Academy of Medical Psychology

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ACADEMY UPDATE FROM THE PRESIDENT
BY STEPHEN GARY MCCLURE, PHD, ABMP

Dear Colleagues,

I am both honored and humbled to assume the role as the next President of the Academy of Medical Psychology (AMP). I have been serving on the board of directors as the chairman of the credentialing committee for the past several years and the experience has been both challenging and rewarding. During my time as an AMP board member, I have witnessed what can be accomplished by a few dedicated psychologists, working toward a common goal.

My goal as president is to build on the foundation established by the Medical Psychology pioneers preceding me that includes Drs. Lawson, Morris, Caccavale, Barngrover, Galle, Cole, Childerston, Nessetti, and Wiggins, to name a few. These leaders have committed their time, resources, experiences and vision to the future of medical psychology and all psychologists have benefitted exponentially from their tireless efforts.

However, despite the tremendous accomplishments of a few, our profession continues to lack a clear identity with the public at large. Psychologist, social worker, therapist, counselor and life coach are often used interchangeably to describe mental health providers, regardless of the **significant** differences in training and clinical experience of each specialty.

To complicate things further, APA is developing a "Masters' Program in Psychology Accreditation Initiative." APA's consensus statement for the Masters' Initiative states,

> We recognize the expertise in science, clinical practice and leadership offered by psychologists. Our responsibility is to address the shifting demographics and behavioral health needs of the U.S. population. We need to bring additional scientifically informed and culturally and linguistically responsible practitioners to all populations, including underserved populations, using approaches distinct from those offered by other behavioral health practitioners.

We believe this can be accomplished by the development of a

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Executive Director's Column
by Dr. Jerry Morris, PsyD, ABMP, ABPP

APA has had a summit and concocted a "Master's Program in Psychology Accreditation Initiative" (http://www.apa.org/pi/mfp/masters-summit/default.aspx)! Once again, as has occurred several times in my lifetime has APA started an initiative to help our academic colleagues who train masters psychologists in opposition to the APA Policy that the title Psychologist is reserved for Doctors of Psychology. The academics indicate that this is a response to both the national counselor's association's maneuver with state licensure to stop allowing master's in psychology (as opposed to counseling's masters) to sit for Professional Counselor Licensure (the market for MS in Psychology departments for years), and due to workforce needs in the mental health industry. Clearly, accrediting master's Degree Programs at Universities is not the only, or even the most helpful solution to the workforce demand for Psychologists. The problem could be solved by making it easier and less expensive, and more collaborative and growth oriented to develop doctorate programs in psychology.

A second problem is that many state psychological associations are dwindling in membership and walk in lock step with APA. They often have most of their board members and leadership that are academics since academics get release time and are paid for this type of service and practitioners must lose $1000 a day of income to take these positions. States are falling in line, as state psychological associations often do and take whatever comes down the pike from APA. Many states, such as my own are appointing academics as a liaison to the APA master's accreditation task force. They are decent people who will represent their industry well, but I have little expectation that they will represent the practitioner movement or practice.

It is immaterial to many states that the practice community is strongly behind the doctorate only position that has long been established in APA, NAPPP, and all Psychology Specialty Boards. There has been little coordination with the practitioner movement and associations that should be involved in these debates. When practitioners speak up people in state associations whose loyalty is greater to APA than the practitioner movement often call them uncivil, negative, or uncooperative. This is the typical in group-outgroup lack of interest in allowing practitioners to have the preeminent say so over any decisions that affect practice. That logic escapes both APA and many state associations.

It is hard for many at APA, in the research industry and in the academic industry, to understand practitioner's angry resistance to just accepting the national's revision of their "Dr" only position that many of us in the past generation fought in the trenches and bled financially and took lots of retaliation to establish in the nation and my home state of Missouri. I am licensed in Missouri, Louisiana, and Kansas and have several specialty Board certifications. I am an aging senior psychologist who understands the importance of the issue at hand. I'm glad we want a depth discussion that thought about this dangerous and complicated move. I'm glad that respect for the idea that many practitioners are not sure or comfortable about this path, and that true respect and belief in how complicated the decision is should notbe just left for APA but should be well discussed and thought

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Patient Education, Informed Consent & Professional Competence

Rory Fleming Richardson, Ph.D., TEP, ABMP

In the early 1970s, Oakland Kaiser Permanente, the Commonhealth Club in Santa Rosa, and other healthcare centers, started to pioneer the field of preventive, and prospective medicine through patient education, and health risk assessment. The introduction of the use of statistics for personal health assessment took a significant leap through the work done by Lewis C. Robbins, MD and Jack Hall, MD which resulted in the publication of How to Practice Prospective Medicine (1970). With the interest in preventative methods, the nurse education program at Sonoma State College began offering courses in Patient Education, and Health Risk Counseling, which were attended by nursing students and one psychology student, myself. We realized that the best way to garner patient compliance with health recommendations was through education, and providing personalized knowledge, of that patient's health risk. The choice was still the patient's to make, but it was more likely that if they were engaged as co-producers of their health care, they would be more likely to make the best decisions.

Informed consent has always been a hallmark of patient care. What is sometimes forgotten is that proper informed consent must be inclusive of adequate knowledge about benefits and risks. If the professional providing the informed consent is unaware of the scope of the benefits and risks, proper informed consent is not possible.

Since beginning in the mental health field in 1976, I have discovered that in the face of time-constraints, practice quality often deteriorates. One of the areas which has been most impacted is attending to patient education. Back in the 1970s, while attending California State College, Sonoma, I started by volunteering at the Commonhealth Club, a preventative/prospective medicine center in Santa Rosa: doing EKGs, and talking to individuals about the need for good nutrition and exercise. Over the years, I have come to understand that ***patient education*** is not an option, but a requirement.

During an intake interview, we will ask about medications being taken and any allergic reactions. As a medical psychologist attempting to determine the subtle problems which are present, we ask about the other health habits. Physicians, who are pressured to see as many patients as possible, will also spend time on these and other issues, but this tends to be limited. How many of us, as practitioners, spend time talking to the patient about the issues of name brand versus generic medications, the complications of taking over-the-counter medicationsand/or drinking alcohol, with prescription medications, or changes in health habits impacting psychiatric and medical treatment?

