Academy of Medical Psychology

The AMP

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

PRESIDENT'S LETTER

Dear AMP Colleagues,

Our academy is undergoing significant personnel changes. The begin with, the composition of the Academy of Medical Psychology (AMP) Board of Directors has seen dramatic changes over the past several months. Most significant is the retirement of two key Board members that founded AMP and have served diligently since inception.

Dr. Jerry Morris served in multiple roles for AMP, as a board member, president and executive director until his semi-retirement in March of 2019. Dr. Morris is an accomplished psychologist who has generously served on multiple boards and contributed tireless time, resources and leadership to professional psychology. Dr. Morris was awarded a lifetime achievement award in March of 2019, from NAPPP executive director, Dr. John Caccavale. Dr. Morris has contributed to AMP in many different roles and his absence will be felt by us all.

Dr. John Caccavale also wears many hats at AMP and other leadership positions in psychology organizations advocating for clinical and medical psychology. He has published extensively on contemporary issues professional psychology faces and he is the Executive Director of the National Alliance of Professional Psychology Providers (NAPPP). Dr. Caccavale's absence will require several people to fill, as he tirelessly offered his wisdom, insight, and vision for the benefit of many.

I am grateful for the opportunity to have worked and learned from these two psychologists who have consistently contributed to the advancement of psychology.

The AMP board of directors unanimously voted to grant Dr. Morris and Dr. Caccavale, Emeritus Status, to acknowledge their tireless contributions, vision, insight and leadership they made to professional, medical psychology.

Dr. Ward Lawson was nominated to fill the AMP Executive Director position which he graciously accepted. Congratulations to Dr. Lawson who was confirmed as the Executive Director of AMP in March of 2019, by the AMP board of directors.

The AMP board of directors had two vacancies from the retirements of Drs. Morris and Caccavale and Dr. Lawson's transition to Executive Director. I am honored to announce that the AMP board of directors unanimously voted to approve two new board members, Amie Cooper, Psy.D., and Keith Petrosky, Ph.D. Drs. Cooper and Petrosky have accepted the appointments. The AMP board congratulates and welcomes Dr. Cooper and Dr. Petrosky and we look forward to working with both of our new board members.

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American Board of Medical Psychology Board of Directors: Gary McClure, PHD, ABMP, President and Head of Credentialing Committee; Ward Lawson, PhD, ABPP, ABMP, Executive Director, Archives Editor; Jeffrey D. Cole, PhD, ABMP, Director, AMP Newsletter, Facebook Page Editor, Archives Assoc. Editor: Susan Barngrover, PhD, ABMP - Secretary, Archives Assoc. Editor; Susana Galle, PhD, ABMP—Director, Archives Science Editor, Cal Robinson, PhD, Director; Keith Petrosky, Phd, ABMP; Amie Cooper, PhD, Student Member, Bethany Nevins administrative 660-200-7135. Newsletter Co-Editor: Rory Richards, PhD, ABMP

Executive Director's Column

Ward Lawson, PhD, ABPP, ABMP

It is with mixed feelings that I assume the role of Executive Director for the American Board of Medical Psychology for the next term. While pleased to serve for the specialty and with such a great board, it is from a wistful place as well. My esteemed predecessor and friend, Dr. Jerry Morris, has held the position with unparalleled energy and passion for years and has done so with professionalism that has advanced our specialty in powerfully significant ways.

Whether on the front lines of treatment or waist-deep in meetings at the top national venues, Dr. Morris has been a fierce advocate for patients and the specialty of Medical Psychology. In so doing, he was deservedly bestowed the highest honor- the Nicholas Cummings Lifetime Achievement Award at the joint NAPPP/AMP conference in San Antonio last March! Still, in his new role as emeritus board member, he continues to serve and contribute as author and Editor for the Archives of Medical Psychology, managing the AMP website, developing the Continuing Education center to a level of excellence, developing the online Master's degree program in Medical psychology,and co-authoring a book with Dr. Caccavale.

We need more leaders like Dr. Morris to champion our specialty! We need to stand up for millions of poorly or untreated Americans who are a part of a health care system that fails to recognized the prevalence data regarding mental illness. This same health care system fails to adequately staff psychologists in primary care, hospitals, nursing home, residential care, and substance abuse rehab centers. The demand is enormous! There are so many unmet mental health treatment needs in our country! Sadly, the academic's solution is to push for a solution that supports their institutional agenda and train more Master's level providers and call them "Psychologists!" We need leaders like Dr. Morris to fight this erosion of the title "Psychologist" and advocate for the training of more psychologists, along with compensation befitting of our years of hard training and clear expertise! Of course, there are times when a nurse is sufficient- for a service that does not require a physician.

Similarly, there are services a counselor can provide and a Psychologist is not needed. However, Psychologists need to be in leadership positions, and Medical Psychologists especially so, when it comes to health care facilities that accept Medicaid and Medicare more workers are needed!

We will soon have board members closing out their term serving and our organization and specialty will need new blood to continue the work! There are opportunities to serve on specialty committees as training ground for board service. We need help with the Archives, this newsletter, the Continuing Education Center, Credentialing, and more. I invite questions from any of you regarding what is involved in service to the Academy. For the general membership, I want to thank those of you that give your financial support and paid your dues on time! As I process my first batch of dues correspondence and payments, it troubles me to note that over half did not pay the $15 late fee. This is sad, disappointing, and does not reflect the type of character befitting our specialty! Fortunately, there are many in our small but mighty ranks that have integrity and illustrate the professional image that makes us proud! Medical Psychologists have so much to offer. If you are not yet involved in the work of the Academy, I challenge you to 'step up your game' and enjoy the enrichment you will experience!

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Congratulations to Iowa, another RxP victory!

By Dr. Elizabeth Lonning and Dr. Susan Barngrover

Yet another success for medical psychology, as RxP becomes a reality thanks to Dr Elizabeth Lonning, Psyd, chair of Iowa's RxP committee and her tireless campaign to increase the scope of practice for prescribing psychologists and her fellow Iowans.

Dr Lonning became an advocate in 2002 when she attended the APA's Practice Leadership Conference and modeled the RxP legislation after New Mexico's bill. As a former president of IPA, she personally surveyed the membership twice (before the luxury of tools like survey monkey existed) to gauge psychologists support. Both the older and younger members were interested but the elder practitioners felt their careers were coming to a close and the newest members reported being burdened by debt and family responsibilities. Despite the lack of active enthusiastic psychologists, Dr Lonning persisted and sponsored psychopharmacological education at every annual IPA conference to promote RxP and foster grass root support among all her contemporaries. She reports at times there was little interest but she persevered believing in the utility of RxP.

With bipartisan support, in the House and in the Senate, the original bill was introduced in 2013. Despite its DOA status in committee, both twice in 2013 and during its reintroduction in 2015, the climate surrounding RxP was evolving and education surrounding its benefits was spreading. Given this mounting wave of support and acceptance, House Bill 2334 was finally signed into law on May 27, 2016 in a 77-33 victory, 11 days after Dr. Greg Febbaro, Dr. Lonning's fellow committee member passed away.

Interestingly, Dr. Lonning's father, a licensed psychologist in his eighties, testified in favor of RxP, before the Iowa Medical and Psychology Boards at the public hearing, providing historical and anecdotal evidence of psychologists and physicians practicing cooperatively. His testimony was most convincing, maintaining his proposition that the law was only codifying the traditional practice of medical psychology.

