child Health, London

Once considered an immune privileged site, it is now clear that immune actions in the brain play a critical role in many fundamental neural processes and are increasingly implicated in the aetiology of mental illness. For example, cytokines, innate immune system proteins responsible for coordinating bodily responses to infection, are also critical to fundamental learning processes such as long term potentiation (LTP) in the brain. Microglial cells, the brains equivalent of macrophages, appear central to dendritic pruning and neural plasticity while MHC proteins central to self/non-self distinctions play a critical role in early neural development. Perhaps unsurprisingly given these roles aberrant immune responses are also increasingly implicated across the range of mental illnesses. In this talk I shall review mechanisms of immune modulation of neural function, summarise evidence implicating aberrant immune responses in common mental illnesses then finally present compelling new data demonstrating anti-depressant properties of a commonly used immuno-modulatory therapy. Together illustrating that psychoneuroimmunology has rapidly become an exciting new frontier for psychiatry.

J Neurol Neurosurg Psychiatry 2013;84:e1
**Alternative Approaches**

**Depression: an inflammatory illness?**

Major depressive disorder (MDD) is associated with significant morbidity and mortality. Findings from preclinical and clinical studies suggest that psychiatric illnesses, particularly MDD, are associated with inflammatory processes. While it is unlikely that MDD is a primary ‘inflammatory’ disorder, there is now evidence to suggest that inflammation may play a subtle role in the pathophysiology of MDD.

Most of the evidence that links inflammation to MDD comes from three observations: (a) one-third of those with major depression show elevated peripheral inflammatory biomarkers, even in the absence of a medical illness; (b) inflammatory illnesses are associated with greater rates of MDD; and (c) patients treated with cytokines are at greater risk of developing major depressive illness.

We now know that the brain is not an immune privileged organ. Inflammatory mediators have been found to affect various substrates thought to be important in the aetiopathogenesis of MDD, including altered monoamine and glutamate neurotransmission, glucocorticoid receptor resistance and adult hippocampal neurogenesis. At a higher level, inflammation is thought to affect brain signalling patterns, cognition and the production of a constellation of symptoms, termed ‘sickness behaviour’. Inflammation may therefore play a role in the aetiology of depression, at least in a ‘cohort’ of vulnerable individuals. Inflammation may not only act as a precipitating factor that pushes a person into depression but also a perpetuating factor that may pose an obstacle to recovery. More importantly, inflammatory markers may aid in the diagnosis and prediction of treatment response, leading to the possibility of tailored treatments, thereby allowing stratification of what remains a heterogenous disorder.

*J Neurol Neurosurg Psychiatry* 2012;83:495-502

**Decreased Brain Levels of Vitamin B12 in Aging, Autism and Schizophrenia.**

Many studies indicate a crucial role for the vitamin B12 and folate-dependent enzyme methionine synthase (MS) in brain development and function, but vitamin B12 status in the brain across the lifespan has not been previously investigated. Vitamin B12 (cobalamin, Cbl) exists in multiple forms, including methylcobalamin (MeCbl) and adenosylcobalamin (AdoCbl), serving as cofactors for MS and methylmalonylCoA mutase, respectively. We measured levels of five Cbl species in postmortem human frontal cortex of 43 control subjects, from 19 weeks of fetal development through 80 years of age, and 12 autistic and 9 schizophrenic subjects.

Total Cbl was significantly lower in older control subjects (> 60 yrs of age), primarily reflecting a >10-fold age-dependent decline in the level of MeCbl. Levels of inactive cyanocobalamin (CNCbl) were remarkably higher in fetal brain samples. In both autistic and schizophrenic subjects MeCbl and AdoCbl levels were more than 3-fold lower than age-matched controls. In autistic subjects lower MeCbl was associated with decreased MS activity and elevated levels of its substrate homocysteine (HCY). Low levels of the antioxidant glutathione (GSH) have been linked to both autism and schizophrenia, and both total Cbl and MeCbl levels were decreased in glutamate-cysteine ligase modulatory subunit knockout (GCLM-KO) mice, which exhibit low GSH levels. Thus our findings reveal a previously unrecognized decrease in brain vitamin B12 status across the lifespan that may reflect an adaptation to increasing antioxidant demand, while accelerated deficits due to GSH deficiency may contribute to neurodevelopmental and neuropsychiatric disorders.

*PloS one*, 2016

Ed: The lead author stated in the press release for this study, “These are particularly significant findings because the differences we found in brain B12 with aging, autism and schizophrenia are not seen in the blood, which is where B12 levels are usually measured. The large deficits of brain B12 from individuals with autism and schizophrenia could help explain why patients suffering from these disorders experience neurological and neuropsychiatric symptoms...While provision of supplemental vitamin B12 may be helpful in treating the aforementioned brain disorders, several issues must be considered. The required dosage may significantly exceed the Recommended Dietary Allowance (RDA) of 2.4 µg/day. (2.4 micrograms/day). Only about 10 mcg of a 500 mcg oral supplement is actually absorbed in healthy people (source NIH4). Supplementation with higher dose levels of the active Vitamin B12 variations (i.e. MeCbl and AdoCbl) may be required to address an oxidative stress-related functional deficiency.”

http://schizophrenia.com/treatments.
**A longitudinal study of depression and gestational diabetes in pregnancy and the postpartum period**

Depression and glucose intolerance commonly co-occur among non-pregnant individuals; however, the temporal relationship between gestational diabetes (GDM) and depression during pregnancy and the postpartum period is less understood. Our objective was to assess longitudinal associations between depression early in pregnancy and GDM risk, as well as GDM and subsequent risk of postpartum depression.