In the treatment of various psychiatric and physiological conditions, practitioners make decisions based on assumptions drawn from research, testing, clinical experience, and observations. This provides the patient with the best available therapeutic intervention. One of the complications comes from patient behavior which the practitioner does not know about. For example, if the patient takes over-the-counter (OTC) medications for an acute condition, such as a bad cold, these medications may compete with the prescribed medications for isoenzymes altering the therapeutic effect.

Just as a prescriber should alert the patient to the possibility of tobacco smoking habits altering Olanzapine levels, or the impact of Prozac on birth control medications, it is the clinicians duty to educate the patient that various changes in health habits can impact his/her reaction to regularly taken medications.[1]

Cytochrome P450 includes over 20 different isoenzymes in humans which are required for metabolizing of different medications. For the prescriber, it would be optimal to be able to use a basic chart of each medication combination and compare it with the specific patient, but there are simply too many variables. To determine the amount of availability of each isoform, and the overall level of P450, one would have to take into account all of the factors which can impact these levels. These include:

Genetic predisposition,
Supplements,
Daily food and substance intake,
Physiology of digestion, metabolism, absorption, and elimination,

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The following article, "**Prescriptive Authority *Enhancing Our Scope of Practice for Patient Welfare", by Dr. Susan Barngrover,*** is reprinted from Missouri Psychologist with permission of their Editor:

Ever feel frustrated at your inability to help your patient's access services? Missouri currently has a deficit of psychiatrists, and according to SAMHSA, this amount is not likely to increase. In 2013, work force demands did not meet projected patient needs, while 20% of behavioral health patients did not receive care from any health professional (SAMHSA, 2010). Primary care and specialty physicians often feel inadequately trained to diagnose and prescribe psychiatric medications, and unless you have a strong bond built on trust and fidelity, they are unlikely to honor your recommendations. In fact, these physicians are risking their own liability not to mention their patient's safety, when they have limited training in behavioral diagnosis and treatment. In reality, complications can include prescribing ineffective or long-term medications that not only increase side effects and iatrogenia but also discourage patients from embracing psychotherapy and healthy lifestyle changes (Galle, 2014). Clearly, a shift in Missouri policy is needed to enhance our scope of practice and improve patient welfare. As licensed psychologists, we are the entrepreneurs of creative, evidenced-based psychotherapy, which remains the backbone of our "psychotherapeutic matrix" (Galle, 2014). Likewise, when we have a case that is outside our scope of practice we refer to a specialty psychologist. If a neurologically compromised patient presents for treatment for reasons such as post CVA, dementia, TBI, etc. we may refer to a neuropsychologist for a more comprehensive evaluation and diagnostic testing to enhance treatment planning. Similarly, a medical psychologist can provide a cost effective, competitive and comprehensive assessment of mind/body interactions through distinctive mental health lenses, while distilling the relevant personal and sociocultural narratives to implement both psychological and medical treatment with "one stop shopping." Therefore, with complex comorbidities especially most prudent psychologists would welcome one of our own guild's diagnoses and treatment recommendations in the form of a medical psychologist, perhaps rather than the myopic view of psychiatry.

So what is a medical psychologist? In addition to being a doctorally trained psychologist, a medical psychologist holds a postdoctoral masters degree from an accredited university in psychopharmacology. They must have supervised practicum and pass a national exam, like the PEP for example. For the American Board of Medical Psychology, of which I serve as a board member, a medical psychologist must also pass a peer review committee including case presentations and a credential review and possess an understanding of complex ethical standards that insure principled practice (Caccavale, 2013).

What kinds of courses are required for this advanced training? These programs require a compendium of medical courses including: biochemistry, clinical medicine, anatomy and physiology, nutrition and lifestyle management, as well as psychopharmakinetics and psychodynamics of medications and their interactions with other drugs and disease states. Properly trained medical psychologists have been prescribing safely since 1995: that includes no ethical complaints or deaths or serious injury caused to their patients. Currently, only five states, including Louisiana, New Mexico, Illinois, Idaho and Iowa as well as Guam, the military and the Indian and Public Health Services allow medical psychologists to prescribe. Most states, for example require five years post doctoral experience in addition to one or two years of supervision of prescriptive authority to insure safe and

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HEALTH AND SCIENCE

Social Construction, Health, Illness and Healing

Review of Webpage article: "Perceptions of Health as Social Constructs" (pdhpe.net))

Reviewed by Jeffrey D. Cole, PhD, ABMP, Director, Board of Directors, AMP, ABMP

Sometimes it's not given as much weight in common discourse as the "bio" and the "psycho" components. But, the "biopsychosocial" model also has a social component!

This is a very interesting and important area of inquiry and important part of informed practice. Our bodies and minds exist in larger social, relational, environmental contexts that extend beyond our personal relationships and families. In addition to the more commonly referenced "social stressors" and "social supports" that contribute to our psychological and physical health and illness there are societal and cultural assumptions and mores about health, illness and healing that are internalized by "society's elements" -- ourselves -- affecting how we relate to our own health and health-and-illness related matters in general

The reviewed webpage, "Perceptions of Health as Social Constructs" (pdhpe.net) provides an explanation of social construction as this concept pertains to health and health-related perception:

From the page:

"Perceptions of health as social constructs requires you to understand that the various understandings and different meanings people have or attribute to health are mostly created by their society. That is, our understanding and interpretation of health is created and developed by our society. A good way to think about it is that your perception of health is greatly affected by your context. Have you ever wondered the question below, because social construction is the answer, as well as the previous individual factors (knowledge, skills, attitude, genetics)" (end quote)

The author notes some of the socioeconomic and sociocultural factors that affect our perceptions of health and illness: :

"Your understanding of perceptions of health as social constructs should identify that an individual's interpretation of health is largely influenced by their: socioeconomic status (education, employment, income), sociocultural status (family, peers, media, religion, culture), and environment (geographical, political, social, access to information and technology) among other things" (end quote)

They also note that these perceptions and mores can change as the society or culture changes:

"Perceptions of health as social constructs also means that the interpretation of health changes with time. This can be seen with the commoditisation of fitness and the growth of the health industry along side pharmaceuticals and the medical system. We have many large groups invested heavily in the concept of health, including what is means to be healthy and how to be healthy" (end quote)

