Success in Practice Means Being Proactive
By John Caccavale, Ph.D., ABMP

For at least two decades, and probably longer, psychology practitioners have been significantly challenged to start, grow, and maintain a successful practice. Whether employed by a corporate or governmental entity or in private practice, for most, it’s been a struggle. There are many reasons why practice is a struggle with most outside of the practitioner’s control. Insurers, budget cuts, APA malfeasance, and a host of other factors have contributed to the decline of private practice and the increased challenges associated with it. However, at some point, just as we ask our patients to take responsibility and control for their lives, practitioners must also look at the ways for us to confront and control our challenges.

The Challenges From Master Level Practice Is An Opportunity
Clearly, APA’s latest attempts to derail doctoral level practice are problematic. Both patients and professional psychology would be better served if APA would have adopted and fought for master level practitioners to provide services under the supervision of doctoral level practitioners. Just as physicians and patients have gained utilizing physician assistants, the same benefits would translate into psychology practice. APA, however, has decided upon a course that not only harms professional psychology practice but also denies patients the benefits from quality, doctoral level practitioners.

That being said, practitioners have little to no control over APA aside from denying them their dues and support. What we do have control over is being proactive to provide patients with the undeniable benefits that can only be provided by experienced and highly trained doctoral level practitioners. From a marketing perspective, psychology practice differs only slightly from highlighting the superiority of one product from another within an environment where consumers have many choices. Since APA really never put sufficient resources into marketing doctoral level practice, we are all paying the price for their lack of commitment. Nevertheless, there still is time for practitioners to provide consumers with the important differences and benefits of being treated by doctoral level practitioners. In fact, there is ample evidence that patients prefer treatment by doctoral level providers.

Register Now!
March 22-24, San Antonio Texas
The NAPPP continuing education conference:
Traditional and Innovative Practice Methods and Treatments
https://nappp.org/registration.html
Post Doctoral Expertise: Distinguishing Masters From Doctoral Level Practitioners

The one factor that practitioners have distinguishing their expertise from others is the ability to demonstrate post doctoral expertise. Walk into any physician, dentist, and even chiropractor office and the most notable wall feature are certificates detailing their board certifications and other recognitions of their expertise. These practitioners know that every plaque residing on their walls are there for the eyes of their patients. Board certifications really speak to patients. They build confidence and trust.

In a world devoid of competition, there is little need to demonstrate additional expertise beyond the doctorate. The present environment in which practitioners must compete demands that practitioners utilize post doctoral expertise to demonstrate the major difference between doctoral and master level providers. As APA moves towards their master plan, providing consumers with well-defined and spelled out post doctoral expertise is more important than ever. In fact, board certification provides doctoral level practitioners tangible evidence to consumers that their provider, you, are more qualified than a counselor or master level psychologist.

Considering that APA and others have devoted time and energy promoting the myth to consumers that there is little to no difference between services provided by master or doctoral level practitioners, we either become proactive in overcoming that challenge or meld into the bland title, "psychotherapist.” Yes, it takes a commitment and some money to acquire board certification. But, it is well worth the effort particularly when expertise is a real marketable commodity. Practitioners must start to think in marketing terms. Moreover, board certified practitioners have been successful in getting third parties to recognize post doctoral expertise with increased reimbursements.

NAPPP and The Academy of Medical Psychology

Recognizing the importance of board certifications to demonstrate expertise, both NAPPP and AMP have developed several effective and low cost programs for practitioners to acquire certifications. AMP, established in 1998, has provided psychologists the means to acquire board certification in medical psychology. NAPPP, since 2006, has provided psychologists the opportunity to get board certified in behavioral health practice and earn a professional certificate in primary care psychology and gerontology. In 2016, NAPPP and AMP established a unique partnership where psychologists can acquire board certification in clinical psychopharmacology and medical psychology at a cost lower than any program of its type. Information about these programs can be found on the NAPPP website at https://nappp.org/ and on the AMP website at http://amphome.org/.

National Institute for Behavioral Health Quality

In 2009, NAPPP collaborated with the National Institute for Behavioral Health Quality, http://nibhq.org/ to develop programs to certify practices as opposed to practitioners. These programs are similar and based upon the same recognition programs typically found in physician...
Success means proactive offices. These certification programs are designed for psychology practices to demonstrate to insurers and consumers that their practices conform to the highest level of behavioral health quality. Physicians have long known the marketing value of having this type of certification.

NAPPP and AMP Training in San Antonio

One of the founding principles of NAPPP is our commitment to provide practitioners with free continuing education with NAPPP membership. We offer 26 CE online programs and on January 2, 2019, we will be adding five new courses to our free offerings. Lastly, NAPPP and AMP jointly present live training opportunities at our CE training meetings. This year we will return to San Antonio, Texas on March 22nd through 24th, 2019. Our program brings to practitioners training in timely clinical issues including practice related marketing know how and strategies. Attendees will earn 18 CEUs for the three day meeting. The cost for our program remains significantly low for programs of this type in keeping with NAPPP’s commitment to practitioners.

The program and information relating to registration and hotel reservations can be accessed at https://nappp.org/program1.pdf

Note: The conference convenes at 8:00 A.M. Friday the 22nd.

We invite psychologists to become proactive now in getting ahead of the challenges that APA’s master policy and plan will place on psychology practice. Take a look at what NAPPP, AMP and NIBHQ have to offer you and your practice.

WE’RE GETTING A NEW WEBSITE

The NAPPP website has been redesigned and will soon be ready to go online as soon as we complete the testing to ensure everything is working.

The new website will be easier to navigate and up-to-date with current standards. The new look is pleasing and very functional. It will also work on any device including desktops, tablets and phones.

As is always the case with redesigns, there may be some glitches when we go online. However, if we missed anything, please let us know.

The public version of the website will go online followed by the Member Only site. We believe that the new site will better serve our members and the public. We look forward to hearing from you when the transition is completed.
The National Alliance Of Professional Psychology Providers and The Academy of Medical Psychology Present a Three Day CE Conference March 22nd to 24th, 2019

Theme: Psychological Methods: Traditional and Innovative Treatments

Hotel Room Reservation
Attendees will receive the conference discounted room rate from Drury's. The conference room rate for is $159.00. To guarantee the above room rates, attendees can register online or call the hotel toll free at 1-800-325-0720 and refer to the code 2350867. There is limited room availability at these prices so please make your reservations as early as possible. You can also make a reservation at http://nappp.org/hotel.html Under reservation, click group reservation and use the 2350867 Group code.

Drury Plaza Hotel-River Walk. Formerly the Alamo National Bank Building, this 24-story skyscraper was renovated to maintain its historical character while creating modern comfort. The Drury Plaza creates the perfect ambiance for your stay and sits on the beautiful banks of the San Antonio River Walk.

Conference Registration: http://www.nappp.org/registration.html

Meeting Chair: Sharna Wood, Ph.D.

Registered participants are eligible for 18 CE credit hours for attending all three days.

The National Alliance of Professional Psychology Providers is approved by the American Psychological Association to sponsor continuing education for psychologists. The National Alliance of Professional Psychology Providers maintains responsibility for the programs and its content.
PRESENTATIONS

John Caccavale, Ph.D., ABMP  “Clinical Practice Is Not Dead Yet “
Ward Lawson, Ph.D., ABPP, ABMP  “Contextual and Lifestyle Factors in Medical Psychology”
Roger Morgan, Ph.D., M.D.  “Culture Counseling Considerations in the Hispanic Population”
Jerry Morris, Psy.D., ABPP, ABMP  “Pain Control and Related Problems: Medical and Practitioner Opportunities”
Keith Petrosky, Ph.D., ABMP  “Analog Thinking in Advancing Our Knowledge of Mental Health”
David Reinhardt, Ph.D., ABMP  “Mental Health Effects of Endocrine Dysfunction: Symptoms, Assessment and Treatment Strategies”
Howard S. Rubin, Ph.D., ABMP  “Medical Cannabis: Guidance for Clinicians”

WORKSHOPS

Lendell W. Braud, Ph.D.  “Relaxation, Imagery & Art – Effective Interventions for Trauma, Behavioral and Emotional Problems”
David Clayman, Ph.D.  “Methods and Knowledge for Innovative Service Delivery”
Karyn Hall, Ph.D.  “Radically Open-Dialectical Behaviour Therapy”
Larry Waldman, Ph.D., ABPP  “Ethical, Effective and Efficient Private Practice Marketing”

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**PRESENTERS**

**Lendell W. Braud, Ph.D.**
Dr. Braud is a licensed psychologist. Dr. Braud was a professor of psychology at Texas Southern University for 42 years. Dr. Braud has worked with abused and delinquent children in Residential Treatment Centers and Group Homes for 25 years. She has been involved in clinical practice and research in the area of trauma therapy, relaxation therapy, and learning disabilities to develop programs and materials that are effective in helping children and teens with a variety of problems and issues. In her clinical practice she has helped children with emotional, behavioral, and learning problems. Currently, she is the Clinical Director of Glacier Hope Homes using her Trauma Therapy with Veterans with PTSD. She is conducting an extensive research study to investigate the effectiveness of a unique therapy program that focuses on trauma, substance abuse, and mental health issues.

**John Caccavale, Ph.D., MSCP, ABMP**
Dr. Caccavale is a California licensed clinical an neuropsychologist and is the executive director of NAPPP. He is a diplomate of the American Board of Medical Psychology. Dr. Caccavale is a long time advocate for the advancement of clinical and medical psychology and its inclusion into primary behavioral healthcare. Dr. Caccavale serves on a number of professional boards including the National Institute of Behavioral Health Quality, the American Board of Behavioral Health Practice, the Lifestyle Medicine Foundation, and the Cummings Institute for Behavioral Health Studies. He has published numerous articles, book chapters and book reviews on a wide array of subjects. His book, “Medical Psychology Practice and Policy Perspectives,” was published in 2013. In recent years, he has confined his writings to the current issues facing the profession. Dr. Caccavale is the 2011 recipient of the Cummings Foundation PSYCHE Award.

**David A. Clayman, Ph.D.**
A 1970 graduate of Trinity College in Hartford, CT, Dr. Clayman received his Ph.D. in Clinical Psychology from the University of Vermont where he specialized in Medical Psychology. In the fall of 1974, he joined the faculty at the West Virginia University School of Medicine in the Department of Behavioral Medicine and Psychiatry, where he served as the Coordinator of the Consultation/Liaison Service. Also, he provided outpatient psychotherapy, and supervised interns and residents with his emphasis on a true bio-psycho-social perspective in dealing with medical problems and health service delivery issues. During this time, he helped found the Society of Behavioral Medicine and Society of Health Psychology (Division 38) of APA. After eight years, he left academia to establish a private practice that eventually grew to over 30 therapists.. Over the past 20 years his practice has evolved into forensic practice covering a wide array of civil and criminal issues demanding the breadth of knowledge that he sees as requisite to being a Clinical Psychologist. No longer in active clinical practice, he provides pro bono services to law enforcement, first responders and military service personnel.