Data came from the prospective National Institute of Child Health and Human Development Fetal Growth Studies-Singleton cohort (2009–2013), and had been collected at 12 US clinical centres. Pregnant women without psychiatric disorders, diabetes or other chronic conditions before pregnancy were followed throughout pregnancy (n=2477). Only women with GDM and matched controls were followed up at 6 weeks postpartum (n=162). GDM was ascertained by a review of the medical records. Depression was assessed in the first (8–13 gestational weeks) and second (16–22 weeks) trimesters and at 6 weeks postpartum using the Edinburgh Postnatal Depression Scale. Postpartum depression was defined as a depressive symptom score ≥10 or antidepressant medicine use after delivery. RR and 95% CI were adjusted for pre-pregnancy BMI and other risk factors. GDM was considered to be the outcome for the first set of analyses, with depression in the first and second trimesters as the exposures. Postpartum depression was considered as the outcome for the second set of analyses, with GDM as the exposure.

Overall, comparing the highest and lowest quartiles of first-trimester depression scores, the scores from the highest quartile were associated with a significant twofold (95% CI 1.06, 3.78) increased risk of GDM, but this was attenuated to 1.72-fold (95% CI 0.92, 3.23) after adjustment; the second-trimester results were similar. The risk was stronger and significant in both trimesters among non-obese women (p for trend 0.02 and 0.01, respectively), but null for obese women. Women with persistently high depression scores in both trimesters had the greatest risk of GDM (highest vs lowest quartile in both trimesters: adjusted RR 3.21, 95% CI 1.00, 10.28). GDM was associated with an adjusted 4.62-fold (95% CI 1.26, 16.98) increased risk of subsequent postpartum depression.

This prospective study demonstrates a modest association between depressive symptoms early in pregnancy and an increased risk of incident GDM, as well as between GDM and subsequent postpartum depression risk, highlighting pregnancy and the postpartum period as an important susceptible time window during the life course for the interplay between depression and glucose intolerance phenotypes. GDM risk associated with elevated depressive symptoms was particularly high among non-obese women and women with symptoms persisting across the first two trimesters of pregnancy.

**Diabetologia, 2016;**

Ed: The summary from Science Daily stated, “A two-way link between depression and gestational diabetes has been uncovered by researchers. Women who reported feeling depressed during the first two trimesters of pregnancy were nearly twice as likely to develop gestational diabetes, according to an analysis of pregnancy records. Conversely, a separate analysis found that women who developed gestational diabetes were more likely to report postpartum depression six weeks after giving birth, compared to a similar group of women who did not develop gestational diabetes.”

Although the simple, pro-pharma conclusion is that we should place every pregnant woman on antidepressants to prevent gestational diabetes, could it be that blood sugar abnormalities caused feelings of sad mood? Certainly some of the 254,000 pubmed articles linking mood and blood sugar indicate this.

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**Air Pollution and Emergency Department Visits for Depression: A Multicity Case-Crossover Study**

The aim of this study was to investigate the associations between ambient air pollution and emergency department (ED) visits for depression.

**Methods:** Health data were retrieved from the National Ambulatory Care Reporting System. ED visits for depression were retrieved from the National Ambulatory Care Reporting System using the International Classification of Diseases (ICD-10), Tenth revision codes; ICD-10: F32 (mild depressive episode) and ICD-10: F33 (recurrent depressive disorder). A case-crossover design was employed for this study. Conditional logistic regression models were used to estimate odds ratios.
Alternative Approaches

For females, exposure to ozone was associated with increased risk of an ED visit for depression between 1 and 7 days after exposure, for males, between 1 and 5, and 8 days after exposure, with odds ratios ranging between 1.02 and 1.03.

Conclusions: These findings suggest that, as hypothesized, there is a positive association between exposure to air pollution and ED visits for depression.

Environmental Health Insights 2016:10 155-161

Fatty Acid Blood Levels, Vitamin D Status, Physical Performance, Activity, and Resiliency: A Novel Potential Screening Tool for Depressed Mood in Active Duty Soldiers

This study examined whether blood fatty acid levels, vitamin D status, and/or physical activity are associated with physical fitness scores; a measure of mood, Patient Health Questionnaire-9; and a measure of resiliency, Dispositional Resiliency Scale-15 in active duty Soldiers. 100 active duty males at Fort Hood, Texas, underwent a battery of psychometric tests, anthropometric measurements, and fitness tests, and they also provided fasting blood samples for fatty acid and vitamin D analysis. Pearson bivariate correlation analysis revealed significant correlations among psychometric tests, anthropometric measurements, physical performance, reported physical inactivity (sitting time), and fatty acid and vitamin D blood levels. On the basis of these findings, a regression equation was developed to predict a depressed mood status as determined by the Patient Health Questionnaire-9. The equation accurately predicted depressed mood status in 80% of our participants with a sensitivity of 76.9% and a specificity of 80.5%. Results indicate that the use of a regression equation may be helpful in identifying Soldiers at higher risk for mental health issues. Future studies should evaluate the impact of exercise and diet as a means of improving resiliency and reducing depressed mood in Soldiers.

Military Medicine, 2016; 181 (9)

New research delimits the possible causes of celiac disease

The amount of gluten could be a more important clue than breast-feeding or the timing of the introduction of gluten for continued research into the causes of celiac disease (gluten intolerance). This is one of the findings from several extensive studies of children with an increased genetic risk of celiac disease conducted by researchers at Lund University in Sweden.

• Swedish children whose reported daily intake of gluten was high (more than five grams) up to the age of two years had twice the risk of developing coeliac disease compared to children who consumed a smaller amount. The results from the same sub-study also show that children with celiac disease ate more gluten.