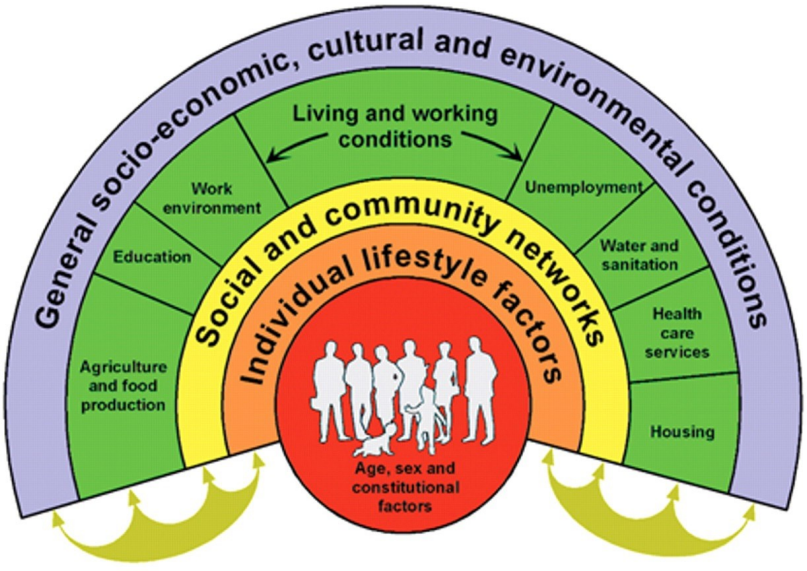
And, they note that these perceptions and mores can vary between cultures and societies:

"We also expect people in different contexts and from different cultures to have different perceptions of health. They have different meanings and interpretations of health because their understanding is a result of their society, just as our perception is a result of ours" (end quote)

Medical psychologists are doctors in psychology with advanced post-doctoral training in medical science and integration of psychological, biomedical and social concepts and approaches to health, illness and healing

Link to reviewed webpage: https://www.pdhpe.net/better-health-for-individuals/what-does-health-mean-to-individuals/perceptions-of-health/perceptions-of-health-as-social-constructs/

Figure below is reposted from the pdhpe.net website and can be accessed at the above link



Introducing New Diplomate:

Christopher Rossilli, PsyD, MS, ABMP

Dr. Rossilli recently met all the stringent criteria set by Academy of Medical Psychology and the American Board of Medical Psychology — post-doctoral studies in psychopharmacology, preceptorship, case writeups, oral and written exams — to qualify as a diplomate in Medical Psychology!

Dr. Rossilli earned his Bachelor of Arts in Psychology from Radford University in 1997. He obtained a Master of Science in Mental Health Counseling from Nova Southeastern University in 2003. He graduated from Carlos Albizu University in Miami, FL, with a Doctorate in Clinical Psychology Psy.D and specialization in Neuropsychology in 2009. Dr. Rossilli completed a post-doctoral residency in Neuropsychology at Lynn University in 2011. He graduated from Nova Southeastern University with a Post-Doctoral Master's in Psychopharmacology in 2014.

He currently serves as the President of Medical Psychology Division of the Florida Psychological Association. He also is a Board member for the RxP political action committee. Dr. Rossilli is commonly asked to present at Grand Rounds on topics such as Post-Stroke Delirium and Traumatic Brain Injury, and his medical errors course, How to think like a RXP psychologist and prevent medical errors. He speaks throughout the community on topics such as stress management, memory disorders, and cognitive changes after brain aneurysm. He currently has a private practice call Cognitive Care. He currently holds privileges in 4 area hospitals. In March of 2018 he passed the Psychopharmacology Examination for Psychologists. He is a adjunct professor at Florida Institute of Technology and teaches Clinical Psychopharmacology. He was recently recruited to be an instructor for GME's for incoming medical residents in hospital settings for HCA.

JOIN OUR GROUP OF PROFESSIONALS

Members are licensed psychologists who have an interest in medical psychology and will have full voting privileges in elections of officers and board members. Members are not Diplomates/Specialists in Medical Psychology, but are licensed psychologists who have an interest in medical psychology… http://amphome.org/wordpress/why-join-amp/

BOARD CERTIFICATION INFORMATION

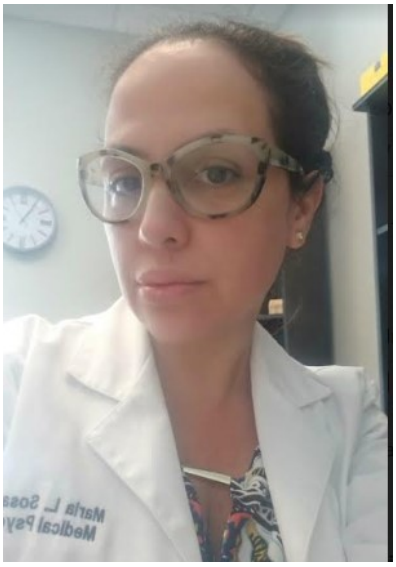
Board certification in Medical Psychology indicates specialty expertise, which distinguishes you from other psychologists who do not have post-doctoral specialty training in medical psychology, basic science, and psychopharmacology and work with patients in or in affiliation with healthcare facilities in the nation's core healthcare system… http://amphome.org/wordpress/abmp-requirements/

GET THE TRAINING YOU NEED

The national practitioner's association (National Alliance of Professional Providers in Psychology) in psychology (www.nappp.org), one of our affiliated organizations has kindly offered the below CE courses relevant to our discipline. There are several continuing education courses available to members… http://amphome.org/wordpress/continuing-education/