Though Iowa legislation was modeled on New Mexico's law, it had its own caveat: a joint administrative body compromised of the BOM (Board of Medicine) and the BOP (Board of Psychology) of which Dr. Lonning was appointed. Having met every 3 months from September 2016, a consensus was finally reached two years later, in April of 2018. Unfortunately, unfounded concerns of lack of training, ethical complaints and patient safety impeded their progress. Despite no findings of ethical complaints against psychologists, the BOM stated that "lack of evidence does not indicate safety" and thus an independent, psychologist driven future for RxP was waylaid. Instead, Iowa's RxP law and its rules and regulations would mandate an ongoing collaborative practice agreement with a physician. Despite all these bureaucratic procedures, including supportive public comment, the Law did not become statutory until February 20, 2019.

As in other states, the Iowa version had to adapt and develop its own idiosyncratic rules in order to be ratified. Some of the most significant additions to this law include mandating: 1) collaboration with a supervising physician; 2) a patient must have a PCP prior to prescription; and 3) the Master's program in Clinical Psychopharmacology must include a practicum of 600 patient encounters in general clinical medicine. This should also include a post psychopharmacology practicum of at least 2 years with a minimum of 300 patients of which traditionally at least 100 of these patients will be prescribed psychotropic medications. Unfortunately, a medical psychologist is not acceptable as a supervisor at this time.

Currently, Dr. Lonning's is con-

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Diabulimarexia: Potentially the Most Deadly Psychiatric Condition

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

An online survey by Dr. J. Renae Norton showed that 38% of responding individuals identified themselves as having bulimiarexia, a combined condition of bulimia nervosa and anorexia nervosa, with purging and starvation.1 This condition is difficult to treat requiring close attention to psychological, sociological and medical factors. When combined with Diabetes Mellitus Type I, the dangers become profound making Diabulimiarexia potentially the most deadly of the psychiatric conditions. Diabulimarexia is a truly biopsychosocialspiritual disorder which requires providers to have an extensive knowledge of all psychological, medical, sociological, and spiritual dynamics of the disorder and recovery.

Medical complications in bulimarexia may include the following:

Water Concentration Defect occurs in bulimia as a result of diuretic abuse, laxative abuse, and vomiting. As a result of abnormal arginine vasopressin (AVP) output in reaction to osmotic stimuli (e.g. hypertonic saline), the balance of water concentration becomes impaired. Arginine vasopressin, a hypothalamic polypeptide and antidiuretic hormone, is released by the anterior hypothalamus traveling to posterior pituitary regulating water concentration. 2. AVP is linked to multiple physiological manifestations which can include neurologic issues, hyponatremia, edema, and vascular smooth muscle function. Pain and anxiety can also cause AVP release.3

Gastric Dilatation is a serious complication where the stomach expands and is at risk of rupturing. This condition can occur in bulimia during a binge and during initial eating after periods of starvation. Due to the probability that the bulimic patient will experience bloating and gastrointestinal complaints during the course of treatment, patient education, nutritional counseling, and monitoring is essential to assist the patient in preventing a relapse into purging behaviors. Cautions should be exercised in the inclusion of fat and milk in the dietary intake. Some patients mayhave lost the ability to digest these substances without experiencing severe gastric distress. 4 5

Adynamic Ileus, which can be caused by hypokalemia and electrolyte abnormalities, is the neurogenic obstruction of the intestines resulting from the impaired peristalsis (involuntary smooth muscle contracting waves) that move fecal matter, which results in constipation and abdominal pain. This in combination with laxative abuse history, and similar actions, that would traumatize the intestinal wall create a compounding impact on intestinal function.6

Hypochloremia is a low level of chloride in the blood. Chloride together with ionized sodium in the extracellular fluid helps to maintain the water balance. Chloride also helps to maintain the proper pH (acid-base) balance in the blood. In the digestion process, chloride which is secreted by the mucosa of the stomach as gastric hydrochloric acid provides the proper acid for digestion and enzyme action to occur. Large amounts of chloride are lost through diarrhea or vomiting contributing to hypochloremic alkalosis producing dehydration.7 8

Hyperuricemia, an excess of uric acid in the blood, can be caused by decreased renal clearance of uric acid during starvation.9 10 Metabolic Alkalosis is a disturbance where the acid-base balance in the body shifts towards the alkaline side. This complication was seen 27.4% of the time in bulimic and atypical eating disorders in the study by Mitchell & Pyle.11 Metabolic alkalosis can be caused by depletion of potassium storage as hydrogen and sodium move into the cell to replace the potassium. Pulmonary impact can be seen in suppressed ventilation as the lungs tend to conserve carbon dioxide with the decrease in hydrogen. In addition, the renal tubule suppresses secretion of hydrogen. This results in the loss of sodium through excretion which would otherwise be absorbed. Through vomiting, hydrogen and chloride (hydrochloric acid) is lost inducing metabolic alkalosis.12 Other symptoms include irritability, weakness, tetany (muscular cramps), and increase pH level.13

Osteomalacia, a defect of bone mineralization, can result from insufficient concentrations of calcium and phosphate reaching the osteoid matrix to the point at which a bone is calcified. It can also occur as a result of Vitamin D deficiency, excessive alcohol intake, chronic renal failure, and impairment in renal tubular reabsorption of phosphate. Clinical characteristics of osteomalacia include pain in the long bones and ribs, muscular weakness, listlessness (in advanced cases), and bowing of long bones.14

Hypomagnesemia (low serum magnesium) can result from diminished absorption or intake, increased loss, or unexplained etiologies. Diminished absorption can result from chronic diarrhea,

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Advancing the Medical Literacy of Non- Medically Trained Mental Health Providers - REVISION- JUNE 2nd 2019

Jerrold Pollak, Ph.D; ABPP; ABN

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John J. Miller, M.D.

Medical Director: Brain Health, Exeter, NH; Staff Psychiatrist, Seacoast Mental Health Center, Exeter, N.H. ; Consulting Psychiatrist, Exeter Hospital, Exeter, N.H; Editor-in- Chief, Psychiatric Times.

Introduction: There is a considerable literature devoted to improving the medical and mental health literacy of the general public (Wei, McGrath, Hayden, & Kutcher, 2015, Zarcadoolas, Pleasant & Greer, 2006). Left unaddressed, however, is the historically low medical literacy of non-medically trained mental health professionals- bachelors degree level human services workers and masters degree clinical social workers and mental health counselors. With the exception of psychologists with formal post-doctoral specialty training in Medical Psychology, Health Psychology, Clinical Neuropsychology and/or Psychopharmacology, most psychologists who work primarily as psychotherapists in non-medical settings also lack adequate medical literacy.

Definition: For the purposes of this discussion medical literacy can be defined as the acquisition of evidence-based medical knowledge which is germane to the diagnosis and treatment of mental health disorders including substance-related mental health and cognitive complaints/ symptoms. This definition encompasses a good working understanding of the role of vital signs and laboratory testing in cases of known or suspected mental status change and the many psychiatric presentations of medical illness. It also includes the range of biological interventions available for mental health disorders and the indications for general medical screening and more specialized assessment, notably neurological evaluation, neuro-imaging and psychological/neuropsychological testing for patients seen in mental health and/or substance abuse care. Additionally, awareness of the many psychiatric side effects of various medical treatments, especially non-psychiatric medications, is critical for augmenting medical literacy for non-medically trained mental health clinicians (Turjanski & Lloyd, 2005).