• The risk of developing the autoimmunity which gives rise to celiac disease was highest in Sweden compared to the other countries in the study (Finland, Germany and USA). The result held after adjustment for some of the most important causes of celiac disease (carrying the risk gene, previous diagnosis in the family and gender).


Evidence for increased behavioral control by punishment in children with attention-deficit hyperactivity disorder

The behavioral sensitivity of children with ADHD to punishment has received limited theoretical and experimental attention. This study evaluated the effects of punishment on the response allocation of children with ADHD and typically developing children.

Two hundred and ten children, 145 diagnosed with ADHD, completed an operant task in which they chose between playing two simultaneously available games. Reward was arranged symmetrically across the games under concurrent variable interval schedules. Asymmetric punishment schedules were superimposed; responses on one game were punished four times as often as responses on the other.

Both groups allocated more of their responses to the less frequently punished alternative. Response bias increased significantly in the ADHD group during later
Alternative Approaches

Conclusions: Punishment exerted greater control over the response allocation of children with ADHD with increased time on task. Children with ADHD appear more sensitive to the cumulative effects of punishment than typically developing children.


Ed: “If a child with ADHD is reluctant in doing a task, or if the child gives up easily, it might be important for the parent or the teacher to check if the task has the appropriate balance of reward and punishment. We are not saying that the task has punishment built in, rather that the effort needed to do the task might be perceived as punishing by the child. The more effortful a task is, the more incentives a child is going to need to keep persisting, and simple but frequent rewards, such as smiles or words of encouragements, can help children with ADHD to stay on the task.” “The same could be said for typically developing children, but this is especially important for children with ADHD, as they seem more sensitive to repeated experiences of punishment or failure, and are more likely to miss opportunities for success.”

Acupuncture for menopausal vasomotor symptoms: study protocol for a randomised controlled trial.

Hot flushes and night sweats (vasomotor symptoms) are common menopausal symptoms, often causing distress, sleep deprivation and reduced quality of life. Although hormone replacement therapy is an effective treatment, there are concerns about serious adverse events. Non-hormonal pharmacological therapies are less effective and can also cause adverse effects. Complementary therapies, including acupuncture, are commonly used for menopausal vasomotor symptoms. While the evidence for the effectiveness of acupuncture in treating vasomotor symptoms is inconclusive, acupuncture has a low risk of adverse effects, and two small studies suggest it may be more effective than non-insertive sham acupuncture. Our objective is to assess the efficacy of needle acupuncture in improving hot flush severity and frequency in menopausal women. Our current study design is informed by methods tested in a pilot study.

This is a stratified, parallel, randomised sham-con-
Care home dementia study finds failure to reduce antipsychotic prescribing @MNT_psychology
There has been no sustained reduction in the prescription of antipsychotics to UK dementia patients, despite government guidance, according to a report published in the medical journal BMJ Open. A study by five universities has found that there was no sustained reduction in the prescribing of antipsychotics to dementia patients in UK care homes following the government's 2009 National Dementia Strategy (NDS), which recommended a review of their use in light of potential serious side effects. The research - led by Professor Ala Szczepura at Coventry University and published in the medical journal BMJ Open - examined prescribing data between 2009 and 2012 from over 600 care homes across the country, concluding that there was no significant decline in antipsychotic prescribing rates over the four year period. Antipsychotics were originally developed for use in patients with schizophrenia or psychosis, but the study shows that 'off-label' prescribing of these drugs to treat the behavioural and psychological symptoms of dementia is a common practice in care homes. The 2009 'Banerjee Report', commissioned by the Department of Health as part of the NDS, examined the use of antipsychotics for people with dementia, concluding that the drugs had a "substantial clinical risk" associated with them and that their overuse "must not be allowed to continue". However, researchers from the universities discovered that - although dosages were usually acceptable - prescribing levels did not reduce over the four years, and length of treatment was 'excessive' in over 77% of cases by 2012, up from 69.7% in 2009 (meaning it exceeded not only the recommended six week course, but also the maximum advised treatment length of 12 weeks). Findings from the study also indicate that older first-generation antipsychotics (FGA) such as haloperidol and chlorpromazine are still being used extensively, with no measurable shift to safer second-generation antipsychotics (SGA) like risperidone - as recommended in the NDS.

Study shows upswing in prescription opioid use disorder and heroin use among young adults @Medical_Xpress
Researchers at Columbia University's Mailman School of Public Health found there was an increase in the probability of having a prescription opioid use disorder in the past year among 18- to 34-year-old nonmedical prescription opioid users in 2014 compared to 2002. This is the first study to investigate time trends and increases over the last decade in prescription opioid use disorder, defined as meeting the criteria for DSM (clinical) abuse and dependence and needing treatment. Study participants included adolescents (12 to 17 years), emerging adults (18 to 25 years), and young adults (26 to 34 years) who used prescription opioids for nonmedical purposes. Results are published online in the journal Addictive Behaviors. Emerging adults had a 37 percent increase in the odds of having the disorder, and young adults doubled their odds from 11 percent to 24 percent. Among adolescents, the prevalence of prescription opioid use disorder remained relatively stable during the same period. Data originated from the 2002 to 2014 National Survey on Drug Use and Health. The researchers also found a four-fold and nine-fold increase over time in the odds of heroin use among emerging adults and young adults who used opioids without a medical prescription, respectively. "We see an increasing trend from 2002 to 2014 among both groups," noted first author Silvia Martins, MD, PhD, associate professor of Epidemiology. The odds of past-year heroin use among emerging adults rose from 2 percent to 7 percent, and from 2 percent to 12 percent among young adults. Nearly 80 percent of 12-
to 21-year-olds who reported initiation of heroin use had previously started using prescription opioids between the ages of 13 and 18. "Given this and the high probability of nonmedical use among adolescents and young adults in general, the potential development of prescription opioid use disorder among youth and young adults represents an important and growing public health concern," noted Dr. Martins. Overall, however, the past-year prevalence of nonmedical prescription opioid use significantly decreased from 2002 to 2014 among adolescents (from 8 percent to 5 percent), and emerging adults ages (from 11 percent to 8 percent), and remained unchanged among young adults at 6 percent.