**Dr. Karyn Hall, Ph.D.**
Dr. Hall is the director and founder of the Dialectical Behavior Therapy Center in Houston, Texas and the founder of DBTSkillsCoaching.com. Certified by the DBT-Linehan Board of Certification, she is a psychologist and DBT trainer. She is on the Advisory Board for NAMI Houston and a founder of Healing Hearts of Families, an annual NEA BPD conference held in Houston. Dr. Hall has trained therapists nationally in Dialectical Behavior Therapy. Dr. Hall blogs for Psychology Today and PsychCentral and is the author of Mindfulness Exercises for DBT Therapists, SAVVY, and The Emotionally Sensitive Person. She is the co-author of The Power of Validation. In her practice, she specializes in treatment resistant depression, borderline personality disorder, and trauma. She is working with Dr. Carla Sharp on a research study about emotional sensitivity.
Presenters

Ward Lawson, Ph.D., ABMP, ABPP
Ward M. Lawson, PhD, ABPP, ABMP, has been licensed as a psychologist in Missouri for 22 years. He has completed post-doctoral fellowships in neuropsychology and forensic psychology and has ABPP status in Family Psychology. He is certified by the American Psychological Association’s (APA) College of Professional Psychology in the Treatment of Alcohol and Other Psychoactive Substance Use Disorders. He is Past President of the Academy of Medical Psychology and is board certified in Medical Psychology. He has taught neuropsychology at Forest Institute of Professional Psychology in Springfield Missouri, has presented at state and national conferences, and has published in The Archives of Medical Psychology, The Clinical Practitioner, Alcoholism Quarterly, and Acta Psychological. Dr. Lawson owns Tri-County Psychological Services, Inc., consisting of psychologists and licensed clinical social workers and counselors, providing mental health services in rural southwest Missouri. Day Care.

Roger Morgan, Ph.D., MD
Dr. Morgan is both a psychiatrist and a psychologist. He is licensed in Tennessee and Arkansas as a clinical psychologist. In addition to his psychology practice, Dr Morgan also is licensed in the country of Mexico as a Medical Doctor with a specialty in psychiatry. Dr Morgan completed his psychiatry residency in Mexico at the general hospital in Mazatlan, Mexico. Dr Morgan currently divides his practice time between Mexico and the United States. He is fluent in the Spanish language and culture. He is also, currently the staff psychologist and Chairman of the Ethics Committee at Crittenden Regional Hospital in West Memphis Arkansas where he has been on staff since 1997, and Chairman of the Ethics Committee for the past 5 years.

Jerry Morris, Psy.D., ABPP, ABMP
Dr. Morris has a doctorate in clinical psychology, MBA in Management, Master’s Degree in Psychopharmacology and is board certified in Medical, Family, School, Case Management, and Behavioral Health. He is the Executive Director of the Academy of Medical Psychology and the American Board of Medical Psychology and the Clinical Director of CMHC, Inc. (www.cmhconline.com) a psychologist owned and managed nationally certified comprehensive community mental health center. He is a former state psychological association president, served 8 years on his state psychological association board, has served on the APA Council of Representatives and on the Rural and Finance Committees of the APA, and as the Hospital and Healthcare Committee Chair for 11 year of the largest clinical division in the APA. He has owned and developed psychiatric hospitals and mental health and substance abuse programs, is on the Board of NAPPP, and has published journal articles, edited books, and book chapters. He is on several hospital medical staffs and is the Chief Psychologist for a medical and multiple primary care clinic system.

Robert North, Ph.D., MD
Dr. Robert North completed his doctoral degree in Psychology and Human Development from George Peabody College of Vanderbilt University in 1980. He completed postdoctoral training in medical psychology from The Psychopharmacology Institute in 2000. In 2004, he completed a doctor of medicine degree (M.D.) from The International University of Health Sciences in St. Kitts, a British Commonwealth WHO-approved medical school. He is approved to sit for the U.S. medical boards. Dr. North has been involved with the psychology prescription privilege movement since helping introduce legislation in 1998 (and many times since) in Tennessee and has served on TPA, APA, and various National committees and organizations toward this endeavor, including presenting to legislative hearings to explain and promote passage of bills. Dr. North has been in private since 1985 and owns a large group geropsychology practice, Medical Psychology Consultants, LLC that presently provides services in 48 intermediate care facilities in Tennessee and Kentucky.

Keith Petrosky, Ph.D. ABMP
Dr. Petrosky received his PHD from Temple University. For more than 25 years he has been in full time private practice in the Main Line Philadelphia suburb of Exton, seeing adults, children, couples, and
David Reinhardt, Ph.D., ABMP
Dr. Reinhardt is the managing editor of NAPPP’s newsletter, The Clinical Practitioner. He is Board certified in Medical Psychology and has degrees in Engineering and Holistic Health as well as his Ph.D. in Clinical Psychology and a post-doctoral Masters of Psychopharmacology from Alliant/CSCP. Dr. Reinhardt is a research scientist, with extensive research on nutrients in mental health and mental health symptoms in physical disorders. In addition to his NAPPP affiliations, he holds memberships in the International Society of Orthomolecular Medicine, the Orthomolecular Health-Medicine Society, the American Society of Clinical Hypnosis, and the Institute of Functional Medicine. Dr. Reinhardt is founder and Director of the Center for Health Science, a holistic health clinic, and Mental Health and Wellness Center, a behavioral healthcare center in Long Beach, California. Dr. Reinhardt also serves on the NAPPP Executive Board.

Howard S. Rubin, Ph.D., ABMP
Dr. Rubin is a Board Certified Medical Psychologist. Dr. Rubin is the founder and Managing Member of Healthcare Options for Patients Enterprises LLC, A Nevada Cannabis Cultivation and Product Development Company. He is an Advisor to Sababa, a Cannabis Research and Development Company, Tel Aviv, Israel. Dr. Rubin is also the Chief Executive Officer of The Museum Center Surgery Group Inc., Managing Member of National Stand Up Imaging LLC, Los Angeles, CA. Dr. Rubin is the Research Director for the Los Angeles Stem Cell Institute at the Miracle Mile Outpatient Surgery Center, Los Angeles, CA. Dr. Rubin also serves on the NAPPP Executive Board.

Cheri Surloff PhD., Psy.D
Dr. Surloff is a Neuropsychologist and a Medical Psychologist. She has over 25 years experience working with traumatic brain injury, spinal cord injury and all areas of physical and psychological injury. She was a Board Member of the Florida Brain Injury Association for seven years and is on the Medical Board of the Florida Brain Tumor Association for over 20 years. She has taught for over 20 years each semester at Florida Atlantic University teaching Neuroscience and Psychopharmacology. Dr. Surloff has Post-Doctoral Masters in Psychopharmacology and passed the national exam for Prescriptive Authority. She was the Director of Neuropsychology at the Memorial Healthcare System for over 15 years. She is on staff at all the Memorial Hospitals, Aventura and Jackson Health Systems. She was on the trauma team at Memorial Regional for over 20 years with daily experience in all forms of trauma. Her service was lauded by the state Brain and Spinal Cord Association and she has reviewed every Level I Trauma Center for the state.

Larry Waldman, Ph.D., ABPP
Dr. Waldman is a licensed clinical, school, forensic psychologist in Phoenix, Arizona who conducted a highly successful private practice for 40+ years. He earned his Ph.D. in Educational/School Psychology from Arizona State University, and his Diplomate (ABPP) was received in 2003. Dr. Waldman was the past president of the Maricopa Psychological Society; the Director of Psychological Services for Charter Glendale Psychiatric Hospital from 1988 to 2000; and an Official Guide on Parenting for SelfGrowth.com. He is a Medical Consultant for the Social Security Administration; an adjunct graduate professor in the counseling and school psychology departments for Ottawa University; serves on the professional board of...
**Presenters**

Stepping Stones of Hope, a charitable social service organization; and is the co-chair of the Early Career Psychologists Committee of the Arizona Psychological Association (AZPA). Dr. Waldman has written numerous articles which have been published in the local Phoenix media and in the national press, and six books. He speaks to the public, corporations, attorneys, chiropractors, and fellow mental health professionals.

**Sharna Wood, Ph.D.**

Dr. Wood is the current program chair for NAPPP and the San Antonio meeting. She is a tireless psychologist and has worked in public hospital, clinic and private practice settings for over 10 years. She is on the executive board for a geriatric psychiatric hospital group in east Texas, operates two physical locations and conducts specialized evaluations all over Texas. She has worked closely with several test publishers in gathering data for new and improving older test instruments such as the WAIS-IV, WMS-IV and NEPSY2. She was also a finalist for the National Academy of Neuropsychology Outstanding Dissertation Award for her research in geriatric neuropsychology. Dr. Wood is an associate editor of The Clinical Practitioner and a member of the advisory board of NAPPP.
I left the APA decades ago when I realized that as a clinician the APA was not my friend and certainly was not worth the expense to remain a member. I joined NAPPP as soon as I could. Nevertheless, the APA still plagues me.

For more than a quarter century I have presented workshops across the country to mental health associations on how to develop, manage and market a thriving, cash-pay private practice. I did it quite successfully for 45 years in Phoenix, studied the topic, learned a few things, wrote a book on the subject and desired to share my knowledge and experience with other mental health practitioners—especially with my fellow psychologists. Interestingly, though, I find my best customers are marriage and family therapist (MFT) and counseling associations. While I have presented to a number of psychological associations over the years, the primary reason I hear why most psychological associations choose not to hire me is because they believe the APA will not approve CE credits for the program. The powers that be that oversee MFT and counseling apparently have no problem with their membership learning how to effectively run a private practice and make a decent living doing it. Our APA, on the other hand, apparently wants psychologists to practice ethically and competently—and be poor.

Curiously, some state and local psychological associations have no problems with this issue. It seems random to me but it seemingly depends on the nature of the relationship that association has with their APA representative. What is particularly vexing, though, is that while the APA essentially prevents most state associations from sponsoring practice development workshops, the APA itself sells those very programs on their website and offers CE’s as well! I fail to comprehend why the topic of private practice management remains taboo.

I enabled every psychological association that wished to work with me obtain CE accreditation. The necessary topics, lingo and buzzwords for certification are well known to me, but many state associations, fearing their “parent,” don’t take it that far. The APA, thus, continues to treat practitioners like second-class citizens-- which only reaffirms why I left years ago.
I have learned a great deal about herbal medications from reading the many articles by Dave Reinhardt, our TCP editor and resident-expert herbalist. I thought I would share my personal experiences with Ashwaghanda, which I have found to be very helpful for issues with sleep and anxiety.

Ashwaghanda is an Ayurvedic botanical medicine. Ayurvedic medicine has been practiced in India for more than six thousand years. In Sanskrit, Ayurveda means the “science of life and longevity.” The Ayurvedic approach treats the person, not just the disease. It is based on the premise that health is a state of balance among the body’s systems. Illness is seen as a state of imbalance.

The scientific name for Ashwaghanda is Withania Somnifera. It is also known by the common name Winter Cherry. From the root of the name “somnifera,” one realizes that it has something to do with sleep. I have a few patients who have emigrated to this country from India and they seem to all be aware of this botanical and many of them use it on a daily basis. In addition to seeing Western medicine physicians, they consult Indian herbalists at times for their health.