Goals/Objectives: The goals of advancing medical literacy include the development of a greater appreciation of the role of neurobiological factors in the genesis of mental health disorders as well as boosting skills in differential diagnosis to address a possible medical basis for a patient's complaints/symptoms with the twin objectives of improved clinical decision making and better treatment outcomes.

The burgeoning movement to integrate mental health and substance abuse care and "co-locate" these services in medical homes and other primary care settings underscores the importance of enhancing the medical literacy of non-medical mental health providers (Crowley & Kirschner, 2015).

The paucity of clinically relevant medical knowledge among these providers is concerning given that these groups account for most of the non-medication based mental health care in private practice and community settings nationwide and that there is a substantial knowledge base pertaining to the relationship of medical illness and substance use to mental health conditions as reviewed below.

A broad array of medical conditions, prescribed medications, over the counter preparations and illicit substances can directly cause, contribute to, exacerbate as well as trigger a recurrence of a myriad of mental health complaints/ symptoms (McKee & Brahm, 2016, Pollak & Miller, 2011).

As many as fifty percent of patients seen in emergency departments with new onset mental status change have medical conditions, including substance- related disorders, which may be at least contributory to their psychiatric presentation (Tucci, Moukaddam, Alam & Rachal, 2017). Approximately seventy percent of elderly patients admitted to geriatric psychiatry inpatient services have two or more medical conditions which are considered relevant to their mental health difficulties (Alam, Rachal, Tucci & Moukaddam, 2017).

Mental health complaints/symptoms, notably depression and somewhat less commonly anxiety and irritability, can be the earliest manifestations ("prodrome") of an occult and potentially life endangering medical condition (Cosci, Fava & Sonino, 2014).

Medical conditions unrelated to a patient's presenting mental health complaints/symptoms can develop in the course of mental health care and result in a worsening of baseline psychiatric symptoms and/or lead to the development of new mental health difficulties related to the change in the patient's medical status. (First, 2017).

A number of mental health conditions, in particular, major depression, bipolar disorder, schizophrenia and eating disorders, have high rates of co-occurring medical illness and confer elevated risk for serious medical complications. In turn, medical co-morbidity can worsen a patient's mental health status (Alam, Rachal, Tucci & Moukaddam, 2017, First, 2017, Jann, 2014).

Serious emergent or concurrent medical illness is relatively common among mental health patients (especially those from at -risk groups- see below) and is associated with reduced efficacy of mental health interventions, functional decline, increased disability and preventable death.

Medication treatment for mental

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HEALTH AND SCIENCE

Relational Therapies and Stress Physiology

by Jeffrey D. Cole, PhD, ABMP,

Reviewed by: Dafne Milne, PhD

Introduction

There are two types of stress experienced by humans: Systemic stress and psychogenic stress. Systemic stress is the set of physiological events that occur when there is a direct physical impingement on bodily tissue. An example is rhabdomyolysis that occurs with "muscle crush." If muscles in the body are physically damaged this can result in other physiological changes including excessive influx of sodium and potassium into the circulation (Zimmerman, 2013) which can ultimately damage the kidneys (Zamorskii & Shchudrova, 2014) and heart, i.e., hyperkalemia,(Mugmon, 2011).

Psychogenic stress is the set of physiological events that occur due to interpersonal-affective conflict resulting in neuroendocrine events (involving the hypothalamic pituitary adrenal – HPA – circuitry) ultimately affecting the immune, cardiovascular, nervous and other systems.

An example of psychogenic stress:

A woman is facing restructuring at work, resulting in loss of hours, at the same time her and her husband are facing mounting bills. The loss of work and the resulting arguments with her spouse over "trying to survive as a one-income family" elicit feelings of fear, resentment, hurt, anger and rage. If these feelings are not resolved due to conflict, e.g., the woman is angry at her boss for decreasing her hours while maintaining hours of a fellow employee with less seniority, but she is afraid to speak up for fear of losing her job – and, meanwhile, she is hurt when hearing perceived criticism from her spouse, but instead lashes out at him with the displaced anger toward her boss (and thus the hurt feelings are not addressed and the conflict with her husband even increases) -- physiological events associated with these emotions and conflict activate the adrenal medullary-hypothalamic-pituitary pathways (Gianferante, Thoma, Hanlin, Chen, Breines, Zoccola & Rohleder, 2014), releasing norepinephrine and glucocorticoids into the system leading to a range of neuroendocrine events resulting in far-ranging effects in the body (Cohen, Gianaros & Manuck, 2016).

While some degree of psychogenic stress is associated with day-to-day living and assimilated by the human system excessive, protracted and unresolved stress is potentially damaging and has been implicated in many diseases (Cohen, Gianaros & Manuck, 2016). Thus, "And, manage your stress" has become an obligatory for most family physicians at the end of patient visits almost regardless of condition.

The problem with the physician's statement, "And manage your stress" is: Many people, including many physicians and other healthcare providers who acknowledge the important role of stress in health, illness and recovery do not know *how* to manage stress. The well-meaning provider might offer suggestions: "Do yoga", "Practice calming breathing", "Go for a walk". However, while these activities have health benefits to the system for their own sake if one looks closely one will see that none of these suggestions look at, let alone address the woman's experience of being passed over at work, or what it meant to her when her husband brought up "trying to live as a one -income family" or how to respond effectively in either of these situations. That is, the provider offered well-meaning suggestions for healthy living but little or nothing toward helping the woman manage her stress.

What is "stress management"?

To understand what is meant by stress management one must take a more in-depth look at what the

(Cont.'d on p. 13)

Introducing New Board Member, Dr. Keith Petrosky:

Keith Petrosky, PHD, ABMP, is a graduate of the University of Pennsylvania. He did his doctoral studies at Temple University. He has been a regular contributor to The Clinical Practitioner for the last several years.

Dr. Petrosky is in full time private practice in the Main Line Philadelphia suburb of Exton. He evaluates and treats adults and children using cognitive behavioral therapy and biofeedback. He performs disability evaluations for veterans as well as employees of a number of private and public corporations. He also evaluates couples who are hoping to adopt children or to become foster parents. He does presurgical evaluations for bariatric and spinal implant surgery. He provides pain management services to several pain practices and physical rehabilitation services.

In addition to his private practice work with adults, children, and families, he is a consultant to a regional cardiology program where he has directed a lifestyle change group for heart attack and post-surgical heart patients for more than 15 years. He developed a number of hospital-based programs, including an integrative health and healing program for cancer patients and an anxiety management program for patients anticipating surgery. He has provided stress management programs for large business corporations and hospital employees.

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/

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

The March 2019 National Alliance of Professional Psychology Providers (NAPPP) Conference in San Antonio, cosponsored by the Academy Medical Psychology (AMP), was a huge success. Dr. John Caccavale and Dr. Sharna Wood coordinated an excellent learning opportunity for attendees that included a wide range of topics and 18 CE units. A highlight of the conference was Dr. Jerry Morris receiving a lifetime achievement award presented by Dr. John Caccavale.

I am pleased to announce that Dr. James Underhill recently completed all the requirements for Board Certification in Medical Psychology and the AMP Board of directors voted to grant him Diplomate status. I would like to congratulate Dr. Underhill on his accomplishment and encourage him to take an active role in AMP by contributing some of his many strengths to the advancement of medical psychology.

AMP is in transition and we welcome any psychologist interested in contributing to the advancement of medical psychology by becoming involved, in some capacity, in the efforts of our academy. There are many opportunities to contribute and the experience is challenging but necessary, if our profession is to survive and thrive.