**How frequent are mental disorders in cancer patients? @MNT_psychology**

In an investigation published in the current issue of Psychotherapy and Psychosomatics a group of German investigators provides the largest survey of mental disorders in cancer. Psychological problems are common in cancer patients. For the purpose of planning psycho-oncological interventions and services tailored to the specific needs of different cancer patient populations, it is necessary to know to what extent psychological problems meet the criteria of mental disorders. The purpose of this study was to estimate the 12-month and lifetime prevalence rates of mental disorders in cancer patients. A representative sample of patients with different cancer entities and stages (n = 2,141) in outpatient, inpatient and rehabilitation settings underwent the standardized computer-assisted Composite International Diagnostic Interview for mental disorders adapted for cancer patients (CIDI-O). Results showed that the overall 12-month prevalence for any mental disorder was 39.4% (95% CI: 37.3-41.5), that for anxiety disorders was 15.8% (95% CI: 14.4-17.4), 12.5% (95% CI: 11.3-14.0) for mood disorders, 9.5% (95% CI: 8.3-10.9) for somatoform disorders, 7.3% (95% CI: 6.2-8.5) for nicotine dependence, 3.7% (95% CI: 3.0-4.6) for disorders due to general medical condition, and 1.1% (95% CI: 0.7-1.6) for alcohol abuse or dependence. Lifetime prevalence for any mental disorder was 56.3% (95% CI 54.1-58.6), that for anxiety disorders was 24.1% (95% CI: 22.3-25.9), 20.5% (95% CI: 18.9-22.3) for mood disorders, 19.9% (95% CI: 18.3-21.7) for somatoform disorders, 18.2% (95% CI: 16.6-20.0) for nicotine dependence, 6.4% (95% CI: 5.4-7.6) for alcohol abuse or dependence, 4.6% (95% CI: 3.8-5.6) for disorders due to general medical condition, and 0.2% (95% CI: 0.1-0.6) for eating disorders.

**Fears of ageing may cause earlier death: UN @Medical_Xpress**

Being afraid of growing old may shorten your life, the UN health agency said Thursday, as new data highlighted the widespread prevalence of ageist attitudes worldwide. In a first-of-its-kind survey released by the World Health Organization, 60 percent of respondents said they believed older people "were not respected." Attitudes towards older people were more negative in richer countries, according to the data from more than 83,000 respondents, who were 18 years of age and older in 57 countries. The data confirms "that ageism is extremely common," said John Beard, WHO's head of Ageing and Life Course. He warned that discriminatory and negative views about older people can have sweeping consequences, including for younger people. "There is very good evidence that people who have negative views of themselves as they grow older... it shortens their lives," Beard told reporters. WHO cited recently published research indicating that "people who hold negative views about their own ageing, do not recover as well from disability and live on average 7.5 years less than people with positive attitudes." Attitudes about ageing are "on the level that racism and sexism were maybe 20, 30 or 40 years ago," Beard said. "Things which are no longer accepted if you were talking about someone on the basis of their race or sex are still tolerated when it comes down to their age." WHO does not define the group of people victimised by ageism. Such discrimination could be directed at a 50-year-old seeking a new job, or a 65-year-old facing mandatory retirement but who remains a productive employee. The WHO official also came out against compulsory, age-defined policies like mandatory retirement, describing them as "problematic".
EEG recordings prove learning foreign languages can sharpen our minds @MNT_psychology

Scientists from the Higher School of Economics (HSE) together with colleagues from the University of Helsinki have discovered that learning foreign languages enhances the our brain’s elasticity and its ability to code information. The more foreign languages we learn, the more effectively our brain reacts and processes the data accumulated in the course of learning. An article of Yury Shtyrov, Leading Research Fellow of the HSE Centre for Cognition & Decision Making, Lilli Kimppa and Teija Kujala (University of Helsinki) summarizing the new findings has been recently published in Scientific Reports. According to the study, the neurophysiological mechanics of language and speech acquisition are underexplored when compared to the brain’s other functions. The reason for such scarce attention is the inability to study verbal function on test animals. Researchers carried out experiments where the brain's electrical activity was measured with EEG (electroencephalography). Twenty-two students in total (10 male and 12 female) participated in the investigation, with the average age being 24. The subjects had electrodes placed on their heads and then listened to recordings of different words in their native language, as well in foreign languages, both known and completely unknown by the subjects. When the known or unknown words popped up, changes in the brain’s activity were tracked. Researchers especially focused on the speed at which the brain readjusted its activity to treat unknown words. Afterwards, the accrued neurophysiological data was compared to the subjects' linguistic background: how many languages they knew, at which age they started to learn it, and so on. Apparently, the ability of the brain to quickly process information depends on one's "linguistic anamneses."