***Introducing Medical Psychology Resident*:**

Maria L. Sosa, Psy.D. Dr Sosa is currently completing her postdoctoral residency at AllCare Medical Centers (ACMC), a Medical Psychology and Neuropsychology Program where she is establishing herself as a knowledgeable and conscientious Clinical Psychologist and Neuropsychologist with specialty in Psychopharmacology. These areas of expertise distinguishes her from other professionals as she can understand the psychosocial complexities of cases commonly seen in medical settings while integrating the biopsychosocial model into her professional practice. Her holistic and patient-centered approach to care encompasses her work at ACMC. This outpatient clinic serves a broad variety within the population from children to pre-teens, teens, young adults, adults and geriatrics. Dr. Sosa is experienced in completing comprehensive assessment of patients suffering from a variety of psychological and neuropsychological conditions including neurodevelopmental and neurodegenerative disorders and diseases. Additionally, Dr. Sosa conducts clinical diagnostic interviews, medication review and management, implements evidenced-base therapeutic interventions, provides supervision to interns and externs, and offers consultation to other health care providers (i.e., physicians, nurses, physical therapists, speech pathologists, occupational therapists, and others). She graduated from an APA- Accredited Clinical Psychology Program offered by Albizu University-Miami campus with concentration in Neuropsychology, and completed her internship year at Miami Dade Community Action Human Services Department (an APA-accredited program). She taught as an adjunct professor in Albizu University for the undergraduate program the subject of Health Psychology. Dr. Sosa completed her Bachelors of Science in Psychology and her Masters in Science of Psychology at Albizu University. During her time in the doctoral program, Dr. Sosa has an extensive teaching assistance experience (5 years) and also has been actively involved in many research projects ranging from cultural factors in suicide prevention to the over-representation of bilingual children in our school systems, and neurodevelopmental and neurodegenerative disorders. Dr. Sosa's research endeavors have led to presentations at national conferences such as at the National Academy of Neuropsychology and regional research symposiums. Being of immigrant descent and multilingual, cultural implications and the impact of neuropsychological functioning is one of her research interests as well as medical psychology and the holistic approach. Remarkably, Dr. Sosa traveled to Bolivia to see the first-hand effects of CHIKV in her native country and became interested in pursuing this area of infection disease a research topic for her dissertation. This research interest became a personal pursuit as she witnessed her mother's affliction with the disease and months of misdiagnosis and suffering. She is hopeful with this contribution to the scientific literature that practitioners will take notice of the impact this disease has on neuropsychological and psychological functions long-term and, ultimately, find a cure.



If you are interested in AllCare Medical Center's (ACMC) Medical Psychology and Neuropsychology Residency Training Program please see their advertisement on the following page

ALLCARE MEDICAL CENTERS (ACMC)

IS OFFERING:
PRE-DOCTORAL INTERNSHIP AND POST-DOCTORAL RESIDENCY TRAINIING OPPORTUNITIES FOR PSYCHOLOGY STUDENTS AND GRADUATES IN:

CLINICAL PSYCHOLOGY, MEDICAL PSYCHOLOGY AND NEUROPSYCHOLOGY

Dr. Matthew Nessetti, one of AMP's pioneering founders and specialists in medical-psychology is also a physician specializing in family medicine. He and his wife, who is also a physician, operate AllCare Medical Centers (ACMC) comprehensive clinics in Florida providing medical, psychological and integrative healthcare services. AllCare is offering a psychological internship as described in the advertisement below.

AllCare is a family owned organization providing primary healthcare to patients of all ages, from newborn to aging adults. A psychological component is integrated throughout the primary healthcare practice, concentrating on the necessity to concurrently treat both the mind, as well as the body. Interns will provide psychological services, including individual and family therapy, to an outpatient population to children, adolescents, adults, and geriatrics that present with acute mental health issues. Interns will have the opportunity to provide neuropsychological assessments to patients presenting with psychological, neuropsychological, and medical conditions. Interns will also provide comprehensive psychological assessments to children, adolescents, and adults for diagnostic clarity and treatment planning.

ACMC offers a one-position two-year Residency in Medical Psychology. Throughout the program, each resident will benefit from a planned, programmed sequence of supervised training experiences. The first year serves as the post-doctoral year required by most states for licensure. Each resident is evaluated based on their experience, training and level of competency in clinical services, with training activities then tailored to meet each resident's needs. The second year serves to meet the licensure requirements in some states and build toward the board certification process. Selection is based upon the quality of the application and the compatibility between the applicant's interests and their ACMC goals and objectives.

Please contact Kelly L. Nessetti Prather at AllCare (contact information below) for additional information on the program and for information on applying:

Kelly L. Nessetti Prather CPC
Practice Administrator AllCare Medical Centers, P.C.
5860 Ranch Lake Blvd.
Suite 200
Bradenton, Florida 34202
Phone: 941-388-8997
www.AllCareMedicalCenters.com

kprather@AllCareMedicalCenters.Com

(President's cont.'d from pg. 1)

complementary model of training and credentialing for master's level practitioners in psychology. This alliance and integration in the field of **psychology that includes both doctoral and master's level practitioners who are committed to the scientifically driven practice of psychology** will greatly expand the reach of our field in the coordinated delivery of behavioral health services.

The cause may be noble, but APA is tasked principally with representing the interests of psychologists. My concern is the Masters' accreditation initiative will confound the identity of psychologists with other behavioral health care providers even further, resulting in the unintended consequence of diluting the identity of psychologists to a greater extent.

Dr. Morris writes eloquently about the pros and cons of the APA Masters' accreditation initiative, in his article in this newsletter.

A second goal is to recruit new psychologists to AMP to secure the future of psychology as an independent profession. AMP is currently guided by a board of directors in their late 50's, 60's and 70's of retired, semi-retired and planning to retire psychologists. Drs. Caccavale and Morris have emphasized on multiple occasions that psychology needs a new generation of leaders willing to commit time and effort to the cause. They speak from experience, both having contributed tireless hours, intellectual property, financial resources and compassion for the greater good of our psychology community.

I recently reached out to several psychologists and AMP members requesting that they increase their participation in the AMP effort. The typical response was, "I am too busy" which is understandable. But having served on the AMP board for the past few years, it is evident that everyone is "too busy." However, I am astounded by what my AMP colleagues accomplish for AMP members and other psychologists, despite their other time commitments and this underlies my intention of recruiting more psychologists to AMP to contribute as members, diplomates or board members.

The future of psychology lies with the next generations of medical psychologists and my intention is to work with the next generation of leaders so that medical psychology survives and thrives as a psychological specialty.

Thirdly, as many psychologists know, the APA has discontinued the Certificate of Proficiency in the Treatment of Alcohol and Other Psychoactive Substance Use Disorders Certification for psychologists. The AMP board is currently discussing alternative options to address the void created by APA's action. The market for substance abuse certification programs is competitive, to say the least, however there may be a need that AMP can fill, specifically for psychologists.

Finally, as the president of AMP, my primary objective is that my service will be measurably beneficial to medical psychologists, our patients and the future of psychology.