(Iowa RxP cont.'d from p. 3)

continuing the fight as she works to establish relationships with insurance companies and physicians willing to supervise practicing psychologists. She is also working to launch an accredited program directly in Iowa. Though medically trained at Fairleigh Dickinson's MSCP program, and a practicing psychologist herself, Dr. Lonning selflessly seeks to help others pursue training and gain prescription psychologists in Iowa, rather than pursue prescription privileges herself. We thank you, Dr. Lonning for your unflagging efforts, passion, and dedication in championing an increased scope of practice for medical psychologists and the patients they serve.

Dr Elizabeth Lonning PhD, MsCP
Davenport, Iowa
Chair RxP Committee
Iowa Psychological Association

Dr Susan Barngrover PhD, MsCP, ABMP
Lee's Summit, Missouri
Board Member, Secretary
Academy of Medical Psychologists

Leah Barngrover Ms, editor

Associations between psychotropic drug exposure and heat-related pathologies explored using univariate analyses

	Cases: subjects admitted for heat-related diseases		Controls: subjects not admitted over the heat-wave period		OR	95% CI[a]
	n	%	*n*	%		
Anxiolytics	22	39.3	189	16.9	3.2	1.8–5.6[b]
Hypnotics	7	12.5	139	12.4	1	0.4–2.3
Antidepressants	17	30.4	122	10.9	3.6	2–6.5[b]
Tricyclics	3	5.4	14	1.3	4.5	1.3–16[b]
SSRIs[c]	6	10.7	81	7.2	1.5	0.6–3.7
Antiepileptics	4	7.1	22	2.0	3.8	1.3–11.5[b]
Antipsychotics	11	19.6	24	2.1	11.1	5.2–24.2[b]
Anticholinergics	7	12.5	11	1.0	14.2	5.2–38.3[b]
Cholinesterase inhibitors	5	8.9	23	2.05	4.7	1.7–12.8[b]

[a] Odds ratio 95% confidence interval.
[b] Significant association.
[c] Selective serotonin reuptake inhibitors.

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:

On June 28, 2018, Dr. Susana Galle, PhD, ABMP was interviewed by NBC News providing an excellent overview of the heat risk associated with psychotropic use. In this interview, she outlines the impact of psychiatric medications on the body's ability to regulate temperature and the interplay of heat risk and medications.

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:

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Practice Administrator AllCare Medical Centers, P.C.
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(Pollak from pg. 5)

health complaints/symptoms can develop in the course of mental health care and result in a worsening of baseline psychiatric symptoms and/or lead to the development of new mental health difficulties related to the change in the patient's medical status. (First, 2017).

A number of mental health conditions, in particular, major depression, bipolar disorder, schizophrenia and eating disorders, have high rates of co-occurring medical illness and confer elevated risk for serious medical complications. In turn, medical co-morbidity can worsen a patient's mental health status (Alam, Rachal, Tucci & Moukaddam, 2017, First, 2017, Jann, 2014).

Serious emergent or concurrent medical illness is relatively common among mental health patients (especially those from at-risk groups- see below) and is associated with reduced efficacy of mental health interventions, functional decline, increased disability and preventable death.

Medication treatment for mental health disorders can be a necessary or sufficient cause of serious medical co-morbidity. This can include but is not limited to lipid disorders and hepatic, renal, endocrine and cardiac disease. Additional medical morbidity includes weight gain, constipation, sedation/ somnolence, discontinuation/ withdrawal syndromes (including withdrawal seizures), tardive dyskinesia and cognitive impairment (Goldberg & Ernst, 2019).

At- Risk Groups: There are several patient groups which are increased risk for having one or more medical disorders which can "mimic" or "masquerade" as mental health disorder (Alam, Rachal, Tucci & Moukaddam, 2017, Pollak & Miller, 2011, Tucci, Moukaddam, Alam & Rachal, 2017).

Indigent and impoverished patients with limited access to medical care.

Pregnant women

Patients with "risky" life styles: Substance abuse, promiscuity, recurrent suicidal behavior, athletic and/or vocational activity associated with elevated rates of head trauma and individuals with impaired self- care and deficient health seeking behavior in connection with denial and minimization of concerning somatic symptoms.

Patients with positive family and personal histories of medical illness which confer an elevated risk for mental health symptoms.

Patients with severe and persistent major mental illness. This at-risk group has a significantly reduced life expectancy due, in part, to concurrent medical illness.

Medically ill children/adolescents

Elderly patients due to the elevated rates of medical illness linked to mental health complaints/ symptoms in this age group.

Clinical Evaluation: Assessment for medical factors in the genesis, persistence and/or worsening of mental health symptoms/complaints is reviewed in a number of publications (First, 2017, Kawboj & Tareen, 2011, McKee & Brahm, 2016, Tucci, Moukaddam, Alam & Rachal, 2017) and a series of compelling case reports reviews psychiatric presentations of medical illness (Castro & Billick, 2013).

Unfortunately, there is no well validated constellation of pathognomonic signs and symptoms which reliably differentiate a primary mental health disorder from a "medical mimic." Still, there are clues from the history and mental status examination which raise the specter of medical influence. These involve new onset, rapid onset and/or progressive alterations in mental status coupled with a worsening functional decline especially in the absence of a congruent or

explanatory psychiatric history. Additional clues include mental health complaints/ symptoms which are qualitatively different than previous or recent complaints/ symptoms (Alam, Rachal, Tucci & Moukaddam, 2017, McKee & Braham, 2016, Pollak and Miller, 2011).

Misdiagnosis of medically- related mental health symptoms as indicative of a primary psychiatric or stress- related adjustment condition which is then treated with non-medical interventions (typically one or more counseling/psychotherapeutic approaches) is not uncommon in everyday clinical practice and represents a serious error in clinical judgment (Shapiro & Smith, 2011). At a minimum, the failure to appreciate that there may be a medical substrate for a patient's mental health complaints/symptoms typically leads to financially costly and wasteful treatment, reduced health care compliance and poorer treatment outcomes. At worst, it can result in considerable patient morbidity- worsening physical health, chronic disability and premature death (Tucci, Siever, Matorin & Moukaddam, 2015). These adverse outcomes increase the risk of ethics complaints to mental health boards as well as malpractice actions (Shapiro & Smith, 2011).

Deficiencies in Medical Literacy: Contributory Factors: There are several reasons for the limited clinically relevant medical knowledge base of non-medically trained provider groups. First, students in these fields self-select for careers in health care that involve little, if any, training in the biological and allied sciences

Second, bachelors level and graduate programs which prepare students for careers in mental health practice involve a nearly exclusive emphasis on the psychosocial underpinnings of mental health disorders and their treatment. At best these programs offer a course or two on the biological basis of behavior and/or psychopharmacology of dubious clinical relevance and which do not confer clinically useful diagnostic skills. Programs with a strong "politically correct" bent (which involves a continuously expanding number

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Third, with the exception of workshops on psychopharmacology for non-medically trained mental health providers there are virtually no continuing education opportunities to boost medical literacy for these providers groups.

Finally, state licensing laws permit non-medically trained masters degree level mental health clinicians providers to practice independently. Therefore, there is no legal obligation to consult with medically trained health care professionals. These provider groups are especially vulnerable to failing to appreciate the possible role of medical difficulties in their cases. They also lack easy access to appropriate medical consultation when working in solo and/or rural practices or in group settings which do not employ medically trained mental health clinicians.