Concussion Symptoms Linked to Proteins in Spinal Fluid for First Time, Suggesting Possibility of Diagnostic Test Dr. Dhruv Khullar ABCNews.go.com

Levels of certain proteins in the brain and spinal fluid of people who suffer continuing issues as a result of concussions are different from those who haven’t had concussions, according to a new small study published today in JAMA Neurology, raising the possibility that doctors may soon have objective markers to assess the severity of brain damage after head trauma. The study is the first to examine biomarkers in the cerebrospinal fluid of athletes with post-concussion symptoms. Researchers studied 31 people, 16 of whom were Swedish professional hockey players with post-concussion syndrome -- a condition in which patients experience symptoms such as headaches, mood changes and difficulty concentrating for extended periods of time after a head injury. Players were compared to 15 neurologically healthy individuals. After sampling the cerebrospinal fluid of all participants, researchers found that compared to the neurologically healthy individuals or players whose post-concussive syndrome symptoms lasted for less than a year, players who had symptoms that lasted for more than year had higher levels of proteins called Neurofilament Light (NF-L) proteins -- found in the white matter of the brain -- suggesting injury to areas that contain nerve fibers connecting various structures within the brain. NF-L proteins were also higher in players who reported having had more concussions and those who had more severe post-concussion symptoms. Researchers also found that players with post-concussion syndrome had lower levels of amyloid-beta in their spinal fluid. Amyloid-beta is protein that can clump together to form plaques that are associated with Alzheimer’s disease. The lower levels found in the study suggests amyloid is being deposited in the brain, as is the case in Alzheimer’s disease.

Concussion Diagnoses in Teens Hit a Record High Alice Park, Time.com

Since laws requiring more stringent monitoring of people who suffer head injuries in sports went into effect, concussion diagnoses have risen. Diagnoses of concussions rose to a record high between 2010 and 2015, particularly among teens, according to a new report published by Blue Cross Blue Shield Association. The insurance company reports that more than 936,000 claims were filed for diagnosed concussions among its members, and that rates for adolescents between age 10 and 19 surged 71% during that time, while rates for adults increased by 26%. Most of the teen spike is due to sports, especially football, since rates increased sharply during the sport’s fall season, according to the claims data. Much of the increased diagnosis can be
tied to heightened awareness of concussions and the health effects of brain injury, after states enforced laws requiring athletes who experienced brain injuries to obtain medical clearance before resuming practice or play in a game, the study authors say. Teens were five times more likely to be diagnosed with a concussion than all other age groups combined. While adolescent males are more likely to be diagnosed than females, rates of concussions among adolescent females is also climbing, increasing by 118% during the last six years compared to a 48% rise among males. The data also revealed that the number of people experiencing post-concussion syndrome, which include headaches and dizziness that can last for weeks after a concussion, doubled during the study’s time period.

Esketamine produces rapid effects in treatment-resistant depression @MNT_psychology
A new study in Biological Psychiatry reports that esketamine, a component of the general anesthetic ketamine, shows rapid and significant improvement in depressive symptoms in patients who do not respond to currently available therapies. The study aimed to demonstrate the efficacy and safety of esketamine in hopes to fulfill a long-awaited clinical need for therapies that can crack treatment-resistant depression. Ketamine piqued researchers’ interest when a study demonstrated that low doses of the drug have rapid antidepressant effects, alleviating symptoms within just 2 hours. This stood in stark contrast to conventional antidepressant drugs, which can take 1 to 3 months to produce an effect. In addition, ketamine appeared to work in patients who did not see improvement in symptoms with conventional antidepressant drugs, about one third of patients with major depressive disorder. Although ketamine entered the field as a promising new antidepressant a decade ago, no strategy has been established to maintain its efficacy. Studies have primarily focused on the effects of a single IV dose, but patients who initially respond tend to relapse within a week after the infusion. In this study, first author Jaskaran Singh from Janssen Research & Development, LLC in San Diego, California and colleagues examined for the first time the safety and efficacy of esketamine in patients with treatment-resistant depression. In a double-blind study, the researchers randomly assigned 30 patients to receive a placebo, or a lower (0.2 mg/kg) or higher (0.4 mg/kg) dose of esketamine. The patients received two IV doses during the double-blind phase, which was followed by a 2-week follow up phase in which patients could receive up to 4 additional optional open-label doses. The earliest onset of an antidepressant effect was measured 2 hours after the first infusion. Within 3 days, over 60% of patients receiving either dose of esketamine saw improvement in depressive symptoms. None of the patients in the placebo group responded. The authors compare this response rate to only 37-56% of patients after 6-12 weeks with conventional antidepressants. "The study shows clear benefits of the drug over placebo and suggests that the lowest of the two doses may be equally efficacious but also safer," said Murray Stein, of the University of California San Diego and a deputy editor of Biological Psychiatry. Seventeen percent of patients taking the higher dose experienced transient perceptual changes immediately after infusion, which subsided within 4 hours.
Get one hour of CE credit by reading this edition of TCP and completing the following questions. E-mail your answers to Dr. John Caccavale, NAPPP, at doctorjc1@ca.rr.com