Illustration: Asclepius was a battlefield physician who later became identified as the Greek god of medicine. His snake-entwined staff is the symbol of medicine today and, when together with the Greek Psi symbol comprises the symbol of Medical Psychology

(Exec. Dir.'s column cont.'d from p. 2)

that has afforded me and patients. I led the efforts to get our law revised to doctorate only licensure. I have been active in the Professional school movement and the Practitioner movement nationally. I have held positions in leadership in APA, NAPPP, two psychology specialty boards, and understand the numerous and powerful factions in APA. I am an LPC as well as licensed Family Therapist and have trained many disciplines including physicians and nurse practitioners. I am an approved supervisor and have employees who are LPCs. I understand their important role and help in our industry and healthcare system.

The issue is bigger than manpower and need. The issue is our identity. I agree we need more practitioners, but I think the solution is "train more doctorate psychologists". I was the largest clinical division in APA Hospital and Healthcare Facilities Chair for 11 years as we fought for parity with psychiatrists and recognition with general physicians as specialists. I know how important our identity is in that effort. I was a lobbyist with Bryant and Donna when we called on HEW and eventually politicized our way into Medicare. I was a lobbyist (registered) when we got hospital privileges and Medicaid Vendorship in MO. I know how important our
Doctor Identity to our efforts to protect, extend, and defend our profession.

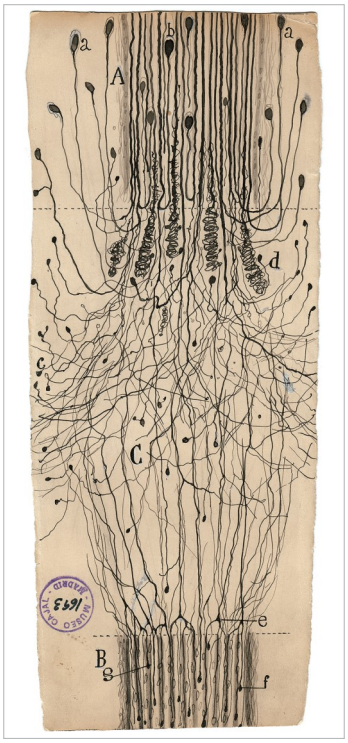
Trust me. I agree that a respect for the complexity of this issue, and not letting the national association lull us into simply accepting master's accreditation is for practitioners in each state. We simply don't have to accept APA's lead on everything. In our specialty board, we are a Doctorate Only Specialty, with one of the most complex and arduous post-doctoral specialization training and examination requirements. We favor allowing doctors to have assistants that function as psychological technicians, and Medicare and many Insurers allow this if they are closely supervised and the doctor ensures the quality of data and does the diagnostic interpretation and treatment plan development. We don't need accredited masters programs in psychology to do that and such an action is the first step toward a dual level licensure down the road. Clearly, our communities need more psychologists, specialized psychologists, and highly skilled diagnosticians and scientifically valid treatment planning. The answer is to pay specialists at a rate that encourages advanced study and specialization and provide more financial support for doctorate education in psychology -not certification of master's graduates called graduate psychologists! Specialty boards need to be heard loud and clear on this issue and about the more realistic solutions. I will be asking our board and specialists and society members to weigh in on this national issue and educate me and the board further. You can contact me at cmhcjerry@sbcglobal.net

Jerry Morris, PsyD, MBA, MsPharm, ABMP, ABPP, ABBHP, NASP, CCM

Executive Director

Academy of Medical Psychology and American Board of Medical Psychology

Illustration: Santiago Ramon Y Cajal (1913) , "Nerve outside the spinal cord"



Transcript of NBC interview with ABMP Board Member and Archives Science Director, Dr. Susana Galle, PhD, ABMP on heat risk associated with psychotropic use, titled:

Here's a Surprising Heat Risk for 1 in 6 Americans: Psychiatric Medications can Interfere with the Body's Ability to Regulate Temperature and Most Patients don't Know, **NBC** News, Avichai Scher, June 28, 2018

It hit 101 degrees Thursday in Wichita, and special education teacher Sherry White knows to stay inside.

That's because this kind of heat -- currently making much of the country sweat -- can be especially dangerous for people like her, who take certain psychiatric drugs.

White has fibromyalgia, which her doctor treats with Cymbalta, an antidepressant that helps treat the symptoms. But because of the drug, White's ankles swell, she sweats profusely, feels faint, and is short of breath when it gets too hot.

"I've seen people who say they are feeling feverish, they don't realize it's the medication."

As a result, she spends her summers cloistered in her home.

"I used to love to garden and taking my granddaughter to the zoo in the summer," White said. "Now, I feel like I've let them down."

White is among the one in six Americans who take psychiatric medications. Many can interfere with the activity of the hypothalamus, a part of the brain that helps regulate temperature and thirst.

Some people taking psychiatric medications can lose some of their thirst even as their body is more prone to dehydration. It's a dangerous combination.

Extreme record heat is hitting much of the U.S. this week, exposing an estimated 160 million Americans to dangerously high temperatures.

It's no secret that such high temperatures can kill. According to the National Weather Service, from 2006-2016, an average of 97 people died each year from extreme heat. Children under four and adults over 65 are most at risk of heat stroke, but people taking a variety of medications have a disproportionate risk. Studies have shown that those with mental illness are at higher risk during heat waves. A study of the 2012 Wisconsin heat wave that killed 27 people found that more than half of those deaths had mental illness, and half of those were taking psychiatric medication.

Not all patients taking psychiatric medication will have increased sensitivity to extreme heat, but many who do suffer in the heat may not understand why.

Dr. Susana Galle, a medical and prescribing psychologist who has researched the effects of heat on people with mental illness, said that there's not enough awareness of the effect psychiatric medications can have. She said psychiatrists prescribing medication need to warn patients about the risk heat presents, and encourage them to drink more water and stay out of the heat.

"I've seen people who say they are feeling feverish. They don't realize it's the medication," Galle told NBC News.

For years, White didn't understand why she struggled more in the summer than other people around her.

She remembers the first time she realized the heat was getting to her. A parent came in to pick up a child and asked her why she was sweating so much and if she was all right. White is overweight and she said she blamed her weight for the extreme sweating.

"It was humiliating," White said. "I didn't know it was the antidepressants."