Addressing the Problem of Low Medical Literacy

What graduate programs can do:
Adopt the perspective that medical literacy is a "core competency;" actively promote a biopsychosocial model for the development and treatment of mental health disorders (Belar, 2008) and include a semester long required course on the medical basis of psychiatric symptoms- a working title might be "Essentials of Medical Literacy." Graduate programs can also establish relationships with emergency departments, primary care practices and nursing homes for practicum and internship placements. These training sites will expose students to medical diagnosis and treatment and provide valuable experience with persons who have combined medical and psychiatric illness- so called "medical/psychiatric" patients. There should also be a greater commitment to increasing the number of adjunct faculty in medical psychology, psychiatric nursing and psychiatry to support these objectives.

What mental health licensing examination boards can do: These boards, which include the Association of State and Provincial Psychology Boards, the National Board for Certified Counselors and the Association of Social Work Boards, could outreach graduate programs regarding the development of a medical literacy friendly curriculum. Licensure examinations for entry level practice should begin to include a section on vignettes specifically pertaining to the role of medical factors in mental status change, differential diagnosis and treatment planning. Medical psychologists could take the lead in developing examination content of this kind.

What clinicians can do: Advocate for a broader selection of continuing education offerings designed to advance medical literacy and also avail themselves of major textbooks and literature reviews on the medical basis of psychiatric symptoms (Kambog & Tareen, 2011, Keshavan & Kaneko, 2013, Morrison, 2015, Schildkrout, 2014)

Recommendations for Clinical Practice: During the intake process carefully review with new patients and periodically with patients in ongoing services (perhaps on a quarterly basis), whether there has been a recent medical evaluation and, if so, whether this has resulted in any formally diagnosed or suspected medical problems. Releases should be obtained for records relevant to this matter.

Both new and established patients should complete a screening history form which includes family and personal medical/psychiatric history as well as a detailed checklist of medical conditions and symptoms, recent/current medications and substance use. Useful forms can be downloaded at no cost from the Internet which are easily modified to meets the needs of the individual practitioner: www.FreePrintableMedicalForms.com

Patients for whom there is concern about a possible medical basis for their mental health difficulties should be strongly advised to have a timely medical examination.

These interventions and recommendations should be carefully documented in the provider's records including whether the patient has followed through or declined the recommendation for a medical assessment. Clinicians working with patients who are considered at high risk for medically- related mental health difficulties and who repeatedly decline a medical assessment may need to interrupt services until such a consultation has been completed.

Directions for Research: Research is needed to more clearly delineate the gaps in clinically relevant medical knowledge among non- medically trained mental health providers and how to best address these deficiencies. This should include needs assessment survey research which samples the attitudes/opinions of students, training faculty and practitioners regarding this issue. The development of a medical literacy scale, along the lines of

(Stress cont'd from p. 6)

a more in-depth look at what the components of stress are at the psychological and psychophysiological levels. Human beings can experience a vast range of emotions from many types of fear (fear, trepidation, dread, foreboding) to multipole variations on anger (anger, rage, resentment, frustration, annoyance) to the various forms of happiness (happiness, glee, joy, ecstasy) and many, many more. All these affective experiences can be understood as a specific set of correlated interpersonal, sensory-perceptual, cognitive and physiological events that the individual identifies as a specific "emotion". These sets of events are not considered "stress events". (Though emotional emergence can be associated with anxiety which can be related to -- but is differentiated from – stress. Emotions are momentary and transient. Stress is a cross-temporal event that assumes unresolved psychological experience manifesting in the body as engaged neuroendocrine circuitry and processes that also occur over time. The body is better-equipped to deal with the transient autonomic events associated with anxiety. I.e., Balances between sympathetic and parasympathetic activity, associated with anxiety, flux and return to their homeostatic state as the anxiogenic event passes. Anxiety associated with chronic situational stimuli or unresolved emotional conflict can become stress.

Thus, stress is unresolved emotional conflict and the associated set of physiological, neuroendocrine events, differentiated from those associated with transient emotional states and with anxiety. Stress management is the resolution of said emotional conflict and, the ensuing returning to homeostasis within the physiological system.

How is this "resolution" achieved psychotherapeutically?

To resolve stress psychotherapeutically it must be kept in mind that the key element in stress where emotions are concerned is not emotion itself (which was differentiated from stress above) but *unresolved emotional conflict*. That is, the individual experiences an emotion but the presence of other interpersonal-affective events – situationally or developmentally (e.g., due to history) – prevent full expression of the emotion. For example, the woman in the example above is angry and resentful toward her boss but fears confronting him because of her expectations of how he might retaliate. Or, she is hurt by her husband's comment but, instead of expressing this hurt (perhaps because her historical experiences have taught her she will not receive a validation of her feelings and her unattended-to hurt will leave her too vulnerable) she lashes out in displaced anger associated with the conflict with her boss instead.

Thus, to respond to stress psychotherapeutically is to help the patient resolve emotional conflict and to develop his or her abilities to access, attend to and resolve said conflicts when these occur. Because emotional conflict is, or is based in – historically/developmentally or situationally – an *interpersonal-affective event,* psychotherapeutic relationally-based interventions should be considered as primary interventions.

Relational therapies approach emotional conflict with the understanding that there is always some developmental basis for current struggles with affect. That is, somewhere along the way a learning event involving relationship and emotional experience did not occur or what was learned was ineffective toward fully resolving conflict. Usually this is due to some form – and there can be many forms – of invalidation in a key attachment relationship. Often these invalidation events occur early in life with primary attachment figures but can occur at any point in development if the relationship is important enough that key learning elements are internalized.

(Cont.'d on page 18)

(Pollak cont.'d form pg. 11)

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Directions for Research: Research is needed to more clearly delineate the gaps in clinically relevant medical knowledge among non- medically trained mental health providers and how to best address these deficiencies. This should include needs assessment survey research which samples the attitudes/opinions of students, training faculty and practitioners regarding this issue. The development of a medical literacy scale, along the lines of recently developed metrics for mental health literacy for the general public, may be useful in facilitating such research (O'Connor & Casey, 2015, Wei, McGrath, Hayden & Kutcher, 2015).

Medically trained mental health providers and primary care providers- the latter are responsible for most of the medication-based mental health care throughout the country, should also be surveyed regarding their views on bolstering the medical literacy of their non-medically trained mental health provider colleagues many of whom are involved in treating their patients.