1. According to the lead article, mathematics has not changed much since the time of Aristotle. True/false
2. The typical psychologist of the past was a middle-aged, English-speaking male, and the patient was most likely a female. True/false
3. The author mentions serious ethical challenges facing the psychologist including cultural, racial, and ________________.
4. The author asserts that psychologists must use evidence-based therapies to prevent further decline in the respect of the field by others. True/false
5. Which variable most accounts for the success of psychological treatment?
6. The author concludes that the real ethical violation is to deny people the right of having access to a professional who can sit with them to talk out their issues. True/false
7. In the author’s opinion, it would be unethical to not inform patients of the potential harm and ineffectiveness of various psychotropic medications. True/false
8. In a critical review of the literature on the newer generation antidepressants, it was concluded that they should be avoided if alternative treatments are available. True/false
9. Nationally, approximately __________ quarters of doctors across five common medical specialties received at least one payment from a pharmaceutical company in 2014.
10. In a study on Alzheimer’s disease, it was found that antipsychotic use was associated with higher pneumonia risk, but that Haldol was by far the worst compared to quetiapine and risperidone. True/false
11. What is the most common symptom for which antipsychotics are given to the elderly?
12. In a study comparing first-generation antipsychotics to second-generation antipsychotics, patient reported quality of life was significantly higher in patients with schizophrenia when given which generation of antipsychotics?
13. Proton pump inhibitors such as Nexium, sold over-the-counter for treatment of gastro esophageal reflux disease should be used only for the short-term, because of an association with myocardial infarction, renal failure, and dementia. True/false
14. All available evidence points to bipolar disorder being a psychiatric disorder, not a physical one. True/false
15. One study found no support for the idea that co-morbid medical illnesses are common in bipolar disorder. True/false
16. C-reactive protein is a marker of inflammation. True/false
17. In a study on elevated serum levels, it was concluded that outpatients with bipolar disorder with symptoms of mania have increased levels of C-reactive protein. True/false
18. There appears to be little support for the idea that aberrant immune responses are involved in various mental illnesses. True/false
19. One third of those with major depression show elevated peripheral inflammatory biomarkers, but only in the presence of medical illness. True/false
20. B12 levels appear to be associated with various neurological and neuropsychiatric symptoms, but supplementation with higher dose levels may be necessary. True/false
21. A longitudinal study of depression found that women with persistently high depression scores had the greatest risk of gestational diabetes, and that gestational diabetes was associated with an increased risk of subsequent postpartum depression. True/false
22. In a crossover study, surprisingly, there was no association between air pollution and emergency department visits for depression. True/false
23. In a study regarding a potential screening tool for depressed mood, the editor suggested that since low vitamin D and low omega-3 accurately predict depressed mood, D supplements and fish oil should be encouraged. True/false
24. Some of the most important causes of celiac disease include: carrying the risk gene, ________________, and ______.
25. In a study on ADHD, the editor commented that the more effortful a task is, the more incentives a child is going to need to keep persisting, and simple but frequent rewards, such as smiles or words of encouragement, can help children with ADHD to stay on task, and this is especially important for children with ADHD, as they seem to be more sensitive to repeated experiences of punishment or failure and are more likely to miss opportunities for success. True/false
Current Listing of Free CE Courses

The following courses are now available free with NAPPP membership. CE credit is provided by NAPPP and alliance partners who are approved sponsors of continuing education by the National Institute of Behavioral Health Quality and the American Psychological Association. Many states require specific courses for licensure and license renewal. NAPPP courses are designed to meet these requirements. However, members should check with their state statutes to determine specific CE requirements. Contact Dr. Caccavale for details at doctorjc1@ca.rr.com

<table>
<thead>
<tr>
<th>Course</th>
<th>Title</th>
<th>Credits</th>
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</thead>
<tbody>
<tr>
<td>Psy #1</td>
<td>Pharmacotherapeutics: 10 CE credit hours</td>
<td>Integration of the principles of psychology in the application of pharmacological agents in the alleviation of mental health concerns.</td>
</tr>
<tr>
<td>Psy #2</td>
<td>Neuropsychological Evaluations: 10 CE credit hours</td>
<td>The selection, administration and integration of neuropsychological data into a comprehensive report.</td>
</tr>
<tr>
<td>Psy #3</td>
<td>Custody Evaluations: 10 CE credit hours</td>
<td>A complete course on the conducting and writing of custody evaluations for the practicing psychologist.</td>
</tr>
<tr>
<td>Psy #4</td>
<td>Forensic Evaluations: 10 CE credit hours</td>
<td>This course will take you through the differing forms of forensic evaluations and discuss the formation of a comprehensive forensic report.</td>
</tr>
<tr>
<td>Psy #5</td>
<td>Treating Childhood Sexual Abuse: 10 CE credit hours</td>
<td>This course discusses the thorough diagnosis and treatment of children who have been sexually abused.</td>
</tr>
<tr>
<td>Psy #6</td>
<td>Domestic Violence - Treatment and Assessment: 10 CE credit hours</td>
<td>The assessment and treatment of domestic violence. Discussion of group and individual treatment is included.</td>
</tr>
<tr>
<td>Psy #7</td>
<td>Ethics &amp; Risk Management: 10 CE credit hours</td>
<td>This course qualifies for an additional 10% discount from NAPPP’s preferred malpractice insurer. This is a program that discusses the newest issues facing Psychologists ethically. A thorough discussion of prescription privileges and pharmacopsychology ethics is included.</td>
</tr>
<tr>
<td>Psy #8</td>
<td>Mood Disorders: 10 CE credit hours</td>
<td>A review of the diagnosis of the spectrum of mood disorders along with a discussion of the psychological and pharmacological interventions for each disorder.</td>
</tr>
<tr>
<td>Psy #9</td>
<td>Physiology For Psychologists: 10 CE credit hours</td>
<td>This course covers basic understanding of critical concepts in human physiology, including being aware of indications for referral to other health care providers for treatment and interrelationships between organs/systems, psychopharmacology, and psychopathology.</td>
</tr>
<tr>
<td>Psy #10</td>
<td>Issues In Postpartum Disorders: 10 CE credit hours</td>
<td>A review of the evaluation and diagnosis of postpartum disorders. A review of the relevant literature is included.</td>
</tr>
<tr>
<td>Psy #11</td>
<td>Doing Pre-Marital Counseling: 10 CE credit hours</td>
<td>Dr. Sandra Levy Ceren details how to do pre-marital counseling. This course is built upon Dr. Ceren’s many years of experience and is replete with case studies.</td>
</tr>
<tr>
<td>Psy #12</td>
<td>Mastering Medical Terminology For Psychologists: 10 CE credit hours</td>
<td>This course is designed for Psychologists who want to learn and master medical terminology. This course will allow clinician’s to communicate effectively with medical practitioners. A must for clinicians who regularly work with medical practitioners.</td>
</tr>
<tr>
<td>Psy #13</td>
<td>Caring For The Elderly: 10 CE credit hours</td>
<td>This course is a basic course designed for Psychologists who want to learn additional skills related to diagnosing and treating the elderly patient. Particular attention is devoted to dementias.</td>
</tr>
</tbody>
</table>
| Psy #14 | Diagnosing and Treating Substance Abuse: 10 CE credit hours | A basic understanding of diagnosing and treating...
Current CE courses

patients with substance abuse problems. The course focuses on alcohol abuse but does cover the abuse of other substances including prescription drugs.