I began recommending this herbal medicine because many of my patients complain of sleep problems and anxiety. Many of them are extremely stressed out and others suffer from lifelong, severe anxiety, which affects their sleep. When I began using Ashwaghanda I did not know how my patients would respond. I was pleased to find that no one reported any negative side effects.

As to therapeutic effects, I found out that almost everyone who tried this botanical reported some improvement in their sleep. As they continued to take it each day their anxiety also decreased. There were a number of people whose positive benefits serve to motivate others in their family to try Ashwaghanda as well. Those that tried it reported similarly positive benefits.

Based on these positive reports, I decided to order some Ashwaghanda to test it on myself for any benefits. I am a person who is naturally anxious but who has learned to control his anxiety. In some testimonial to the success of this effort one of my former patients used to like to refer to me as the “human tranquilizer.”

In terms of my sleep patterns I always felt that I slept adequately although I was often still tired in the morning. I thought this was my natural state and a cup of coffee or two seemed to overcome this tired feeling. Occasionally I would wake up in the middle of the night if I had some “unfinished business,” some “loose ends” that I needed to attend to the next day that would pop up in my subconscious mind during sleep. Normally I would fall back to sleep without too much effort and continue sleeping until it was time to wake up.

However, upon awakening I never felt particularly good. I was often a little stiff with minor aches and pains. I have been involved in two major car accidents where I was hit by drunk drivers (once in the front passenger seat and once while driving). Because of these issues I would normally need to stretch and twist my back a little to obtain a reasonable vertebral alignment before getting out of bed. I got used to this over time and just felt this was my “normal” state of affairs.

Upon trying my first dose of Ashwaghanda I was pleased to note that I did not experience any side effects. After using Ashwaghanda for about a week or so I noticed that for the first time in many years that when I woke up in the morning I actually felt “good.” Since I was used to needing more sleep in the morning I thought about going back to sleep at first but quickly recognized that if I felt good there was really no reason not to just get up.

A few weeks later I noticed a second improvement which was that I was not stiff in the morning and was able to toss my legs over the side of the bed and just “spring” out of bed. Aches and pains that I had been bothered by seemed to go away. There was no need for stretching before getting up.

A third improvement was that my baseline level of calmness seemed to deepen. When doing therapy with a particularly difficult person or a working with...
an angry couple I was more calm than usual. When driving, if someone drifted into my lane of traffic (typically while texting), I was less bothered and was able to extinguish the brief flash of anxiety quicker.

The above improvements continued. I did have a somewhat ironic concern that perhaps I was becoming “too” calm and relaxed. It was as if I wondered whether I would respond with the necessary adrenaline if I happened to be in a real emergency. (I had a similar feeling a long time ago when I had experimented with taking calcium and magnesium supplements and vitamin B after reading Carl Pfeiffer’s book on “Mental and Elemental Nutrients”).

It turned out that this worry was accidentally bypassed when I got sick with bronchitis and had to take some medications. At the time I felt that I should eliminate anything else my body was metabolizing and that meant stopping Ashwaghanda. Two antibiotics later, I finally turned a corner and began to kick this illness. I have been off of Ashwaghanda for about six weeks now but I continue to feel its positive benefits. I plan to resume this botanical if at some point I start missing my deep, restful sleep.

It is important to note that one of the advantages of using an herbal medication versus a drug is that if the herbal is stopped for any reason there is no rebound effect as you would have with a drug. If you stop a benzodiazepine abruptly you get the opposite of a relaxation effect- intense anxiety. However, I felt no such rebound when I stopped Ashwaghanda.

Ashwaghanda is felt to act on the H-P-A Axis to soothe the body’s response to stress. It calms the overtaxed adrenaline response. It is also thought to help one’s immune system. Since I am not aware of any pain-relieving properties of Ashwaghanda I have to assume that my decrease in stiffness and discomfort in the morning had to do with an improved quality of sleep.

Every person should ideally enjoy two to three periods of prolonged, deep, restorative sleep per night. Ashwaghanda may help you to sleep longer in deep, restorative sleep for longer periods of time. People who are anxious or stressed can descend into deep sleep but they tend to bounce out of it after relatively brief amounts of time. They spend the majority of the time in light sleep which does not really rejuvenate someone.

Restorative sleep is supposed to allow your body to remove toxic chemicals to restore and maintain one’s overall health. From personal experience I believe it does this. By calming down the H-P-A Axis its benefits seem to extend beyond what is accomplished by symptom reducing psychotropic medication, which only lasts until the particular drug is completely metabolized from your system.

From speaking with Dave I recognize the importance of obtaining herbals from sources that one can count on for purity and freshness. While other suppliers may sell a particular product with the herbal included among other ingredients, these other items and fillers detract from the potency of the herbal you are using. The Ashwaghanda that I recommend and have used myself is one hundred percent pure with no additives or fillers. When you open the bottle there is a very pleasant but potent smell that attests to its quality. As a set rule, I always consult with Dave first before selecting a particular brand of herbal.

In summary, I invite other practitioners to use herbal medications in their practices. There are many articles about herbals that Dave has posted on our TCP website. You can always look at some of the back issues of TCP if you missed something.

You may direct your comments to drkeith1@verizon.net

References
Guidelines for the evaluation and treatment of perimenopausal depression: summary and recommendations

An expert panel was convened to systematically review the published literature and develop guidelines on the evaluation and management of perimenopausal depression. The areas addressed included: 1) epidemiology; 2) clinical presentation; 3) therapeutic effects of antidepressants; 4) effects of hormone therapy; and 5) efficacy of other therapies (eg, psychotherapy, exercise, and natural health products).

Overall, evidence generally suggests that most midlife women who experience a major depressive episode during the perimenopause have experienced a prior episode of depression. Midlife depression presents with classic depressive symptoms commonly in combination with menopause symptoms (ie, vasomotor symptoms, sleep disturbance), and psychosocial challenges. Menopause symptoms complicate, co-occur, and overlap with the presentation of depression. Diagnosis involves identification of menopausal stage, assessment of co-occurring psychiatric and menopause symptoms, appreciation of the psychosocial factors common in midlife, differential diagnoses, and the use of validated screening instruments.

Proven therapeutic options for depression (ie, antidepressants, psychotherapy) are the frontline treatments for perimenopausal depression. Although estrogen therapy is not approved to treat perimenopausal depression, there is evidence that it has antidepressant effects in perimenopausal women, particularly those with concomitant vasomotor symptoms. Data on estrogen plus progestin are sparse and inconclusive.


Ed: In a recent commentary on these “Consensus Guidelines” in Medscape Psychiatry, “Managing Depression in Perimenopausal Women” by Andrew M. Kaunitz, MD, found: “I want to acknowledge that hormone therapy is not US Food and Drug Administration–approved for the treatment of mood disorders. Nonetheless, clinicians treating perimenopausal women with depression which is not responding to conventional antidepressant therapy should consider either prescribing hormone therapy or referring the patient to a clinician who is knowledgeable in doing so.”

Dr. Kaunitz recommends prescribing “anti”depressants prior to addressing the CAUSE with estrogen therapy.

Risks of Benzodiazepines in Chronic Obstructive Pulmonary Disease with Comorbid Posttraumatic Stress Disorder

Benzodiazepines are associated with mortality and poor outcomes among patients with chronic obstructive pulmonary disease (COPD), but use of benzodiazepines for dyspnea among patients with end-stage disease may confound this relationship. To assess the mortality risks of long-term benzodiazepine exposure among patients with COPD and comorbid posttraumatic stress disorder (PTSD), patients with chronic non-respiratory indications for benzodiazepines we identified all patients with COPD and PTSD within the Veteran’s Health Administration between 2010-12. We calculated propensity scores for benzodiazepine use, and compared overall and cause specific mortality of patients with long-term (=90 days) benzodiazepine use relative to matched patients without use. Secondary analyses assessed propensity-adjusted survival by characteristics of benzodiazepine exposure.

Among 44,555 eligible patients with COPD and PTSD, 23.6% received benzodiazepines long-term. In the matched sample of 19,552 patients, we observed no mortality difference (HR for long-term use 1.06, 95%CI 0.95-1.18), but greater risk of death by suicide among those with long-term use (HR 2.33, 95%CI 1.14-4.79).

Conclusions: Among matched and unmatched patients, short-term benzodiazepine use was associated with increased mortality.

Annals of the American Thoracic Society, 2018; DOI: 10.1513/AnnalsATS.201802-145OC

Prenatal fluoride exposure and attention deficit hyperactivity disorder (ADHD) symptoms in children at 6–12 years of age in Mexico City

Highlights
- We measured urinary fluoride in 213 pregnant women living in Mexico City who were part of the ELEMENT pregnancy cohort study.
- Higher concentration of maternal urinary fluoride
was associated with more ADHD-like symptoms in school-age children.

• Prenatal exposure to fluoride was most strongly associated with behavioral ratings of inattention, but not hyperactivity and impulse control.

• Findings are consistent with the growing body of evidence suggesting neurotoxicity of early-life exposure to fluoride.

Epidemiologic and animal-based studies have raised concern over the potential impact of fluoride exposure on neurobehavioral development as manifested by lower IQ and deficits in attention.

We aimed to examine the association between prenatal fluoride exposure and symptoms associated with attention-deficit/hyperactivity disorder (ADHD).

213 Mexican mother-children pairs of the Early Life Exposures to Environmental Toxicants (ELEMENT) birth cohort study had available maternal urinary samples during pregnancy and child assessments of ADHD-like behaviors at age 6–12. We measured urinary fluoride levels adjusted for creatinine (MUFcr) in spot urine samples collected during pregnancy. The Conners’ Rating Scales-Revised (CRS-R) was completed by mothers, and the Conners’ Continuous Performance Test (CPT-II) was administered to the children.

Mean MUFcr was 0.85 mg/L (SD=0.33) and the Interquartile Range (IQR) was 0.46mg/L. In multivariable adjusted models using gamma regression, a 0.5mg/L higher MUFcr (approximately one IQR higher) corresponded with significantly higher scores on the CRS-R for DSM-IV Inattention (2.84 points, 95% CI: 0.84, 4.84) and DSM-IV ADHD Total Index (2.38 points, 95% CI: 0.42, 4.34), as well as the following symptom scales: Cognitive Problems and Inattention (2.54 points, 95% CI: 0.44, 4.63) and ADHD Index (2.47 points; 95% CI: 0.43, 4.50). The shape of the associations suggested a possible ceiling effect of the exposure. No significant associations were found with outcomes on the CPT-II or on symptom scales assessing hyperactivity.

Conclusions: Higher levels of fluoride exposure during pregnancy were associated with global measures of ADHD and more symptoms of inattention as measured by the CRS-R in the offspring.
Public health approaches for global dental caries reduction that do not involve systemic ingestion of fluoride are urgently needed.


Ed: Fluoride displaces calcium ions on the surface of tooth enamel, making the enamel harder and more resistant to acids. A case can be made for topical fluoride treatments and toothpaste, however generalizing this approach to adding fluoride to drinking water seems questionable.

A Cochrane study in 2015 found “We did not identify any evidence, meeting the review's inclusion criteria, to determine the effectiveness of water fluoridation for preventing caries in adults.”