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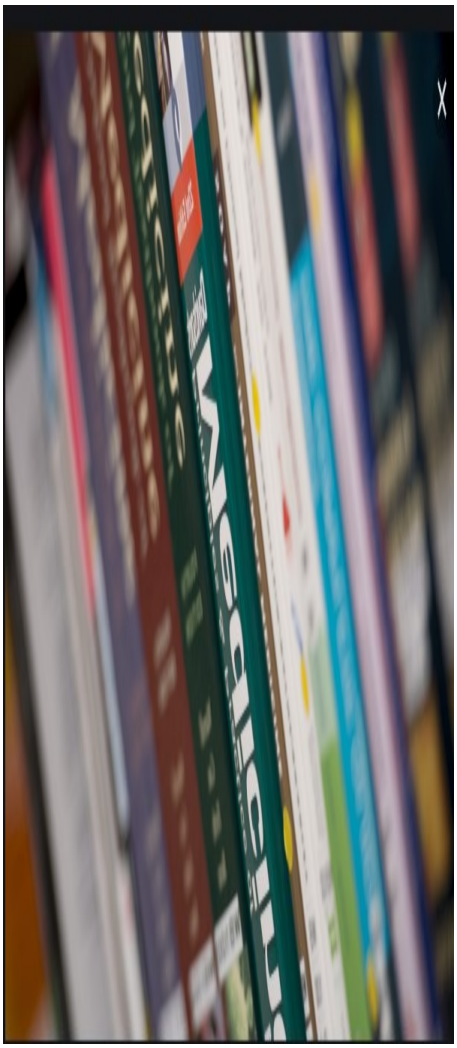

(Diabulimarexia Cont'd from p. 4)

laxative abuse, malnutrition, and small bowel bypass. Increased loss can result from diabetic ketoacidosis, diuretic therapy or abuse, diarrhea, hyperaldosteronism, and renal magnesium wasting. Common symptoms of hypomagnesemia include: weakness, muscle cramps (hypomagnesemia tetany), tremors, nervous irritability, hypertension, arrhythmias, tachycardia, and a positive Babinski response. Hypomagnesemia and hypocalcemia often occur together. The effect of hypomagnesemia on the ECG is a prolonged QT interval particularly due to lengthening of the ST segment.12 Psychiatric symptoms usually are the first symptoms presented which include nervousness, irritability, restlessness,

and eventually depression. Hallucinations may also be experienced as a result of rapid magnesium loss.15

Esophageal Rupture is a life-threatening event which can occur as a results of repeated exposure to gastric acids, weaknesses in the esophagus, and the force of vomiting gastric contents upward through the esophagus.16

Menstrual Cycle Disturbances are common in eating disorders. They can be linked to the hormonal changes in Gonadotropin releasing hormone (GnRH), luteinizing hormone (LH) and follicle stimulating hormone (FSH).17

Blunted Thyroid Stimulating Hormones in response to Thyroid Releasing Hormones is found in eating disorders. A study by Gwirtsman and associates reported that eight out of ten bulimic patients studied showed a blunted thyroid-stimulating hormone (TSH) response to thyroid-releasing hormone (TRH) administration. The study also showed an inappropriate increase in the secretion of growth hormone (GH) in response to the TRH administration.18 Other studies have shown some level of blunted response to TRH administration; however, the rate of occurrence was in the range of 0 to 33 percent where the study by Gwirtsman and associates was at 80 percent. At this point, there are no consistent abnormalities in thyroid function documented and proven through scientific study.19

Electroencephalogram Abnormalities have been reported in 64.4% of the 79 bulimic patients studied in studies by Rau, Green and others. The most common abnormalities were in the paroxysmal dysrhythmia (14- and 6-spike patterns). A follow-up blind study, performed by James E. Mitchell and associates, only found four out of the twenty-five bulimics tested to show any abnormalities.18 In a study on sleep EEG of bulimics by James I. Hudson, Harrison Pope, Jeffrey Jonas, Joseph Lipinski and David J. Kupfer, EEG results during sleep were within normal ranges. It is possible that these results were affected by the younger age of patients tested. Rapid eye movement (REM), measured during the study, did show an increased REM density during the first REM period which is similar to that of depressed patients.20

Hypozincemia (low level of plasma zinc) is one of the potential complications of eating disorders, impairing taste, causing wounds to heal slower, and promoting psychiatric symptoms such as depression and confusion. Malabsorption and diarrhea are two common causes of a zinc deficiency.21 Zincuria has been found to be elevated in diabetic patients.22

Hypercholesterolemia is an excess of cholesterol in the blood. Cholesterol metabolism has been found to be accelerated in patients with anorexia nervosa. Elevated cholesterol in these cases may reflect a diminished cholesterol turnover which is secondary to a delayed low-density lipoprotein metabolism. Low-density lipoproteins transport cholesteryl esters (one type of hydrophobic lipids) to tissues in peripheral areas in the body so membrane synthesis can take place.23 5

Abnormal Liver Function may be present during weight loss and may increase during weight gain. This may be reflective of fatty degeneration of the liver. Serum enzymes such as serum glutamic-oxalacetic transaminase (SGOT), lactate dehydrogenase (LDH), and alkaline phosphatase (Aik.Phos.) can be elevated in anorexic patients.24 5

Diabetic Glucose Tolerance and flat curves have been reported in cases of anorexia nervosa. Abnormal glucose tolerance has also been noted in chromium deficiency, in combination with neuropathy (a functional disturbance of the peripheral nervous system), encephalopathy (any degenerative disease of the brain), hypercholesterolemia and hypertriglyceridemia.25 With individuals with diabetes, this is extremely serious.

Hypocalcemia is the reduction of the blood calcium below normal. This condition can produce a range of mental difficulties including depression, anxiety, or a catatonic state if serum calcium levels are below 7 mg/dl. Normal calcium levels are between 8.5 mg/dl to 10.5 mg/dl. Possible causes of hypocalcemia in anorexic patients include laxative

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use/abuse, vitamin D deficiency, and malnutrition. The effects on the neuromuscular functioning produces cramps, tetany, convulsions, and other symptoms.5

Bradycardia, resulting from the metabolic effects of starvation, refers to a condition where the resting heart rate is below 60 beats per minute. This condition can result from not only starvation, but also from increased vagal tone. Mild bradycardia can be found in youth and well conditioned athletes. This reduced heart rate can be associated with the experiencing of hypothermia or cold intolerance.26 5

Pericardial Effusion is the escape of fluid into the fibroserous sac that surrounds the heart. Pericardial effusion has been noted in some anorexic patients. As the pericardium stretches from the effusion, the stroke volume is reduced, lowering the pressure of the pulse. The result can be shock and death. Symptoms of pericardia! effusion include dysphagia (difficulty swallowing), chest pain (varying from acute to absent), coughing, and dyspnea which forces the patient to sit or lean forward, and enlargement of the cardiac area. If the effusion is large enough to require catheterization, symptoms will also include: distension of the neck veins during inspiration, narrowed pulse pressure, leg edema, and finally shock. Overhydration or hypoproteinemia and the refeeding process may be related to this condition, in addition to other cardiovascular conditions.27 21 28

Hyponatremia (low serum sodium) can be caused by laxative abuse, diuretic abuse, chronic vomiting and starvation; and can be one of the causal factors leading to the kaliopenia nephropathy and water concentration defect. In hyponatremia with increased extracellular fluid volume resulting from decreased renal perfusion, sodium retention

by the body, and secretion of antidiuretic hormones can cause edema.12

Hypokalemia (low level of potassium content in the blood) is a primary factor in the development of arrhythmia. Potassium is extracted from the serum and is used in carbohydrate metabolism. When glucose is converted to glycogen for storage, potassium is stored with the glycogen. Potassium is also required for storage of nitrogen in the muscle tissue. If muscle tissue is lost as a result of a starvation diet, potassium and nitrogen is lost. Hypokalemia is a serious condition since it will impact cardiac function.29 5

These are just a few of the potential medical complications. Other complications which are specific to diabulimia and diabulimarexia include: severe dehydration, electrolyte imbalance, peripheral artery disease, diabetic ketoacidosis, bacterial skin infections, retinopathy, neuropathy, stroke, atherosclerosis, coma, and death.