No doctor ever told her, either. She took it upon herself to read up on all the medications she was taking and saw that dehydration and sensitivity to heat was a possible side effect. Other medications that cause sensitivity to heat and interfere with temperature regulation include antihistamines, beta-blockers and amphetamines. Patients taking drugs should look into the side effects and plan ahead. they should also take care to properly store medication.

The Centers for Disease Control and Prevention offers a guide for how to prepare for and withstand extreme heat, as well as a more detailed explanation of heat-related illnesses.

Galle stressed that the importance of being informed about heat-related side effects of medication isn't just physical, but emotional too."Not knowing what is wrong with them exacerbates their problems," she said.

(Pt Education cont.'d from p. 3)

neurotoxins, radiation, environmental variants, etc.).
One of the best known food that impacts on P450 levels is that of the intake of grapefruit juice which lowers P450.[2] Although there has been controversy over the research, there has been evidence that P450 is also impacted by environmental contaminants such as glyphosate, a key ingredient in Round Up herbacide and in GMO products.[3]

To complicate this picture, P450 isoenzymes have different affinity for different medications (or chemicals), choosing to metabolize one chemical prior to another. This results in the level of one medication being higher in the body than another, possibly causimg unpredictable drug interactions and complications.[4]

The best way to address the practical issues involved consists of a two step process: (1) avoid taking potentially competing medications at the same time, and (2) monitor patient symptoms and reactions to medication changes. Since the patient is likely to change eating habits, health habits, and take over-the-counter medications without the prescriber's knowledge; one of the most important tasks of the prescriber is to educate the patient as to the impact these changes can have on effectiveness of their medications. Just as a prescriber of Olanzapine should caution his/her patient as to the impact of tobacco smoking on the effectiveness of the medication, the prescriber should provide the necessary information for a patient to self-monitor.

Another variable which can occur without the awareness of the prescriber, and sometimes the patient, is the substitution of a generic medication or one from a different manufacturer. Although the equivalency is designed to minimize concerns, differences are present which, for some patients, can significantly alter the effectiveness of the medication. The exact reason is unclear, but may be related to the combination and type of fillers and congeners used. Prescribers and pharmacies attempt to minimize these concerns to prevent a placebo (or nocebo) affect from occurring, but awareness of the potential problems are needed.

One of the things that is not covered in the information on most medications is the other ingredients in the medications, and the fact that the exact amount of active ingredients will vary from pill to pill. So what is the "other stuff" in the pills? These are what are known as inactive ingredients, which is somewhat of a misnomer. They are only inactive in that they are substances which do not relate to the purpose of the medication. These include:

Anti-adherents (used to resolve problems in medication manufacturing),
Binders (such as lactose, sucrose, microcrystalline cellulose, malitol, sorbitol, or xylitol to hold medications together and add weight),
Coatings (such as hydroxypropylmethocellulose making it easier to swallow pills, modulate breakdown, and reduce deterioration),
Disintegrants (such as sodium starch glycosylate to promote breakdown and absorption),
Fillers and diluents (such as lactose, sucrose, magnesium stearate, glucose, plant cellulose, and calcium carbonate that add bulk),
Lubricants (such as silica, talc, stearic acid, magnesium stearate),
Preservatives (such as vitamin A, C, E, selenium, amino acids, methyl paraben, propyl paraben),
Coloring (for differentiation of medications and dosages).
Artificial flavoring[5]

Since different manufacturers of a medication are likely to use different excipients and fillers, a medication manufactured by one company may impact the patient different than another. In addition, some individuals appear to present unusual hypersensitivity to some excipients and fillers. This can bring on additional complications. It is also a currently common practice for pharmacies to substitute medications unless the prescriber specifically states, "No substitution," or "Name Brand Only," or "No substitutions without prior approval by prescriber." Generics are frequently substituted for Name Brand because of cost. Periodically, this is less than "cost saving." In one of my long-term patients who had an extremely complicated profile, she had been on Name Brand fluoxetine (Prozac) for three years without problems. The pharmacy changed the medication to generic without the knowledge of the prescriber. Within a week, the patient deteriorated to the point that hospitalization was

(Pt. Ed. Cont.'d from previous pg.)

necessary.

In the coarse of practice, some elements of informed consent and patient education can be omitted. But it is important for us to remember the subtle, everyday habits of our patients to be able to provide the best treatment possible.

1 Chiu CC, Lu ML, Huang MC, Chen KP. Heavy smoking, reduced olanzapine levels, and treatment effects: a case report. Ther Drug Monit. 2004 Oct;26 (5): 579-81.

2 Hukkanen J1, Jacob P 3rd, Benowitz NL. Effect of grapefruit juice on cytochrome P450 2A6 and nicotine renal clearance. Clin Pharmacol Ther. 2006 Nov;80(5): 522-30.

3 Seneff S, Samsel A. Glyphosate's Suppression of Cytochrome P450 Enzymes and Amino Acid Biosynthesis by the Gut Microbiome: Pathways to Modern Diseases. Entropy 2013, 15(4), 1416-1463; doi:10.3390

4 Gakis C1, Cappio-Borlino A, Pulina G. Enzymes (isoenzyme system) as homeostatic mechanisms the isoenzyme (ADA2) of adenosine deaminase of human monocytes-macrophages as a regulator of the 2'deoxyadenosine. Biochem Mol Biol Int. 1998 Oct;46(3):487-94.

5 5 http:// www.ndhealthfacts.org/wiki/ Excipients_and_Fillers practitioners, etc. to write prescriptions, we would be

able to order labs that would

(Prescriptive Authority, cont.'d from p. 4)

efficacious treatment.

So what are some of the advantages to our patients? Besides the shortage of trained physicians, nurse practitioners, etc. to write prescriptions, we would be able to order labs that would help rule out or confirm diagnostic comorbidities. For example, hypothyroidism or vitamin deficiencies could be referred back to the appropriate physician for treatment in concert with a psychotherapeutic approach that focuses on lifestyle and nutrition interventions by a medical psychologist or referring psychologist.