An unanswered question: Does hardening (and increasing brittleness) of your skeletal system through ingestion of excess fluoride increase risk of fractures?

Aspirin alone a good clot buster after knee surgery

When it comes to preventing blood clots after a knee replacement, good old aspirin may be just as effective as newer, more expensive drugs.

That swap could help reduce the cost of caring for the nearly 1 million Americans who have a knee fixed each year, Michigan Medicine researchers say.

After knee surgery, there’s a risk of blood clots in the legs or lungs. So it’s routine for patients to take clot-preventing drugs for some time afterward.

Some doctors choose powerful anti-clotting drugs like heparin (Lovenox) and rivaroxaban (Xarelto), but it hasn’t been clear whether these expensive prescription drugs work any better than cheap, readily available aspirin.

Science Daily October 23, 2018

Positive Topline Results for Novel Alzheimer’s Drug

A novel drug is showing promise for helping improve cognition in patients with mild to moderate Alzheimer’s disease (AD), according to new topline results.

A phase 3 trial of more than 800 patients showed that those who were randomly assigned to receive oral GV-971 (Green Valley Pharmaceutical Co, China) met the primary endpoint of significant change from baseline to week 36 on the 12-item cognitive subscale of the Alzheimer’s Disease Assessment Scale (ADAS-Cog 12) compared with those who received placebo.

“GV-971 is a novel, marine-derived oligosaccharide, which has multi-targeting mechanisms, including inhibition of amyloid-β fibril formation, neuroinflammation, and recondition of dysbiosis of gut microbiota,” Meiyu Geng, PhD, Shanghai Institute of Materia Medica, Chinese Academy of Sciences, said in a news release from the manufacturer.

“We are encouraged by our findings from this phase 3 clinical trial,” added Geng.

The topline results were released at the 11th Clinical Trials on Alzheimer’s Disease Conference in Barcelona, Spain.

Medscape psychiatry October 25, 2018

Ed: Not so much “novel” or a “drug.” GV-971 is a naturally occurring oligosaccharide. Oligosaccharides are carbohydrates which have 3-10 simple sugars linked together. They are found naturally in many plants. Plants with large amounts of oligosaccharides include chicory root, from which most commercial inulin is extracted, and Jerusalem artichokes. They are also found in onions, leeks and garlic, legumes, wheat, asparagus, jicama, and other plant foods.

Oligosaccharides were the first group of “prebiotics” promoted by “alternative” healthcare providers (and are finally just being recognized by doctors of medicines) as helpful for their protective value from colon cancer, ulcerative colitis, improved immune function, improved insulin sensitivity and lowering of triglycerides.

This “wonder drug” works, and by extension this study verifies the importance of natural substances with benefits “including inhibition of amyloid-β fibril formation, neuroinflammation, and recondition of
dysbiosis of gut microbiota.” It further supports the hypothesis that loosening of the gut tight junctions by exposure to many chemical preservatives, colorings, “conditioners” and other food adulterants is reflected by a loosening of the tight junctions of the blood-brain barrier and subsequent brain inflammation, where incomplete sequestering of invaders (by locking them in plaques) results in dementia.

A Multi-Center Study on Human Brain Glutathione Conformation using Magnetic Resonance Spectroscopy

In a breakthrough human study, anti-oxidant, glutathione (GSH), which protects the brain from stress, has been found to be significantly depleted in Alzheimer’s patients compared to normal subjects. As GSH is a very important anti-oxidant that protects the brain from free radicals, the findings give us another measure to use when diagnosing potential for the advancement of Alzheimer’s disease or recognizing those that are in the throes of Alzheimer’s advancement.

“If routine non-invasive tests for lower levels of GSH in the hippocampus regions are performed, we might be able to mitigate the advancement of Alzheimer’s disease by providing GSH supplements- A observational study is planned” Dr. Mandal said.


Ed: Glutathione is a small protein made from three amino acids: glycine, cysteine, and glutamic acid. What a great idea, recommending an inexpensive over-the-counter nutritional supplement, but only after an assessment finding cognitive impairment (irreversible damage already done), and an MRI scan.

“Glutathione is a substance produced naturally by the liver. It is also found in fruits, vegetables, and meats. People take glutathione by mouth for treating cataracts and glaucoma, preventing aging, treating or preventing alcoholism, asthma, cancer, heart disease (atherosclerosis and high cholesterol), hepatitis, liver disease, diseases that weaken the body’s defense system (including AIDS and chronic fatigue syndrome), memory loss, Alzheimer’s disease, osteoarthritis, and Parkinson’s disease. Glutathione is also used for maintaining the body’s defense system (immune system) and fighting metal and drug poisoning.” (WebMD)

“Recent evidence shows that children diagnosed with an ASD have lower levels of plasma reduced glutathione (generally 20–40% lower) than typically developing children and their levels of oxidized glutathione are higher than typically developing children.” (Med Sci Monit. 2011; 17(12): CR677–CR682.)

Glutathione is available as an oral supplement, a transdermal cream, and by injection. It is poorly absorbed orally due to it being the substrate of proteases (peptidases) of the alimentary canal, and due to the absence of a specific carrier of glutathione at the level of cell membrane.

“Because direct supplementation of glutathione is not always successful, supply of the raw nutritional materials used to generate GSH, such as cysteine and glycine, may be more effective at increasing glutathione levels. Other antioxidants such as ascorbic acid (vitamin C) may also work synergistically with glutathione, preventing depletion of either. The glutathione-ascorbate cycle, which works to detoxify hydrogen peroxide (H2O2), is one very specific example of this phenomenon. Additionally, compounds such as N-acetylcyesteine (NAC) and alpha lipoic acid (ALA) are both capable of helping to regenerate glutathione levels. NAC in particular is commonly used to treat overdose of acetaminophen, a type of potentially fatal poisoning which is harmful in part due to severe depletion of glutathione levels. Calcitriol (1,25-dihydroxyvitamin D3), the active metabolite of vitamin D3, after being synthesized from calcifediol in the kidney, increases glutathione levels in the brain and appears to be a catalyst for glutathione production. About ten days are needed for the body to process vitamin D3 into calcitriol. S-adenosylmethionine (SAMe), a cosubstrate involved in methyl group transfer, has also been shown to increase cellular glutathione content in persons suffering from a disease-related glutathione deficiency.” (Wiki)

The medical “journals” say that we get all the nutrients we need from diet, a “fact” that continuing USDA studies prove false (NHANES, https://www.ars.usda.gov/northeast-area/beltsville-md-bhnrc/beltsville-human-nutrition-research-center/)
of course, if this was true, there would be no cognitive impairment/dementia that benefits from supplementation.

Transdermal glutathione creams are available for Apex Energetics and Swanson. The Apex product is available from Dr. Reinhardt at 714-886-9026.

Healthy dietary indices and risk of depressive outcomes: a systematic review and meta-analysis of observational studies

The aim of this systematic review was to synthesize the link between diet quality, measured using a range of predefined indices, and depressive outcomes. Medline, Embase and PsychInfo were searched up to 31st May 2018 for studies that examined adherence to a healthy diet in relation to depressive symptoms or clinical depression. A total of 20 longitudinal and 21 cross-sectional studies were included. These studies utilized an array of dietary measures, including: different measures of adherence to the Mediterranean diet, the Healthy Eating Index (HEI) and Alternative HEI (AHEI), the Dietary Approaches to Stop Hypertension, and the Dietary Inflammatory Index. The most compelling evidence was found for the Mediterranean diet and incident depression, with a combined relative risk estimate of highest vs. lowest adherence category from four longitudinal studies of 0.67 (95% CI 0.55–0.82). A lower Dietary Inflammatory Index was also associated with lower depression incidence in four longitudinal studies (relative risk 0.76; 95% CI: 0.63–0.92). There were fewer longitudinal studies using other indices, but they and cross-sectional evidence also suggest an inverse association between healthy diet and depression (e.g., relative risk 0.65; 95% CI 0.50–0.84 for HEI/AHEI).

Conclusions: Adhering to a healthy diet, in particular a traditional Mediterranean diet, or avoiding a pro-inflammatory diet appears to confer some protection against depression in observational studies. This provides a reasonable evidence base to assess the role of dietary interventions to prevent depression.

Molecular Psychiatry https://doi.org/10.1038/s41380-018-0237-8

Ed: Hmm, which to try first, “anti”depressant or improved diet?

Diet and weight may affect response to bipolar disorder treatment

Data from a clinical trial has shown that how people respond to treatment for Bipolar Disorder may be influenced by their weight and the overall quality of their diet, including whether they are eating a diet high in foods thought to contribute to general inflammation. These are early results, but if replicated may mean that treatment of some mental health problems could benefit from the inclusion of dietary advice. This is presented at the ECNP Conference in Barcelona.

A total of 133 participants were randomly assigned to take a combination of nutraceuticals (compounds derived from foods such as vitamins or minerals that treat or prevent a disease or disorder) including the anti-inflammatory amino acid n-acetylcysteine (NAC), or NAC alone, or a placebo (a dummy pill) for 16 weeks. Participants received the study medication in addition to any stable treatments they were already receiving. Researchers measured BMI at the beginning of the study, and then measured depression and how a person is able to function in their day to day life. Researchers also rated whether a participant was improving and, if so, how much, over the next 20 weeks. Participants filled in a questionnaire about what they usually eat over the year and researchers calculated a diet quality score, where good diets included a healthy diet with lots of fruit and vegetables, whereas poorer-quality diets had more saturated fat, refined carbohydrates and alcohol. These types of diets were then categorised as either anti-inflammatory or pro-inflammatory based on foods that affect inflammation.

Melanie Ashton continued, “We found that people who had a better-quality diet, a diet with anti-inflammatory properties, or a lower BMI, showed better response to add-on nutraceutical treatment than did those who reported a low-quality diet, or a diet including foods that promote inflammation, or who were overweight.

Association of Use of Omega-3 Polyunsaturated Fatty Acids With Changes in Severity of Anxiety Symptoms: A Systematic Review and Meta-analysis

To evaluate the association of anxiety symptoms with omega-3 PUFA treatment compared with controls in varied populations, PubMed, Embase, ProQuest, ScienceDirect, Cochrane Library, ClinicalKey, Web of Science, and ClinicalTrials.gov databases were searched up to March 4, 2018. A search was performed of clinical trials assessing the anxiolytic effect of omega-3 PUFAs in humans, in either placebo-controlled or non-placebo-controlled designs. Of 104 selected articles, 19 entered the final data extraction stage.

In total, 1203 participants with omega-3 PUFA treatment (mean age, 43.7 years; mean female proportion, 55.0%; mean omega-3 PUFA dosage, 1605.7 mg/d) and 1037 participants without omega-3 PUFA treatment (mean age, 40.6 years; mean female proportion, 55.0%) showed an association between clinical anxiety symptoms among participants with omega-3 PUFA treatment compared with control arms (P=.01). Subgroup analysis showed that the association of treatment with reduced anxiety symptoms was significantly greater in subgroups with specific clinical diagnoses than in subgroups without clinical conditions. The anxiolytic effect of omega-3 PUFAs was significantly better than that of controls only in subgroups with a higher dosage (at least 2000 mg/d) and not in subgroups with a lower dosage (<2000 mg/d).