The psychological/ neuropsychological issues are significant including depression, anxiety, impaired body image, and neurocognitive impairment. Addressing these issues will require a professional with extensive training in psychotherapy and in eating disorder treatment. To complicate this, it is common for there to be comorbid conditions such as Obsessive Compulsive Disorder (OCD), and various anxiety and mood disorders. Since OCD and similar anxiety conditions are common, I offer this beginning treatment outline:

1. learning to recognize when an elevated reaction is occurring, and practicing defusing techniques to allow a time to reassess the situation before reacting;
2. learning to control anxiety and stress using centering and focusing techniques;
3. learning to pick one's battles;
4. creating identify/label/ reattribute skills to cope with obsessions and compulsions (see the book Brain Lock);
5. develop ways of letting go of frustration and reaction to obstacles which work;
6. learn how to cope with automatic negative thoughts and thinking (see the book Healing Anxiety and Depression); for checking behaviors, create a "conscious moment" to lock onto, and practice a "trust the memory";
7. prepare the environment (situational opportunities) for this individual to succeed;
8. perform the "OCD Brain versus Logical Brain" exercise;
9. use the "OCD hyperactive 2-year-old" image to identify runaway obsessive anxiety;
10. practice emotional "time-outs";
11. use small step practices when overwhelmed;
12. abstain from crisis situations (a 12-Step approach).

So what is the "OCD hyperactive 2 -year-old" analogy? For the person suffering from OCD, it sometimes feels like

having a hyperactive 2–year-old on sugar inside. When the 2-year-old has something to lock his/her attention on or have something to do, it is fine. When anxious or not having enough to occupy him/her, the 2-year-old runs around in circles screaming, "Oh my God. Oh my God. Oh my God. Oh my God." Like others with OCD, the patient may tend to try harder and harder, frequently forgetting that trying softer will work better. Use of ma-

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terial from Aikido and similar philosophies often help. Reading books like the Tao Te Ching and recovery books such as One Day At A Time can help. Role playing and role training can also be used to help one test out alternatives to handling situations.

It is essential that all eating disorder team members be well versed on the subtleties of living with an eating disorder, and that at least the treating therapist and the principle physician have extensive training and experience with treating eating disorders. One source for individuals with this level of training is the International Association of Eating Disorder Professionals.

Support systems and the ability to access faith are also very important components. Having at least on person who is in recovery from an eating disorder is profoundly important since that individual knows first-hand what it feels like trying to change the patterns of behavior to move toward recover.

There is a therapeutic dance that occurs during the initial parts of treatment. The patient will start to abstain from purging, which motivates them to further restrict intake. Getting them to a point where they can make consistent progress toward abstaining from purging (vomiting, excessive exercise, diacritic abuse) and from restriction takes the support of the team members, behavioral change supports (when needed), and affirmation for any progress made. It is important to keep in mind that these patients are masters at emotionally abusing themselves and negative self-talk. It is important not to feed into this negative spiral.

Inclusion of family members is also important. If there are 12-step support groups for eating disorders in the area, attendance and developing this support system is of significant value.

In the presence of diabetes type I or II, inclusion of an experienced endocrinologist is important. All of the complications of eating disorders are "super-sized" by diabetes, and can result in hospitalization and death. For the patient, the feeling of wanting to give up is high. Although they may not be overtly suicidal, they may be motivated to play a "medical Russian roulette" where not following through with medical recommendations is likely to cause death. This passive suicidal approach is obviously not limited to patients with eating disorders. It is important that therapists address this and strongly encourage patients to commit to work on fixing the problem rather than giving up.

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(Stress, cont'.d from p. 12)

There is no necessary relationship with "bad parenting" (though of course such events do occur with poor parenting skills). There must simply be an interference in the sequencing of the individual's experiencing of an emotion and the attachment figure attuning to and validating – i.e., "containing" – the emotion. (Many factors can interrupt this sequence). Humans' affective experiences are *contained* – a primary element in affect modulation – when an attachment figure attunes with and validates the emotion which helps to restore the individual's relative sense of safety in the presence of the emotion. The individual learns to *have* an emotion instead of being overwhelmed by an emotion or the emotion *having* him or her. When an individual is overwhelmed by an emotion he or she learns to distance from the emotion, i.e., psychological defenses – suppression, repression, dissociation, acting-out and others – occur. Constellations of such defenses are what we know as *mental health disorders*.

Therapeutic approaches that address these problems of being overwhelmed by or distanced from emotions are those that foster development of interpersonal-affective experiences that increase the patient's sense of security and safety with his or her own emotional experiences. That is, these (relational) therapeutic approaches are attuned, validating and containing. The individual, as he or she develops a relationship with the therapist allows increasing access to his or her own emotional experience in the therapeutic space which offers the therapist the opportunity to attune with and validate these emotions. The patient experiences this process as strengthening as the presence of a capable other *in the shared emotional space* reassures the patient the emotion is survivable, tolerable and manageable. Patients learn to become relatively at-ease-with and at-home-with their emotional experiences and, as such their behaviors are determined *in the presence of their emotional experience* as opposed to determined *by* their emotional experience.

Over time, and as the patient experiences said strengthening in his or her relationship with his or her own emotions in relationship with the therapist this new experience of emotions is internalized and is accessed increasingly in other relationships. This process can occur concomitantly with developing new interpersonal behaviors, e.g.. communication skills that address emotional experience, needs and expression in the individual's interpersonal relationships. The individual learns to be aware of the presence and role of emotion in his or her interpersonal situations, the importance of validating these, both by validating his or her own emotional experience and communicating in such a way as to highlight the emotional component of the conflict and to own the emotion. Thus, the proverbial "'I' statement." "I am angry" versus "You are a jerk."

"'I' statements" and their equivalents – while elemental therapeutically – can be recruited and applied very effectively in growth and healing processes when practiced in the informed context of the larger relational therapy model. "Ah… so this is what is meant by an 'I' statement and why it works and is healthy." It is the expression of fundamental developmental truths where interpersonal-affective experience is concerned. The individual has an emotion, recognizes the emotion, recognizes the validity and manageability of the emotion – and its essential interpersonal dimension – and expresses it as same; thus, validating the individual and his or her experience as well as the emotion itself."

As the individual has these validating interpersonal-affective experiences in psychotherapy with the informed therapist and learns to practice these methods in his or her own personal life in general the readiness and ability to address emotional conflict increases. The patient learns that all emotion – whether in conflict with other emotions or interpersonally-affectively – is addressable and manageable (i.e., containable). For instance, given the example of the woman whose hours were cut back above, she might say: "I appreciate the company is facing increased costs

(cont.'d next page)

(Stress, cont.'d from previous page)

and something has to be done to address the matter. I want to do my part to help. But, I am uncomfortable with giving my hours to a less senior associate. Please restore my hours or help me understand the dynamics of the situation better." Or (to one's self), "I am outraged that Mr. S_ is giving my hours away to a less senior associate. Mr. S_ is unapproachable and retaliatory. I need to look for work at a company more worthy of what I have to offer and meanwhile keep my chin up here so I have income while I'm looking for a more respectable organization." Or (in response to her husband), "I heard what you just said about the impossibility of us 'living as a one-income household.' I am hurt by what I hear as an accusation as if I reduced my own hours by choice. But, frankly I am so angry with Mr. S_ right now I need to check whether what I am hearing is directed at me or I am filtering it through my own anger. Please, let me know how you are feeling about this situation, of course without personal attacks on me as those are never helpful."

As the individual becomes more at-ease-with and comfortable with having emotions expression of said emotions and assertiveness increases. The at-easement and assertiveness reduces the conflict – as alternative, effective responses emerge – and physiological events associated with protracted, unresolved conflict abate and homeostasis is restored in the system resulting in return to health over time.