**Psy #15 - Ethics II: 4 CE Credit hours**

This 4 unit course is for those Psychologists who do not require the more extensive 10 unit course.

**Psy #16 - Introduction To Medical Psychology: 10 CE Credit hours**

A basic course in medical psychology for Psychologists. Reading materials focus on the understanding and treatment of diseases and illnesses that Psychologists can treat.

**Psy #17 - Primary Care Psychology: 15 CE Credit hours**

An introduction to how clinical psychology is practiced in a primary care setting. Reasons for integrating psychology into primary care are discussed along with treatment models and the different aspects of practice in a primary care setting.

**Psy #18 - Forensic Practice: 15 CE Credit hours**

An introduction to the practice of forensic psychology for Psychologists who want to expand their services into this area of practice. Topics include psychological evaluations for the court (child custody; competency; insanity), psychological factors in eyewitness testimony, trial consultation, and criminal investigation.

**Psy #19 - Clinical Supervision: 6 CE Credit hours**

Ethically and legally, supervisors are responsible for patient care as well as the training and development of their supervisees. Supervision becomes a balancing act between the needs of the patient population and the needs of the supervisee. This course will help you do your job better and give you skills to rely on in your supervision of interns.

**Psy #20 - Neurology For Psychologists: 15 CE Credit hours**

An introduction to basic neurological practice for Psychologists. It provides participants with a thorough understanding of the structure of the nervous system. Topics include: performing a competent neurological work-up, basic description and components of typical neurological disorders, behavioral neurology, muscle disorders, sensory disorders, and ethical issues in practice.

**Psy #21 - Understanding The Affordable Care Act: 15 CE Credit hours**

This course presents a thorough presentation of the new healthcare reform laws and how both patients and practitioners will be affected as the new rules and regulations are implemented. This is a must course for those wanting to get the most out of these reforms.

**Psy #22 - Entrepreneurship For Psychologists: 10 CE credit hours**

An introductory course for Psychologists who want to expand their knowledge about the opportunities and benefits of becoming an entrepreneur in mental health. With the new Affordable Care Act now law, there are many opportunities for Psychologists if we can learn the concepts and success behind entrepreneurship. This is what has been missing from graduate psychology education.

**Psy #23 - Crisis Management Intervention Consulting: 15 CE credit hours**

This course is designed for clinical Psychologists who want to develop a significant and workable knowledge base to provide crisis management consulting services to municipalities and private organizations. It will also serve the function of providing practitioners with a good knowledge base to understanding crisis management interventions.

**Basic Neuropsychology (10 Contact Hours)**

This course is designed to introduce clinical psychologists to basic neuropsychological evaluation. It provides participants with a substantive understanding of what constitutes a neuropsychological workup. Psychologists who complete this course will learn how to identify important neuropsychological disorders and how to evaluate dysfunction. This course is an introduction to what neuropsychology is but it is not intended to convey or imply certification as a neuropsychologist.

**Interpreting Blood Panels For Psychologists (6 contact Hours)**

Having an understanding about these tests and what they mean is essential to all healthcare providers. This course is designed to provide psychologists with general information to assist in their practices and professional development. The information provided in this course is based on research and consultation with medical and other authorities, and is, to the best of our knowledge,
There is a famous proverb, “He who fails to plan, plans to fail.” It’s easy to notice when a submission (even with the best intentions) has not been planned well or organized. An organized and structured writing piece shows our readers (and editors!) that your arguments are clear, concise and coherent. Hopefully with careful planning and the application of the following tips, a great submission will not be far behind!

Please keep in mind that The Clinical Practitioner is the public face of NAPPP. Internal discussions, squabbles, rants and raves, politics and so on are best submitted to the members’ listserv. Although we entertain political discussions within our ranks only official policy positions will appear in TCP.

We Welcome Member Submissions!
NAPPP is a practice organization. Please keep all submissions to practice issues.

All Submissions regardless of type should be proof read, spell checked, grammar and punctuation checked. Minor editing can be done to prepare a submission for print; However, if more than minor corrections are needed the submission will unfortunately have to be returned.

Technical Considerations
1. Please attach submissions to your email as Word files (.doc), unless you have checked with us about other formats.
2. Use standard fonts. We have found Verdana and Georgia to be the most readable in electronic format.
3. If your submission must have special characters or fonts, please embed these in your document.
4. If your submission includes objects (pictures, graphs, drawings, etc.) these MUST be included as separate files.
5. Please include technical references and links as appropriate.

Letter Submissions
We welcome short submissions which deal with issues such as insurance and billing, reports on published research, reports on conventions attended, the business of practice, interesting solutions to patient problems, and other practice related topics.