Conclusions: This review indicates that omega-3 PUFAs might help to reduce the symptoms of clinical anxiety. Further well-designed studies are needed in populations in whom anxiety is the main symptom.

Interestingly, the results are also consistent with our recent findings that somatic anxiety is associated with omega-3 PUFA deficits and the genetic risks of PUFA metabolic enzyme cytosolic phospholipase A2 in major depressive disorder and interferon α–induced neuropsychiatric syndrome. Brain membranes contain a high proportion of omega-3 PUFAs and their derivatives and most animal and human studies suggest that a lack of omega-3 PUFAs in the brain might induce various behavioral and neuropsychiatric disorders, including anxiety-related behaviors. Emerging evidence suggests that omega-3 PUFAs interfere with and possibly control several neurobiological processes, such as neurotransmitter systems, neuroplasticity, and inflammation, which is postulated to be the mechanism underlying anxiety and depression.


Serial circulating omega 3 polyunsaturated fatty acids and healthy aging among older adults in the Cardiovascular Health Study: prospective cohort study

To determine the longitudinal association between serial biomarker measures of circulating omega 3 polyunsaturated fatty acid (n3-PUFA) levels and healthy aging, a prospective cohort study was conducted in four communities in the United States (Cardiovascular Health Study) from 1992 to 2015, with 2622 adults with a mean (SD) age of 74.4 (4.8) and with successful healthy aging at baseline in 1992-93. Cumulative levels of plasma phospholipid n3-PUFAs were measured using gas chromatography in 1992-93, 1998-99, and 2005-06, expressed as percentage of total fatty acids, including α-linolenic acid from plants and eicosapentaenoic acid, docosapentaenoic acid, and docosahexaenoic acid from seafood.

Main outcome measure Healthy aging defined as survival without chronic diseases (ie, cardiovascular disease, cancer, lung disease, and severe chronic kidney disease), the absence of cognitive and physical dysfunction, or death from other causes not part of the healthy aging outcome after age 65. Events were centrally adjudicated or determined from medical records and diagnostic tests.

Higher levels of long chain n3-PUFAs were associated with an 18% lower risk (95% confidence interval 7% to 28%) of unhealthy aging per interquintile range after multivariable adjustments with time-varying exposure and covariates. Individually, higher eicosapentaenoic acid and docosapentaenoic acid (but not docosahexaenoic acid) levels were associated with a lower risk: 15% (6% to 23%) and 16% (6% to 25%), respectively. α-linolenic acid from plants was not noticeably associated with unhealthy aging (hazard ratio 0.92, 95% confidence interval 0.83 to 1.02).

Conclusions: In older adults, a higher cumulative...
level of serially measured circulating n3-PUFAs from seafood (eicosapentaenoic acid, docosapentaenoic acid, and docosahexaenoic acid), eicosapentaenoic acid, and docosapentaenoic acid (but not docosahexaenoic acid from seafood or α-linolenic acid from plants) was associated with a higher likelihood of healthy aging. These findings support guidelines for increased dietary consumption of n3-PUFAs in older adults.

BMJ 2018; 363 doi: https://doi.org/10.1136/bmj.k4067 (Published 17 October 2018)

Study Finds Modifiable Dementia Risk Factor in Elderly

Aortic Stiffness is Associated with Increased Risk of Incident Dementia in Older Adults

Cardiovascular disease risk factors, including age, hypertension, and diabetes, contribute to aortic stiffness and subclinical cardiovascular and brain disease, increasing dementia risk. Aortic stiffness, measured by carotid-femoral pulse wave velocity (cfPWV), reduces the buffering of pulsatile blood flow, exposing cerebral small arteries to microvascular damage. High cfPWV is related to white matter hyperintensities and brain amyloid deposition, and to cognitive decline, but it is unclear whether cfPWV independently predicts incident dementia. Therefore, we tested the hypothesis that cfPWV predicts incident dementia in older adults, independent of potential confounders.

The Cardiovascular Health Study Cognition Study followed 532 non-demented older adults with annual cognitive exams from 1998-99 through 2013. CfPWV was measured on 356 (mean age = 78, 59% women) between 1996–2000.

Over 15 years, 212 (59.6%) developed dementia (median time from cfPWV measurement = 4 years). In age and sex-adjusted Cox models, cfPWV was significantly associated with increased risk of dementia, but systolic blood pressure, mean arterial pressure and pulse pressure were not. CfPWV (transformed as $-\frac{1}{\text{cfPWV}}$) remained significantly associated with dementia risk when further adjusted for education, race, APOE ?4, diabetes, body mass index, mean arterial pressure, and anti-hypertensive medication (hazard ratio = 1.60, 95% CI = 1.02, 2.51).

Results were similar when further adjusted for baseline global cognition, subclinical brain measures, and coronary artery calcification. Finally, higher cfPWV was related to lower physical activity intensity and higher systolic blood pressure, heart rate, and waist circumference measured 5 years prior. An important unanswered question is whether interventions to slow arterial stiffening can reduce the risk of dementia.

Journal of Alzheimer’s Disease, vol. 66, no. 1, pp. 297-306, 2018

Ed: Arterial stiffness increasing with aging was less pronounced in physically active men and women. Several studies have shown the efficacy of aerobic exercise in preventing age-related arterial stiffness in healthy individuals and reversing arterial stiffness in patients with vascular risk factors as well.

Antihypertension drugs with vasodilation activity such as ACE inhibitor (ACEI), angiotensin receptor blocker (ARB), calcium channel blocker (CCB) and some β-block (BB) have shown advantage in ameliorating arterial stiffness.

Vitamin D supplementation has been shown to reduce arterial stiffness in those who are vitamin D deficient, in a dose-response manner. Most studies used 2000 to 4000 iu per day. Vitamin D deficiency affects an estimated three-quarters of the United States population, and has been found to affect 73.5% of NBA basketball players! (Orthop J Sports Med. 2018 May 21;6) An excess dose of vitamin D is considered to be 40,000 iu per day.

Vitamins K1, K2 MK-4 and K2 MK-4 have been shown to reduce arterial stiffness through activation of matrix Gla-protein, which inhibits calcium from being deposited in artery walls. Although in theory sufficient Vitamin K1 is available from diet, studies have shown that it is poorly absorbed; in green leafy vegetables poor absorption (estimated at 10%) may be a function of its location in chloroplasts and tight association with the thylakoid membrane, and deficiency may affect up to 97% of the population. (www.jscimedcentral.com/Nutrition/nutrition-4-1077.pdf).

L-Alanine activates hepatic AMP-activated protein kinase and modulates systemic glucose metabolism

AMP activated protein kinase (AMPK) is recognized as an important nutrient sensor contributing to regulation of cellular, tissue, and systemic metabolism.
We aimed to identify specific amino acids which could modulate AMPK and determine effects on cellular and systemic metabolism.

We performed an unbiased amino acid screen to identify activators of AMPK. Detailed analysis of cellular signaling and metabolism was performed in cultured hepatoma cells, and in vivo glucose metabolism and metabolomic patterns were assessed in both chow-fed mice and mice made obese by high-fat diet feeding.

Alanine acutely activates AMP kinase in both cultured hepatic cells and in liver from mice treated in vivo with Ala. Oral alanine administration improves systemic glucose tolerance in both chow and high fat diet fed mice, with reduced efficacy of Ala in mice with reduced AMPK activity. Our data indicate that Ala activation of AMPK is mediated by intracellular Ala metabolism, which reduces TCA cycle metabolites, increases AMP/ATP ratio, and activates NH3 generation.

Conclusions: Ala may serve as a distinct amino acid energy sensor, providing a positive signal to activate the beneficial AMPK signaling pathway.

“All these data together suggest that amino acids, and specifically alanine, may be a unique potential way to modify glucose metabolism,” Patti sums up. “If it eventually turns out that you can do that by taking an oral drug as a pre-treatment before a meal, that would be of interest. However, this is early-stage research, and we need to test the concept both in mice and ultimately in humans.”

Molecular Metabolism 11 August 2018 https://doi.org/10.1016/j.molmet.2018.08.002

Ed: AMP kinase is an enzyme that plays an important role in insulin signaling, whole body energy balance and the metabolism of glucose and fats. The effectiveness of Metformin, the first line treatment for control of blood sugar, partially comes from increasing the concentration of AMP.

The researcher’s comment on chemical development, “you can do that by taking an oral drug as a pre-treatment before a meal,” promotes the drug industry as saviors, however it is only fair to point out that the natural amino acid alanine itself was the focus of this study. It is available over the counter for about $0.14 per dose. Other nutritional supplements have been found to promote AMP kinase: Metformin itself is a synthasized form of the extract of French lilac; hesperidin, an extract from oranges, and gynostemma leaf, a common vine, also have been shown to promote AMP kinase.

The finding of most interest from this study was that taking your Metformin, your alanine, your orange extract, or your gynostemma leaf 1/2 hour BEFORE your meal was most effective!

Pathogen elimination by probiotic Bacillus via signalling interference

Probiotic nutrition is frequently claimed to improve human health. In particular, live probiotic bacteria obtained with food are thought to reduce intestinal colonization by pathogens, and thus to reduce susceptibility to infection. However, the mechanisms that underlie these effects remain poorly understood. Here we report that the consumption of probiotic Bacillus bacteria comprehensively abolished colonization by the dangerous pathogen Staphylococcus aureus in a rural Thai population. We show that a widespread class of Bacillus lipopeptides, the fengycins, eliminates S. aureus by inhibiting S. aureus quorum sensing—a process through which bacteria respond to their population density by altering gene regulation. Our study presents a detailed molecular mechanism that underlines the importance of probiotic nutrition in reducing infectious disease. We also provide evidence that supports the biological significance of probiotic bacterial interference in humans, and show that such interference can be achieved by blocking a pathogen’s signalling system. Furthermore, our findings suggest a probiotic-based method for S. aureus decolonization and new ways to fight S. aureus infections.

Nature, 2018; DOI: 10.1038/s41586-018-0616-y

The composition of gut bacteria almost recovers after antibiotics

The trillions of bacteria in the human gut affect our health in multiple ways including effects on immune functions and metabolism. A rich and diverse gut microbiota is considered to promote health providing the human host with many competences to prevent chronic diseases. In contrast, poor diversity of the gut ecosystem is a characteristic feature of chronic diseases including obesity, diabetes, asthma and gut
inflammatory disorders.

Due to the general bacterial-killing nature of antibiotics, it has been speculated that repetitive use of antibiotics deprives people of a rich gut bacterial environment and through this lead to adverse health effects.

Now, an international team of researchers led from the University of Copenhagen and Steno Diabetes Center Copenhagen report when 3 antibiotics were given to young healthy men for 4 days it caused an almost complete eradication of gut bacteria, followed by a gradual recovery of most bacterial species over a period of six months.

After the six months, however, the study participants were still missing nine of their common beneficial bacteria and a few new potentially non-desirable bacteria had colonized the gut. The findings are published today in Nature Microbiology.