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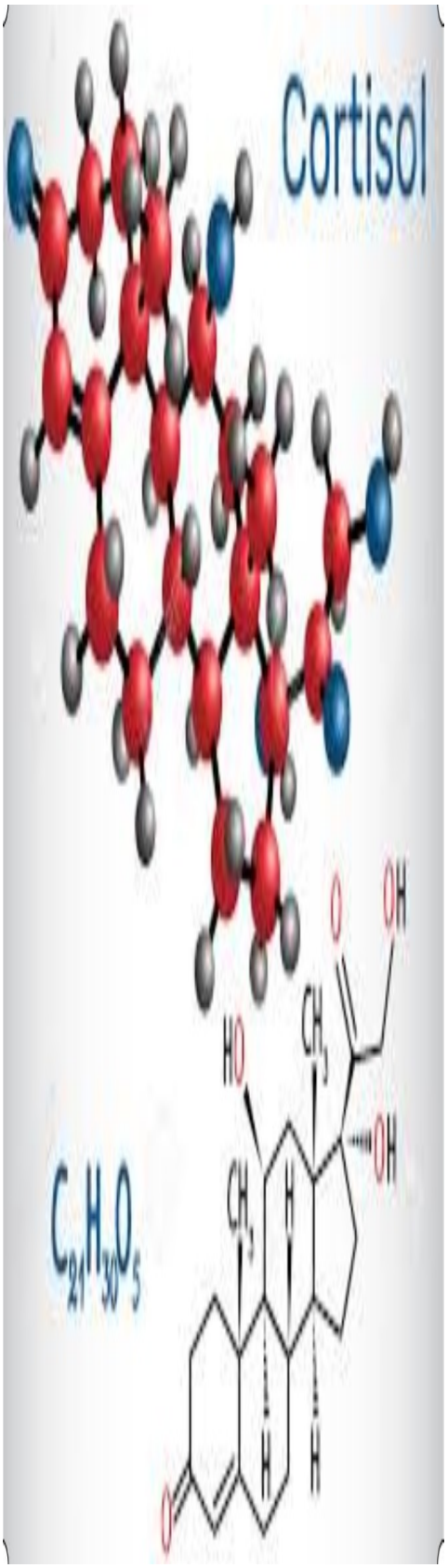

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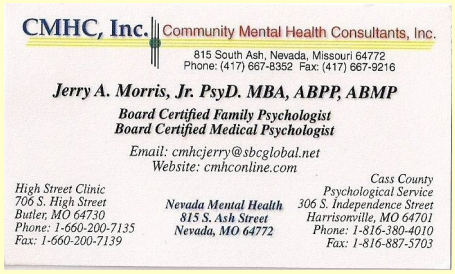

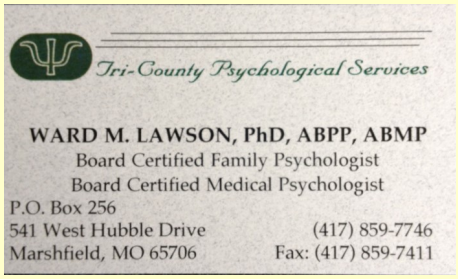

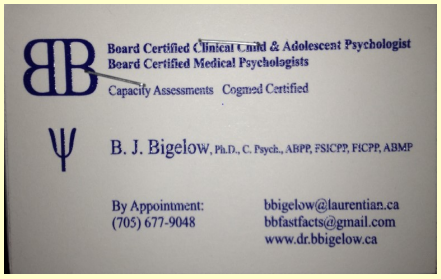

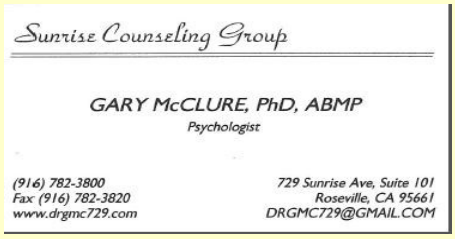

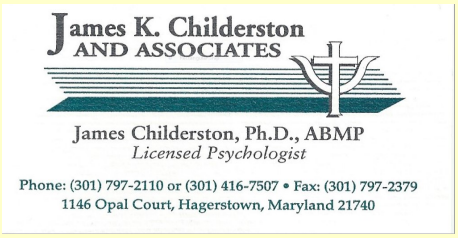

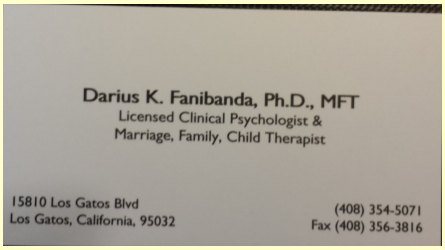

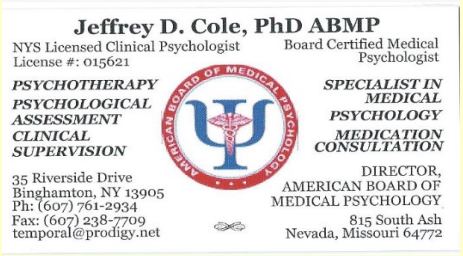

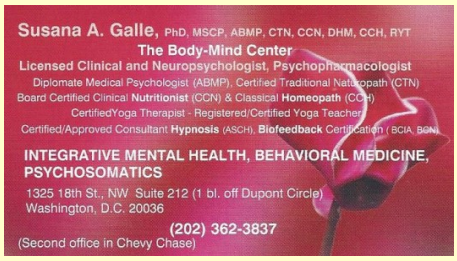

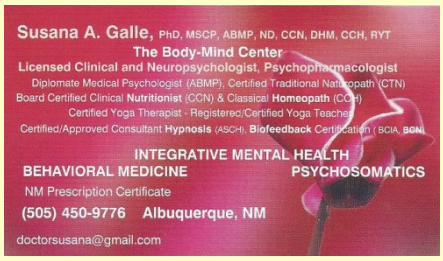

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DEAR AMP MEMBERS AND ABMP DIPLOMATES:

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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:

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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.

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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

Always change and growth going on at AMP. Dr. Gary McClure, in his President's Column announces the resignation of Dr.'s Morris and Caccavale from our Board of Directors and how they will be sorely missed for their substantive contributions to AMP, medical and clinical psychology and healthcare and advocacy as a whole. Of course, both will continue with many contributions to the field through writing, education and speaking. But, we are all sad they will not be continuing in a formal leadership role with AMP as their contributions have been beyond substantial. As Dr. McClure notes, the departure of Dr. Morris and Dr. Caccavale create openings for new board members and already we have recruited medical psychologists in specialist Dr. Keith Petrosky and student board member Dr. Aimee Cooper. They have already proven themselves as able and contributing professionals and we look forward to their contributions in AMP leadership. With Dr. Morris's exit from the Executive Director position Dr. Lawson stepped up to fill that role. We heartily welcome Dr. Lawson, already well-known to AMP for his years of service as a director on the Board, as past-President of AMP and ABMP and as Archives Managing Editor. Welcome to the Executive Director Position Dr. Lawson. I would also like to welcome our new Co-Editor for the AMP Newsletter, Dr. Rory Richardson. Dr. Richardson is one of our specialists, long-time AMP member and long-time contributor to the newsletter with his many learned and informative articles. Welcome Dr. Richardson!

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