We could also UNPRESCRIBE! Many of the patients that I treat as a medical psychologist are on a plethora of drugs, and that cocktail may be producing psychological sequelea that are an unnecessary burden on the patients mind and body. With prescriptive privileges, we have the skills to recommend a slow titration off many psychiatric medications or recommend to their physician, a medication with a dual purpose. For instance, a blood pressure medicine that treats anxiety or PTSD as well as hypertension. Another current advantage, with the advent of ASPPB and MOPA's PSYPACT promoting interstate telepsychology, psychologists would be able to reach more underserved populations, for example, including rural and geropsychology patients. This is psychology's golden opportunity to increase scope of practice and insure our ability to treat patients within the unique perspective of a psychologist's prevue. Unfortunately, we are in needless competition with other midlevel providers, perhaps because psychologists have not advocated for their own unique and superior skills of diagnosis, most notably with psychological testing, evidence-based psychotherapy and treatment evaluation. If given prescriptive authority, medical psychology will no longer be mitigated to fractional treatment, but will instead promote state of the art care on behalf of our most vulnerable patients.

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Supply and Demand for Selected Behavioral Health Practitioners 2013-2025 November, 2010.

Prescriptive Authority
Enhancing Our Scope of Practice for Patient Welfare

INTEGRATED CARE COMMITTEE MEMBER
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(Brochure continues on next page)

(Brochure continues from previous page)

FRIDAY March 22, 2019

Keith Petrosky, Ph.D., ABMP: "Analog Thinking in Advancing Our Knowledge of Mental Health"

Howard S. Rubin, Ph.D., ABMP: "Medical Cannabis: Guidance for Clinicians"

David Reinhardt, Ph.D., ABMP: Mental Health Effects of Endocrine Dysfunction: Symptoms, Assessment and Treatment Strategies

Larry Waldman, Ph.D., ABPP : "Ethical, Effective and Efficient Private Practice Marketing "

David Clayman, Ph.D. "Methods and Knowledge for Innovative Service Delivery"

SATURDAY March 23, 2019

John Caccavale, Ph.D. "Clinical Practice Is Not Dead Yet "

Jerry Morris,Psy.D., ABPP, ABMP."Pain Control and Related Problems: Medical and Practitioner Opportunities"

Ward Lawson, Ph.D., ABPP,ABMP. "Contextual and Lifestyle Factors in Medical Psychology"

Roger Morgan, Ph.D., MD. "Culture counseling considerations in the Hispanic population."

Karyn Hall, Ph.D. "Radically Open DBT Treatment"

SUNDAY March 24, 2019

Robert North, Ed.D., MD. & Roger Morgan, Ph.D., MD.

"Use and Misuse of Antipsychotic Medications in a Nursing Home Setting Per CMS Guidelines"

Lendell W. Braud, Ph.D. "Relaxation, Imagery & Art – Effective Interventions for Trauma, Behavioral and Emotional Problems"

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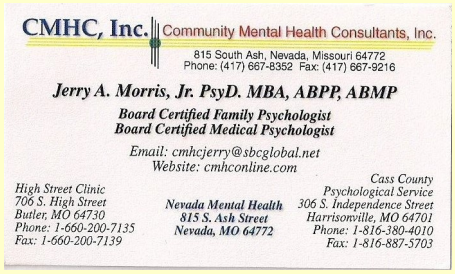

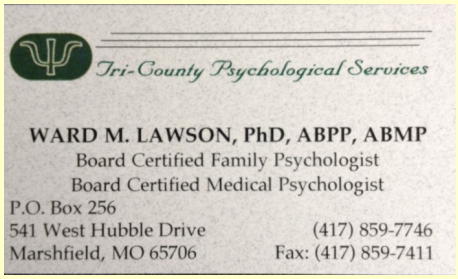

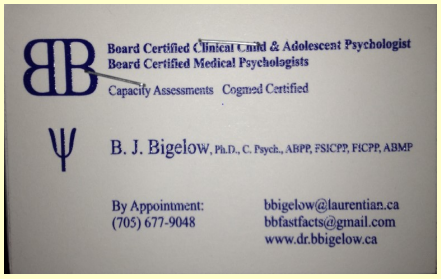

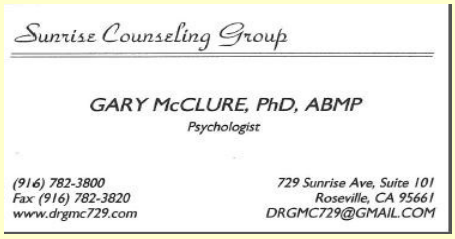

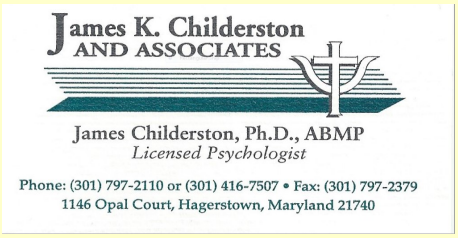

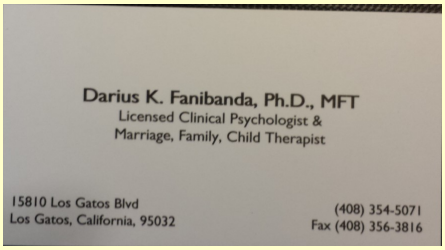

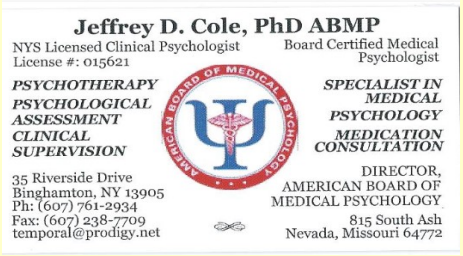

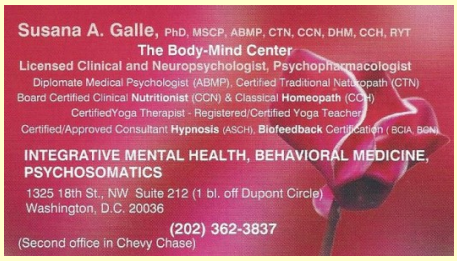

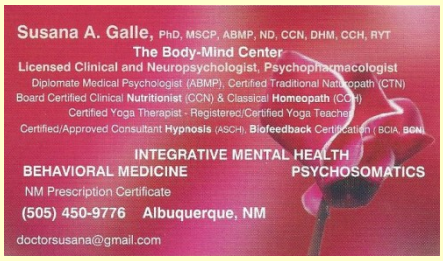

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DEAR AMP MEMBERS AND ABMP DIPLOMATES:

If you would like to have a copy of your business card included on the page please scan your card and email the scan to me, Dr. Jeff Cole, Editor "The AMP" at: DrJeffDCole@gmail.com and, your card will be included on our Business Cards page with the next issue of "The AMP"!