“We show that the gut bacterial community of healthy adults are resilient and able to recover after short-term simultaneous exposure to three different antibiotics. However, our findings also suggest that exposure to broad-spectrum antibiotics may dilute the diversity of the intestinal bacterial ecosystem. Antibiotics can be a blessing for preserving human health but should only be used based upon clear evidence for a bacterial cause of infection,” explains study lead, Professor Oluf Pedersen, Novo Nordisk Foundation Center for Basic Metabolic Research.

Sciency Daily october 23 2018

Ed: After 6 months, many bacteria recolonized, although gradually. Many never recovered. “The concern, however, relates to the potentially permanent loss of beneficial bacteria after multiple exposures to antibiotics during our lifetime. There is evidence that Western populations have a considerably lower diversity of their gut microbiota that native people living in certain parts of Africa and Amazonas. One possible explanation for this may be the widespread use of antibiotics in treatment of infectious diseases,” says Oluf Pedersen.

The smell of lavender is relaxing, science confirms

Lavender works its relaxing magic all around us: from garden borders to bath bombs to fabric softener. But why not in our hospitals and clinics? And what is the science behind the magic?

Research published in Frontiers in Behavioral Neuroscience shows for the first time that the vaporized lavender compound linalool must be smelt -- not absorbed in the lungs- to exert its calming effects, which could be used to relieve preoperative stress and anxiety disorders.

Kashiwadani and colleagues tested mice to see whether it is the smell of linalool -- i.e. stimulation of olfactory (odor-sensitive) neurons in the nose -- that triggers relaxation.

“We observed the behavior of mice exposed to linalool vapor, to determine its anxiolytic effects. As in previous studies, we found that linalool odor has an anxiolytic effect in normal mice. Notably, this did not impair their movement.” This contrasts with benzodiazepines, and linalool injections, whose effects on movement are similar to those of alcohol.

However, crucially there was no anxiolytic effect in anosmic mice -- whose olfactory neurons have been destroyed -- indicating that the relaxation in normal mice was triggered by olfactory signals evoked by linalool odor.

What’s more, the anxiolytic effect in normal mice disappeared when they were pretreated with flumazenil, which blocks benzodiazepine-responsive GABAA receptors.

“When combined, these results suggest that linalool does not act directly on GABAA receptors like benzodiazepines do -- but must activate them via olfactory neurons in the nose in order to produce its relaxing effects,” explains Kashiwadani.

Science Daily October 23, 2018

Ed: Lavender oil is used extensively in many skilled nursing facilities for just this purpose.
Can apathy predict dementia? @mnt, Tim Newman
Because there is no cure for dementia, accurately predicting who will go on to develop it is vital to minimize its impact. According to a new review, apathy may hold the key. Dementia overwhelmingly impacts older adults. Although scientists know about some risk factors, predicting who will eventually develop dementia is challenging. As people age, cognitive abilities tend to decline, and 5–20 percent of those over 65 years old will develop mild cognitive impairment. Older adults with a mild cognitive impairment who visit memory clinics — which are centers dedicated to diagnosing memory problems — often fear that they will receive a dementia diagnosis. In reality, most individuals’ memories will either return to normal levels of functioning or not deteriorate any further. However, while the person is in the clinic, doctors are keen to understand who is most at risk. There is no cure for dementia, so early detection is the best way to ensure the best care. Observing changes in behavior might be a useful way to assess an individual who might otherwise fly under the radar. One behavior of interest is apathy, which is defined as a loss of motivation, a lack of interest, and reduced emotional expression. If apathy is related to an increased chance of developing dementia, it might become a relatively easy way to identify increased risk — even in a short consultation. Already, researchers have noted that apathy is a common feature of dementia, occurring in around half of the people with Alzheimer’s disease. To date, studying the role of apathy before dementia develops has received little attention. Recently, researchers set out to see whether apathy could become an early marker for dementia. To do this, they dipped into the findings from previous studies and carried out a fresh analysis of the pooled data. As the authors explain: "We aimed to systematically review and meta-analyze the evidence from longitudinal cohorts for the association between apathy in older people and the risk of incident dementia." In total, the researchers assessed and collated data from 16 studies, including 7,365 participants. Their results were published earlier this month in JAMA Psychiatry. The authors concluded that "[a]pathy was associated with an approximately twofold increased risk of dementia in memory clinic patients."

Research uncovers key differences in brains of women and men with schizophrenia @Medical_Xpress, The Mount Sinai Hospital
Researchers from the Icahn School of Medicine at Mount Sinai have found clear disparities in the way males and females—both those with schizophrenia and those who are healthy—discern the mental states of others. The research, the first of its kind, will be published online on October 30, in Social Neuroscience. The research team examined emotional processing in 37 clinically stable participants diagnosed with schizophrenia or schizoaffective disorder, compared with 31 healthy controls. Subjects identified emotions of other people by looking at pictures of eyes and listening to stories. Smell tests were also administered to measure odor detection and odor identification ability. Most animal species rely on their sense of smell to determine the intentions of other animals. Intelligence scores measured more complex brain processing and
olfactory or scent scores measured simpler mental processing. They found that females without schizophrenia used more complex areas of their brains to identify someone else’s mental state, including other’s beliefs, desires, intentions, and emotions. The healthy males used less complex brain regions to process others’ mental states. Both women and men with schizophrenia used less complex brain regions to process the emotional states of others. Men with schizophrenia used less complex brain regions for processing than healthy men. "Women and men are fundamentally different, and it is critical to perform sex-specific research across psychiatry and all of medicine," said the study’s senior author, Dolores Malaspina, MD, Director, Psychosis Program, Icahn School of Medicine at Mount Sinai. "Sex-stratified research is essential for studying social processes in general and especially for conditions such as schizophrenia that present differently in women and men."

**Could omega-3 supplements help reduce anxiety? @mnt, Tim Newman**

A recently published meta-analysis concludes that omega-3 oil supplements might reduce symptoms of anxiety for some people. It can appear as a standalone anxiety disorder or as part of another mental disorder, such as depression. Pharmaceutical interventions such as serotonin reuptake inhibitors can treat anxiety. However, people with anxiety disorders are often concerned about side effects and dependence. Other options include talking therapies, but these are time-consuming and can be costly. An estimated 1 in 5 adults in the U.S. develop an anxiety disorder each year, so finding a safe, cost-effective way to manage anxiety would be of great benefit to millions of people. Omega-3 polyunsaturated fatty acids (PUFAs) are present in fish oils. Over the years, researchers have ascribed a wide range of health benefits to them, but not all are supported by evidence. In recent years, some scientists have tested omega-3’s potential to help in the treatment of psychiatric conditions, including mood and anxiety disorders. Studies investigating the anti-anxiety effects of omega-3 PUFAs in animal models have seen some success; for instance, a study in rats found that a diet rich in a PUFA called eicosapentaenoic acid reduced anxiety-like behaviors. In humans, research has shown a relationship between PUFA levels and anxiety. For instance, one study found that people with anxiety disorders have lower levels of circulating omega-3 PUFAs. Another showed that omega-3 supplements reduced inflammation and anxiety in medical students during exams. These studies and others, though, have been limited by their small size. To rectify this, researchers recently carried out the first systematic review on this topic. They explain their aim: "[W]e examined," they point out, "the anxiolytic effects of omega-3 PUFAs in participants with elevated anxiety symptoms in the results of clinical trials to determine the overall efficacy of omega-3 PUFAs for anxiety symptoms irrespective of diagnosis." The researchers took data from 19 clinical trials including a total of 1,203 participants. Their findings were published in the JAMA Network Open journal. After analysis, their findings supported their initial theory. Although the studies varied significantly in the type of participants that were involved and the ways that anxiety was measured, they saw a significant reduction in anxiety in the groups treated with omega-3s compared with the placebo groups. Most of the studies demonstrated a positive effect of omega-3 PUFAs on anxiety, even though not all effect sizes were significant. However, when the data were pooled, the combined effect was statistically significant. "This review indicates that omega-3 PUFAs might help to reduce the symptoms of clinical anxiety. Further well-designed studies are needed in populations in whom anxiety is the main symptom."

**Dopamine drives early addiction to heroin @Medical_Xpress, eLife**

Scientists have made a major advance in untangling the brain circuits that lead to the powerful addictive effects of heroin, a study in the open-access journal eLife reports. The discovery could lead to more effective treatments for addiction and a new generation of less addictive painkilling medicines. Addiction develops when a drug has beneficial outcomes, such as pleasure or reward, which reinforce repeat behaviour—known as drug reinforcement. By understanding the brain processes that contribute to drug reinforcement,
scientists hope to better understand and prevent drug addiction. "It has been repeatedly argued that the initial reinforcing effects of opioids do not involve dopamine, but the question is still hotly debated," explains author Michaël Loureiro, Postdoctoral Fellow at the University of Geneva, Switzerland. "In this study, we used advanced genetic tools to selectively manipulate and observe distinct groups of nerve cells to revisit this fundamental question." First, the team used a genetically coded fluorescent sensor to measure levels of dopamine in the nucleus accumbens of the brain—a primary site involved in reward behaviour. Less than a minute after the mice were given heroin, there was a peak in fluorescence which represented a significant increase in dopamine. They next recorded the activity of dopamine neurons by measuring activity of calcium. They found that dopamine neurons were activated after repeated heroin infusions, and that this matched the pattern of dopamine release seen in the previous experiment. Having established a role for dopamine, the scientists set out to map the neural signals it triggers. They used two tracer molecules that move to distinct regions of the brain. By studying their location after heroin treatment, they found that most of the activated dopamine neurons send signals to the 'medial shell' region of the nucleus accumbens in the brain. To prove that increased dopamine directly causes drug reinforcement, the team looked at the effects of silencing dopamine in mice with a well-established heroin addiction and were consistently self-administering the drug using a lever. They found that when they silenced the dopamine neurons, the mice were much less likely to self-administer heroin. Crucially, when they did this early in the addiction phase, the mice were less likely to develop the habit of self-administering heroin. This showed that activation of dopamine neurons in the nucleus accumbens is required for the early positive reinforcing effects of opioid drugs. Finally, they used mice with genetically manipulated dopamine neurons that are activated by light, which the mice can self-stimulate by pressing a lever, to see whether heroin would replace the positive reinforcement effect of the light. As expected, the mice given heroin and then free access to laser light stimulation were much less likely to press the lever to obtain light stimulation than those which only had access to the light. This confirmed that the reinforcing effects of heroin is operating via dopamine.

Exploring the brain networks behind our free will @mnt, Ana Sandoiu
New research now published in the Proceedings of the National Academy of Sciences explores the brain circuits involved in free will and the decision to move. We may like to think of our sense of agency as something mystical, but new research reveals the brain circuits that underpin our free will. Neuroscience can dive into deep, philosophical problems, only to emerge with palpable proof that even the most ethereal questions have a very concrete answer in the machinery of our brains. Take religion, for example. Recently, Medical News Today have covered a range of studies showing that out-of-body experiences actually originate in the brain's superior parietal cortex networks, and that our perception of bodily boundaries changes with the size of our prefrontal cortex. The "theory of mind" — or a person's ability to imagine what another person is thinking or feeling — has also preoccupied philosophers and psychologists for centuries. Recent findings have not only shown which brain areas and circuits are involved in such a process, but they have also suggested that some of these brain regions may even predict a person's willingness to forgive others' mistakes. Now, new research forays into the brain in search of answers to another age-old question: what is it that gives us the perception of free will? Scientists who were led by Dr. Ryan Darby, an assistant professor of neurology from the Vanderbilt University Medical Center in Nashville, TN, set out to examine what occurs in the brain when people make the decision to move.