1. Please make submissions @50-150 words.
2. The editors will select submissions based on relevance and space needs.

Submissions for feature articles
We will consider feature articles of any length dealing with practice issues, “How To” articles, and any topic directly relating to practice. Please submit your article ideas to editor.theclinicalpractioner@gmail.com

1. A brief statement of topic and short outline of your proposal will allow us to guide you on article development.
2. Articles can be any length. Please have your editor check that every sentence has a purpose and appropriate structure.
3. An Introductory Paragraph introducing your subject and main Idea of your article is a MUST.
4. Supporting Paragraphs that develop the main idea of your topic:
   - Should list the points that develop the main idea of your article
   - Please place each supporting point in its own paragraph
   - Develop each supporting point with facts, details and examples.
5. End with a Summary Paragraph or Conclusion and do this by:
   - Restating the strongest points that support the main idea
   - Conclude by restating the main idea in different words
   - Give a personal opinion or suggest a plan of action.

Keep in mind that readers will only continue as long as they are presented with new information. Do not rehash information or ideas, but do summarize in the final paragraph(s).
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A Board Certification for Clinical Psychologists

ABBHP diplomate status in behavioral healthcare practice recognizes a set of specialty skills within general healthcare. The diplomate recognizes experience and skills in working with behavioral health problems in ways that are coordinated with allopathic medicine. The Specialty of Behavioral Healthcare Practice integrates behavioral health into medical care in diagnosing, treating and providing the necessary monitoring of post-treatment behavioral follow up care.

Board certification by ABBHP is an indication to both patients and providers that you are a specialist in providing behavioral healthcare diagnoses and treatments. Our board certification, the first of its kind, tells the public and your referral sources that you are a specialist and partner in the primary care of patients.

Requirements

The ABBHP board certification is not a vanity board. It was designed by an experienced and influential board to be rigorous and to ensure the public, healthcare providers and the healthcare industry that those who possess this diplomate have achieved a high level of training and experience in providing behavioral healthcare services. Those possessing ABBHP certification are making a statement that they are behavioral healthcare practitioners who work and belong in the healthcare industry. ABBHP diplomates are doctoral level Psychologists who provide much more than psychotherapy services but can provide a wide range of interventions that only a doctoral level Psychologists can. For information on qualifying for board certification, please go to http://www.abbhp.org/

Summary of Requirements

Current and valid license to practice psychology.

Successfully pass an examination.

Complete specific coursework.

Provide a product sample.

Provide letters of recommendation

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**Continuing Education Providers**-

Are you a current continuing education provider or want to be one? Then NIBHQ accreditation of your organization will attract behavioral healthcare professionals to your courses.

Our requirements for CE providers can be obtained at [http://www.nibhq.org/](http://www.nibhq.org/)

NIBHQ
Want to know what Medical Psychology is and how we practice?  
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If you purchase this book you can do both. All revenues from the sale of this book goes to our PsychAdvocacy Fund to help us deliver the message that doctoral level psychological services are valued and needed. We cannot do this without your support.

Book Description  
In 2009, over fifty-two million prescriptions for antipsychotic medications were written, totaling over $14.6 billion in sales. Such is just one small indication of how our current medical system treats its patients with medication as a first-line approach. This is not the answer. There is a growing need for integrated health care systems which include psychological care, particularly those services provided by medical psychologists. Medical psychologists are not physicians, but they do many of the same things that physicians do or should be doing. Medical psychologists are also doing things that clinical psychologists have never done. A medical system which profits from and relies primarily upon medication is not sustainable, especially when these medication-only treatments may be at the least ineffective and, at worst, harmful to patients.  
This reader seeks to define medical psychology's place in this complex and challenging environment.

To purchase the book, click here:  
Nicholas A. Cummings: Psychology's Provocateur

This book is not only a biography of professional psychology's innovator and visionary. It is a book that documents the long history and struggle of professional psychology. Dr. Nicholas Cummings, “Nick” to so many of his friends, has been at the front lines of talking and making the fight for psychologists to be recognized and included in the healthcare system. Nick’s biography is the biography of every psychologist. It is our history and, absent the accomplishments of Nick Cummings, there is no doubt that professional psychology would not exist.

The Cummings Foundation is making copies of the book FREE of charge to TCP readers who would like one for the $5.00 shipping charge, only. If you would like your free copy of the book, email Linda Goddard at l.goddard0@gmail.com and she will arrange to have the book sent to you. A faster way to get your copy is to send a check for $5.00 to:

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Cummings Foundation For Behavioral Health
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Nicholas A. Cummings
Psychology's Provocateur

Carol Shaw Austad, Ph.D
Handbook of Health and Behavior:
Psychological Treatment Strategies for the Nursing Home Patient

BY JOSEPH M. CAJCIAN, PHD

This Handbook of Health and Behavior gives readers a portable and concise reference tool to help nursing home patients better manage and cope with their medical conditions. It places an emphasis on behavioral health principles and approaches, using health and behavior CBT skills, and helps psychologists function within an integrated care model by rotating the profile of behavioral health services in those settings. It can serve as a guide for health care professionals whose older patients face psychological barriers to the treatment of their medical problems.

The Handbook is published by Concept Healthcare, LLC and can be ordered at Amazon, Lulu.com, or take a 30% discount and send and mail this form to orders@coh-health.org.

Joseph M. Cacian, PhD, is the President of Concept Healthcare, LLC. He has a 30-year career in long term care as a psychologist, manager of psychology services, and program developer. He is the co-founder and former executive officer of a national mental health group practicing in senior homes in eight states.

Dr. Cacian is the co-editor of Contemporary Long Term Care: A Practitioner's Guide (Sage, 2006), a former board member of the Council of Professional Cacian Psychology Training Programs, and past President of Psychologists in Long Term Care.

As current company, Concept Healthcare, is the management services organization for professional corporations delivering mental health services to LTC facilities in four states.

In 2014, Concept Healthcare was acquired by another company with the goal of expanding Concept Healthcare’s LTC work into additional states, adding EMR, and other practice Thoms.

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