There is a $20 fee for the service, payable to "Academy of Medical Psychology" deliverable to our Nevada, Missouri corporate office address as shown on our home page.

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Perk!: ***the $20 fee is waived for all Board members and AMP governance and for editorial staff of our "Archives of Medical Psychology" peer-reviewed journal!!***

Dr. Cole

Editor, "The AMP"

INVITATION FOR CONTRIBUTIONS

"THE AMP" NEWSLETTER -- NEWSLETTER OF THE ACADEMY OF MEDICAL PSYCHOLOGY (AMP) – INVITES YOU TO CONTRIBUTE SHORT ARTICLES AND BRIEF PIECES FOR OUR UPCOMING ISSUE!

Our theme is the integration of psychological and medical theory and practice and movements within psychology that increase psychology's role in both mental healthcare and medicine, all falling under the rubric and specialty designation of "Medical Psychology".

Specific topics that past articles have addressed, or that would be welcomed, include but are not limited to the following:

*Psychological and behavioral approaches as first-line treatments and in combination with medication and other medical treatments

*Behavioral health, placebo phenomena, and psychosomatics in healthcare and mental healthcare

*Interdisciplinary practice, e.g., Psychologists as part of — or leaders of — health teams in clinics and institutional medical and mental health settings

*Reviews and discussions of scientific and scholarly articles and books supporting medically and psychologically- integrated understanding of psychiatric and medical illnesses, *e.g., research into stress and immune response, stress and protective factors (e.g.., relationship and oxytocin phenomena), cardiovascular health, epigenetics*

*Commentary, on matters associated with relevant to Medical Psychology e.g.,:

DSM, and other diagnostic nosologies their uses, abuses and relevance to healthcare; RDoc

*Emerging Practice Trends, e.g., *Articles on Telehealth and other alternative delivery modalities*

We have a column specifically dedicated to student writing. "Student" can include any one in the course of his or her formal learning process, e.g., undergrad, grad, post-doctoral or specialty/diplomat training

If you would like to sample previous editions of "The AMP" to see what sort of entries are there, here is the link to our newsletter archives:

http://www.amphome.org/newsletter.php

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AMP
ARCHIVES OF MEDICAL PSYCHOLOGY

Invitation to Join the Archives of Medical Psychology Team

Ward M. Lawson, PhD, ABPP, ABMP
Managing Editor, Archives of Medical Psychology

The Academy of Medical Psychology received final approval of its trademark and logo of the Archives of Medical Psychology in November 2009. The Board of AMP and ABMP seeks your assistance in the editing and publishing of the Archives of Medical Psychology.

The Academy of Medical Psychology was founded as an organization of practitioners for practitioner interests through volunteerism. Service on the Board is an unpaid duty of psychologists dedicated to the advancement of Medical Psychology. Medical Psychology's goal is to enhance access to specialty behavioral health care that is in such short supply that it has been declared an emergency in some states and recognized by military and veterans' services as a critical shortage. State prisons have been designated as mental health shortage areas by HRSA and prisons in some states are in the hands of federal receivership. Thus, the Academy has a crucial role as practitioner organization in advocating for the health and safety of the public at large and the military and other governmental agencies designed to serve public needs. The advocacy role for public health service must be a primary mission of the Academy.

The Archives of Medical Psychology, on the other hand, is a repository of information that can serve this advocacy function of the organization and collect valuable new data for continuing education of members of the Academy. Editing of the Archives must be by people that have the necessary experience in medical psychology and the skills to carry out these functions. Editing also requires electronic communication skills for the actual publication of the Archives. The variety of the skills necessary for publication in the journal are unlikely to be found even in a complete Editor. Members of the Board of the Academy are already assigned specific tasks and duties within the organization and cannot be expected to contribute routinely in the editing and publishing of the Archives. Therefore, the Board has begun a search for members of the Academy to volunteer in the editing and publishing of the Archives and ask your personal support. The Board of AMP invites you to contribute your services to the Archives. We welcome AMP members with prior publishing experience and those with computer expertise who are willing to learn the rudiments of editing and electronic publishing. For further information contact Ward Lawson at ozarkscare@yahoo.com .

Dr. Ward M. Lawson: Editor

Call for Manuscripts

The Archives of Medical Psychology is now accepting submissions for the next issue. We welcome original articles of interest to readers of medical psychology. For information about requirements for submission of articles go to www.amphome.org and click on Journal Archives in the left-hand column or simply type in Archives of Medical Psychology on Google.

Editor at OzarksCare@yahoo.com.

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AMP's new journal needs specialty editors and authors. Help us have a great place to keep our specialists aware of emerging practice issues, science, and opportunities. Volunteer! Sign up for the Journal at http://amphome.org/.

ANNOUNCEMENTS FROM YOUR EDITOR

In this issue of "The AMP" a little "yin" and a little "yang". On the "yin" side, President Dr Gary McClure and Executive Director Dr. Jerry Morris write about the problem of the APA push for licensed Master's level psychologists and the effect this will have on our doctoral level profession.

On the "yang" side, both also write about the emergence of our specialty as an increasingly-established entity in healthcare. The Academy of Medical Psychology (AMP) and the American Board of Medical Psychology (ABMP) are leading medical psychology into a new era: The era of medical psychology residency training programs. Multiple new residencies, directed by Executive Director, Dr. Jerry Morris and AMP pioneer, physician and medical psychologist Dr. Matthew Nessetti are actively training residents in integrated treatment. Established medical psychology residencies will help to coalesce, systematize and provide structured training venues for our up-and-coming specialists.

Board member and Specialist Dr. Susan Barngrover writes about the role of expanded RxP training and credentialing in our specialty and psychology as a whole and Specialist Dr. Rory Richardson writes about his own training experiences early in the interface of medicine and psychology.

While I say it every issue, it is because it remains true: This is an exciting time to be a Medical Psychologist! The specialty is both new and established, and, from a solid base is continually and exponentially growing

Jeffrey D. Cole, PhD, ABMP

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