Three percent of children hit daily activity target @Medical_Xpress, University of Exeter
Only one in 30 children does the recommended amount of daily physical activity, new research suggests. Guidelines from the Chief Medical Officer say people aged five to 18 should do at least 60 minutes of "moderate-to-vigorous intensity physical activity" every day. Previous research has often used less
than seven days of data on children's activity and created an average based on that. But a study by the universities of Exeter and Plymouth of Year Five children (aged nine or ten) found that although almost a third (30.6%) achieved an average of 60 minutes per day, just 3.2% did so every day. Activity levels among girls were even lower, with just 1.2% hitting the 60-minute daily target—compared to 5.5% of boys. "Previous studies based on average activity are likely to have overestimated the percentage of children meeting the recommendations," said Dr. Lisa Price, of the University of Exeter. "Our findings suggest that just under a third of children are achieving an average of 60 minutes per day, but only 3.2% meet the 60-minute target every day.

**Bipolar disorder: A good diet may boost treatment** @mnt, Maria Cohut

Diet quality can affect many aspects of one's physical health and psychological well-being. New research investigates whether or not these factors can also affect the effectiveness of treatments for mood disorders—particularly bipolar. How does diet impact response to treatment in bipolar disorder? A new clinical trial takes a closer look. The moods of people who have bipolar disorder fluctuate between two extremes. These are the "highs," during which the person feels euphoric and may engage in dangerous behaviors, and the "lows," characterized by depression and lethargy. Since two opposite mood extremes characterize this disorder, it is often difficult to treat both the "highs" (or "manic episodes") and the "lows" (or "depressive episodes") with the same efficacy. New research presented at the European College of Neuropsychopharmacology congress, held in Barcelona, Spain, now suggests that weight and dietary habits may influence how effective treatments for bipolar disorder actually are. In particular, a healthful diet may aid therapy for depressive episodes, note the study authors. They also explain that, conversely, a poor diet could contribute to heightened inflammation, which may have a negative impact on a person's symptoms. "If we can confirm these results, then it's good news for people with bipolar disorder, as there is a great need for better treatments for the depressive phase of bipolar disorder," states lead researcher Melanie Ashton, from Deakin University in Geelong, Australia. The team comprised scientists from numerous academic and research institutions across Australia, Germany, and the United States.

**Team identifies new brain region that suppresses fear** @Medical_Xpress, Elena Watts, Texas A&M University

A study conducted at Texas A&M University has identified a new area in the brain involved in inhibiting fear, a discovery that holds potential for clinical interventions in patients with psychiatric diseases such as post-traumatic stress disorder (PTSD). The article was published in Nature Communications on Oct. 30. Dr. Stephen Maren, University Distinguished Professor of psychological and brain sciences and Claude H. Everett, Jr. '47 Chair of Liberal Arts at Texas A&M University, and his team have discovered that a small brain region in the thalamus called the nucleus reuniens plays a role in inhibiting fear in rats. Prior to his discovery, the region was thought to act primarily as a pathway by which sensory information travels from the periphery of the brain to the cortex, the part responsible for performing complex thought. "It's interesting because we know that the prefrontal cortex plays an emotion regulation role, and so there has been a lot of interest in how it accomplishes that," Maren said. "So this basic research, identifying this particular projection from the prefrontal cortex to the nucleus reuniens in the thalamus, points us to parts of the brain that are important for the inhibitory function of fear, which could be an avenue to new drugs, therapies and interventions for psychiatric disorders." Currently, most drugs that physicians use to treat psychiatric disorders are indiscriminate and target all neurons in the brain. However, behavioral therapies, such as extinction therapy for PTSD, during which patients undergo prolonged, repetitive exposure to their traumas in safe settings, are effective in diminishing fear, but patients often relapse. In his Emotion and Memory Systems Laboratory at Texas A&M, Maren and his team exposed rats to tones paired initially with mild foot shocks to create the fear
What's the link between brain fog and rheumatoid arthritis? @mnt, Jenna Fletcher

Rheumatoid arthritis causes chronic inflammation that affects not only the joints but other organ systems, too. One of the lesser-known symptoms of the condition is brain fog. Many people with rheumatoid arthritis, or RA, report having trouble thinking clearly, problems with memory, and difficulty concentrating. These symptoms, known as brain fog, are widespread in people with chronic inflammatory conditions, including RA, Sjogren's syndrome, and multiple sclerosis. With proper treatment and by taking preventative steps, a person with RA may be able to get the brain fog to lift. Poor memory and trouble concentrating are characteristics of brain fog. People mostly associate RA with swollen and painful joints. However, for many people with RA that is only one of the symptoms they face. RA is a chronic condition that causes inflammation throughout the body. This inflammation can lead to joint pain and stiffness, swelling, and decreased joint mobility. RA can also affect the eyes, skin, lungs, and brain. Many people with RA and other chronic inflammatory conditions also complain of feeling mentally foggy and having difficulty thinking. Scientists believe there may be a link between chronic inflammation and the cognitive impairment that people refer to as brain fog. A 2018 study published in Nature Communications looked at how chronic inflammation might affect the brain. They used MRI scanners to take images of the brains of 54 people with RA. The results showed a link between RA inflammation and changes in the patterns of brain connections. It also showed a lower volume of gray matter in an area of the brain known as the inferior parietal lobe. The study suggests that fatigue, pain, and an impaired ability to think are associated with these brain changes.

New evidence pot may harm the teen brain @Medical_Xpress, Dennis Thompson, Healthday Reporter

Teens who stop smoking pot can think and learn better afterward, even if they are only light users, a new study reports. Compared to teenagers and young adults who continued using marijuana, those who abstained for a month displayed a "modest but reliable improvement in their ability to learn," said lead researcher Randi Schuster. "Most of this improvement surprisingly happens rather quickly, within the first week of abstinence," added Schuster, director of neuropsychology at Massachusetts General Hospital's Center for Addiction Medicine. The results show that kids need to be kept from using pot, Schuster said. This is a growing concern as recreational marijuana becomes legal in more U.S. states, she added. "As we as a country move toward widespread legalization, we should pay attention to smart prevention programming for children," Schuster said. The researchers cited a 2016 survey that found almost 14 percent of middle and high school students had used pot in the prior month. It also showed daily use doubling between eighth and 12th grades. Maturation of critical parts of the brain occurs in adolescence, and regular pot use in those years may cause more harm than later use, the researchers said in background notes. Marijuana legalization proponents countered that the new study supports their contention that the effects of pot are temporary. "These conclusions are consistent with those of prior studies finding that cannabis exposure is not likely to be associated with any sort of permanent adverse impact on the brain or cognitive performance," said Paul Armentano, deputy director of NORML. "These findings dispute the long-standing 'stoner-stupid' stereotype and should help to assuage fears that cannabis' acute effects on behavior may persist long after drug ingestion, or that they may pose greater potential risks to the developing brain," Armentano said. For their study, Schuster and her colleagues asked two-thirds of a group of 88 marijuana users ages 16 to 25 to drop pot for a month. The Boston-area participants were not all heavy users, but did use regularly. "We have kids using a minimum of one day a week or more," Schuster said. Urine tests revealed that 9 out of 10 participants did follow through on their promise to stop using pot for the study period. Once a week, the young people took part in computerized
brain games that tested their attention and memory, to see if stopping their pot use would help improve their brain function. The computer tests showed that memory—specifically the ability to learn and recall new information—improved only among those who stopped using cannabis. The improvement occurred largely during the first week. The study only showed an association between quitting pot and better learning ability, not a direct cause-and-effect relationship. Still, specialists are taking note of the findings. "Cannabis use impacts learning and memory, and this study showed improvement in these domains after quitting," said Dr. Scott Krakower, assistant unit chief of psychiatry at Zucker Hillside Hospital in Glen Oaks, N.Y.

Why depression, trauma can make you age faster @mnt, Ana Sandoiu
A new study has found that people living with major depressive disorder are biologically older than people without depression, and that childhood trauma exacerbates this effect. The results illuminate the epigenetic mechanisms that might explain this discrepancy. In fact, more than 16 million adults will have had at least one major depressive episode during the past year. The condition has been linked to various other adverse outcomes, from a shorter lifespan to a higher risk of cardiovascular problems. New research shows that major depression may also mean premature aging. Scientists led by Laura Han — from the Amsterdam University Medical Center in the Netherlands — studied the DNA structure of people with depression and made an intriguing discovery. Han and colleagues found that the DNA of people with major depression is older by 8 months, on average, than that of people who do not have the condition. The researchers presented their findings at the European College of Neuropsychopharmacology conference, held in Barcelona, Spain, and they published their study in the American Journal of Psychiatry. This effect of premature aging was more significant in people who had had adverse childhood experiences, such as violence, trauma, neglect, or abuse. In the U.S., almost 35 million children have experienced some form of trauma, according to a national survey. That is almost half of the nation's child population.

New study—reduced screen time for young highly recommended for well-being @Medical_Xpress, San Diego State University
Too much time spent on gaming, smartphones and watching television is linked to heightened levels and diagnoses of anxiety or depression in children as young as age 2, according to a new study. Even after only one hour of screen time daily, children and teens may begin to have less curiosity, lower self-control, less emotional stability and a greater inability to finish tasks, reports San Diego State University psychologist Jean Twenge and University of Georgia psychology professor W. Keith Campbell. Twenge and Campbell's results were published in an article, "Associations between screen time and lower psychological well-being among children and adolescents: Evidence from a population-based study," which appeared this month in Preventative Medicine Reports. Twenge and Campbell were particularly interested in associations between screen time and diagnoses of anxiety and depression in youth, which has not yet been studied in great detail. Their findings provide broader insights at a time when youth have greater access to digital technologies and are spending more time using electronic technology purely for entertainment, and also as health officials are trying to identify best practices for managing technology addiction. "Previous research on associations between screen time and psychological well-being among children and adolescents has been conflicting, leading some researchers to question the limits on screen time suggested by physician organizations," Twenge and Campbell wrote in their paper. The National Institute of Health estimates that youth commonly spend an average of five to seven hours on screens during leisure time. Also, a growing body of research indicates that this amount of screen time has adverse effects on the overall health and well-being of youth.
Is sleeping too much bad for your brain? @mnt, Tim Newman

The largest sleep study ever concludes that sleeping too little or too much has a negative impact on our cognitive ability, but not on our short-term memory. As years of research mount up, we are steadily improving our understanding of sleep. However, despite making up around one third of our entire lives, sleep still holds many mysteries. The strains of modern life often mean that we sleep less than we might like. Increased screen time, caffeine, and stress are among the many reasons why people do not get the sleep that they require. So, as our sleep quality deteriorates, understanding the impact on health and performance is more important than ever. To add to our growing knowledge of sleep, researchers from Western University's Brain and Mind Institute in Canada set up the largest sleep study to date. Launched in June 2017, the online sleep study collected data from more than 40,000 participants in just the first few days. As Adrian Owen, a cognitive neuroscience researcher at Western, explains, "We really wanted to capture the sleeping habits of people around the entire globe. Obviously, there have been many smaller sleep studies of people in laboratories, but we wanted to find out what sleep is like in the real world." The number and diversity of participants allowed them to compare the impact of sleep deprivation on people of different ages, professions, and lifestyles. Their preliminary findings, based on an analysis of 10,000 people, were published recently in the journal SLEEP. To get an in-depth understanding of the people involved in this study, the team collected detailed data from participants. As Owen goes on to explain, "We had a fairly extensive questionnaire, and they told us things like which medications they were on, how old they were, where they were in the world, and what kind of education they'd received because these are all factors that might have contributed to some of the results." This gave the scientists the opportunity to test a range of theories and gain an understanding of how sleep quantity might affect people. Volunteers underwent a battery of 12 well-established cognitive tests so that the amount of sleep could be correlated with mental ability. About half of the participants slept for 6.3 hours or under per night, which is around an hour less than the study's recommended level. It took the scientists by surprise that getting 7–8 hours of sleep each night was associated with the highest cognitive functioning. Both shorter and longer duration of sleep caused a dip in performance. Interestingly, this effect was constant, regardless of age. That said, older adults were more likely to have a shorter sleep duration, meaning that as a whole, they were impacted more by sleep deprivation than other age groups. Both more and less sleep negatively impacted a variety of cognitive functions, such as identifying complex patterns and manipulating information to solve problems. It was verbal ability that was most significantly impacted. One of the most surprising findings from the cognitive tests was that people who slept for 4 hours or under each night performed as though they were almost 8 years older. "We found that the optimum amount of sleep to keep your brain performing [at] its best is 7 to 8 hours every night, and that corresponds to what the doctors will tell you [you] need to keep your body in tip-top shape." He continues, "We also found that people that slept more than that amount were equally impaired as those who slept too little." Though the researchers had expected to see cognitive deficits in those who slept for less time, seeing deficits in those who slept for longer was surprising.
1. In the lead article, Dr. Caccavale asserts that APA caused the problems for the private practice of psychology, and it is up to APA to fix it. True/False

2. There is ample evidence that patients prefer treatment by Masters level providers. True/False

3. According to the lead article, what can practitioners do build confidence and trust in their patients?

4. Name 2 board certifying bodies supported by NAPPP.

5. NAPPP offers how many free on-line CE programs for NAPPP members?

6. What herb was discussed by Dr. Petrosky that can be helpful with issues of sleep and anxiety?

7. This herb is presumed to act on the ____________ Axis to ____________ the body’s response to stress.

8. Regarding risks of benzodiazepines in COPD with comorbid PTSD, long term use was associated with increased mortality, though short term use was not. True/False

9. In a study regarding fluoride, it was found that higher concentrations were associated with ADHD like symptoms. True/False

10. The medicinal use of fluoride for the prevention of dental caries began when?


12. Which antioxidant, that protects the brain from stress, was found to be significantly depleted in Alzheimer’s patients?

13. Avoiding what type of diet appears to confer some protection against depression?

14. Omega-3 PUFA’s may be beneficial in helping to reduce the symptoms of clinical ____________.

15. Circulating omega 3 PUFA appears to be associated with healthy aging. True/False

16. Arterial stiffness is a modifiable risk factor for dementia. True/False

17. Exposure to broad spectrum antibiotics may dilute the diversity of the intestinal bacterial ecosystem. True/False

18. Vaporized lavender can be calming but has its effect via the olfactory system. 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

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<td>Diagnosing and Treating Substance Abuse</td>
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**Psy #1 - Pharmacotherapeutics: 10 CE credit hours**
Integration of the principles of psychology in the application of pharmacological agents in the alleviation of mental health concerns.

**Psy #2 - Neuropsychological Evaluations: 10 CE credit hours**
The selection, administration and integration of neuropsychological data into a comprehensive report.

**Psy #3 - Custody Evaluations: 10 CE credit hours**
A complete course on the conducting and writing of custody evaluations for the practicing psychologist.

**Psy #4 - Forensic Evaluations: 10 CE credit hours**
This course will take you through the differing forms of forensic evaluations and discuss the formation of a comprehensive forensic report.

**Psy #5 - Treating Childhood Sexual Abuse: 10 CE credit hours**
This course discusses the thorough diagnosis and treatment of children who have been sexually abused.

**Psy #6 - Domestic Violence - Treatment and Assessment: 10 CE credit hours**
The assessment and treatment of domestic violence. Discussion of group and individual treatment is included.

**Psy #7 - Ethics & Risk Management: 10 CE credit hours**
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.

**Psy #8 - Mood Disorders: 10 CE credit hours**
A review of the diagnosis of the spectrum of mood disorders along with a discussion of the psychological and pharmacological interventions for each disorder.

**Psy #9 - Physiology For Psychologists: 10 CE credit hours**
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.

**Psy #10 - Issues In Postpartum Disorders: 10 CE credit hours**
A review of the evaluation and diagnosis of postpartum disorders. A review of the relevant literature is included.

**Psy #11 - Doing Pre-Marital Counseling: 10 CE credit hours**
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.

**Psy #12 - Mastering Medical Terminology For Psychologists: 10 CE credit hours**
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.

**Psy #13 - Caring For The Elderly: 10 CE credit hours**
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.

**Psy #14 - Diagnosing and Treating Substance Abuse: 10 CE credit hours**
A basic understanding of diagnosing and treating 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 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, current and accurate.
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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  \- **Fire Legal Liability Coverage:** $150,000 liability limit for fire damage to third party property.

  \- **Premises Liability:** Bodily Injury Coverage and/or Damage to property of patients on your primary office location(s) with no additional cost.

  \- **Information Privacy Coverage (HIPAA):** Up to $25,000 defense provided for Federal and state regulators who investigate you for violations of privacy protections statutes (where allowed by law).

  \- **Limits up to $2 million per occurrence/$4 million per policy year** “Prior Acts” coverage is available; therefore, it is not necessary to purchase tail coverage to change to our company.

  \- **No Surcharge for Claims,** No Deductible and No association membership required.

  \- **Individual, group and corporate coverage** - separate limits of liability are included.

  \- **Broad coverage** at affordable rates includes Personal and Advertising Injury Coverage, Publishing of articles or books and broadcasting activities, Tele-therapy Coverage and Forensic Practice Coverage.

  \- **Coverage for Peer Review** and Utilization Review Activities.

  \- Payment of **Defense Expenses is in addition to the Limit of Liability** for Professional and General Business Liability Coverages.

  \- Insuring company has an **A.M. Best rating of “A”** with strong financial stability.

  \- **Online application processing** and confirmation is available the same day in most cases.

  \- **Experienced and knowledgeable claims professionals** and customer service representatives are easily accessible by telephone.

  \- **Interest-free quarterly payments** (annual premium over $1000) and online credit card processing.

RISK MANAGEMENT SERVICES

• **Risk Management Consultation Services** are accessible for our policyholders with experienced and professional risk managers, on a variety of topics, such as record requests/record retention, privacy questions and other practice related issues.

• **Discounted online Risk Management** and Continuing Education Courses with AtHealthCE.com and BehavioralHealthCE.com.

MULTIPLE PREMIUM DISCOUNTS

• **35% Part Time Discount** is available for up to 20 client hours a week – employment can be excluded.

• **35% New Graduate Discount**

• **10% New Policyholder Discount** if you are new to our company (must be claims free for the last 6 months).

• **10% Practice Setting Discount**

• **5% Risk Management Discount** for 3 hours of Risk Management Courses.

• **5% Continuing Education Discount** for 6 hours of CEU.

• **20% Discount for Members of:**
  - American Board of Professional Psychology (ABPP)
  - California School of Professional Psychology (CSPP)
  - National Alliance of Professional Psychology Providers (NAPPP)
  - National Register of Health Service Psychologists (NATR)
  - Psychologists for Social Responsibility (PsySR)
  - Texas Psychological Association (TPA)
  - American Academy of Pediatric Neuropsychology Services (AAPdN)

(Above Coverage Features and Discounts are subject to individual state approval and underwriting requirements.)
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.
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"My experience with the Automated Medical Assistant has been remarkable. The program is very comprehensive, yet exceptionally straightforward and easy to use. It has saved us significant time and money. We love the Progress Notes feature, the Scheduler, the electronic claims reports, and the ability to access our data from anywhere. It is very affordable, which made it all that much more accessible. The support is outstanding. They are patient, extremely knowledgeable, and available - they literally hold your hand and walk you through any questions you may have. I am a very satisfied customer and would enthusiastically recommend this software to anyone."

Robyn J. Geelhoed, Ph.D., HSPP
Director and Licensed Psychologist
Still Waters Professional Counseling, LLC

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Highlights:

- Created for Mental Health Providers
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- Prints on new HCFA 1500
- Numerous useful reports
- Graphs for visual analysis
- Scheduler with multiple features
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- Warns you when re-authorization is needed
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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

Board of Directors

Nicholas Cummings, Ph.D.                Jerry Morris, Psy.D.
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The Billing Center for Therapy Practices

Too busy to do your own billing? Not experienced enough with the nuances? We can do the work for you!

Our state-of-the-art, web-based software system gives you 24/7 access to your data, schedule, clinical notes, reports, graphs, and many other powerful features. Our staff are experts in billing for mental health practitioners, trained in all aspects of insurance billing and HIPPA compliance. We only work with mental health providers. We know how to handle patient interactions in a sensitive manner, while assuring that you are paid what you are owed. We manage all aspects of the billing process so that you can focus your energy on patient care.

WE GET YOU PAID!

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- Quicker reimbursement
- Prompt mailing of patient statements
- No personnel management
- Reduced telephone & Postage costs
- All software provided at no extra cost
- Timely follow-up on claims
- Less stress for your office
- No hidden fees

Service Highlights:

- Data Entry
- Insurance Claims Processing
- Patient billing
- Payment Posting
- Follow-up on denied claims
- Authorization Tracking
- Insurance Verifications
- Clinical Notes
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The accreditation process for professionals and service providers engaged in behavioral healthcare is sorely lacking and mostly absent. Consequentially, consumers and professionals alike, have little idea or notion of what constitutes quality practice, services, and products. The mission of NIBHQ is to provide accreditation to licensed, doctoral level behavioral healthcare professionals and service providers. NIBHQ is a profession specific agency that awards accreditation based on standards developed by behavioral healthcare professionals. Our mission is to award accreditation only to those individuals and entities that can meet and maintain adherence to standards specifically developed to promote quality in the provision of behavioral healthcare services and products.

Do You Want To Distinguish And Promote Your Practice?
Then NIBHQ accreditation is your best way to do this. We offer a unique accreditation that demonstrates your practice has met a high standard and is committed to quality care and services that patients, insurers, and other healthcare professionals can rely on. See our requirements at http://www.nibhq.org/

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/

NIBHQ