The Clinical Practitioner

National Alliance of Professional Psychology Providers

A Professional Association Representing the Interests of Psychology Doctors in the Health Care System

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The Time To Prepare For Universal Healthcare Is Now

John L. Caccavale, Ph.D., M.S. Clinical Psychopharmacology

Universal healthcare is no longer a wishful "concept". States and the Federal government appear committed to implement healthcare insurance plans that cover all citizens. Massachusetts and California are actively pursuing universal coverage. The Congress has indicated a commitment to universal coverage and many presidential candidates are making universal healthcare a centerpiece of their campaigns. Lobbyists for large industry groups also are positively weighing in on universal coverage. The time is right and professional psychology needs to avoid the mistakes of the past and prepare to get a seat at the table. Many knowledgeable people on this subject see universal coverage being implemented no later than 2010. This is only four years away. We need to be prepared.

What Will Universal Coverage Mean To Psychologists?

In one word, EVERYTHING! All plans, no matter how implemented, will cover mental illness and behavioral disorders. It is not likely that any plan will disenfranchise mental healthcare. Because so much will be at stake, it is important that professional psychologists start to anticipate universal coverage and start to develop position papers, data, and other reliable documentation to support psychologist's interests.

The following issues will be important to psychologists.

1. What conditions will and will not be covered?
2. Which professions will be reimbursed for service?
3. What will reimbursement rates look like?
4. Will manage care still play a big part in providing coverage?

What Conditions Will And Will Not Be Covered?

Given the political process, it's a good bet that Medicare will be the government's model

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Will Managed Care Still Play A Big Part In Providing Coverage?
I would not want to predict that universal health coverage will put managed care out of business. Their lobbying clout is significant. However, as a single payer system is sure to be one option in the larger mix, they will have to compete for both business and panels of practitioners. This will present several important opportunities to psychologists who understand the business of practice. Universal coverage will favor group practices for the simple reason that groups can practice on an economy of scale. They can be more economically efficient. Psychologists who are able to practice in a group will be better able to attract patients and compete with managed care. However, solo practitioners will also have expanded opportunities. Managed care requires large panels of practitioners to market their products. Look at what has happened with the expanded drug coverage for seniors. Everyone has a plan! Universal coverage for mental healthcare will allow solo practitioners to gain a bargaining chip with managed care companies. By simply deciding to only be on panels that pay at a specific reimbursement rate will shift some power to solo practitioners. Remember, managed care companies will be competing with a single payer system and this will facilitate better negotiation of rates.

In conclusion, the likelihood of universal healthcare becoming a reality is very high.

Psychologists must prepare better than we did when Medicare became law. Please see Dr. Cummings paper on what happened when Medicare came into existence. His article can be read at http://www.nappp.org/NAPPPNick.php
We need to be ready to differentiate ourselves from other practitioners. We need to support proficiency training.
We need to become mature advocates for our interests and recognize that psychology is also a business. We are in the business of making the life of our patients better. We can do this, however, without sacrificing our own livelihood. We must seize every opportunity to effectively compete and convey our special training and skills to others. Most important, we have every right to get the highest return for the investment that we have made in becoming psychologists. As long as we practice ethically and selflessly
No one should tell us differently.

Virgin Islands Psychologist Prescribing Bill Derailed

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The American Psychiatric Association (ApA) was happy to report in their *Psychiatric News* (vol.41 #2) that they have been able to stop the expansion of psychologists' scope of practice in the Virgin Islands (a US territory). Sen. Usie Richards sponsored the bill based on model legislation from the American Psychological Association (APA). Several local psychologists, and one from Louisiana with prescriptive authority testified in support of the bill. Opponents included Annelle Primm, M.D., director of ApA's Office of Minority and National Affairs and representatives of Virgin Islands hospitals, the Virgin Islands Medical Society, and the Virgin Islands Alliance for the Mentally Ill.

The Senate Health, Hospitals, and Human Services Committee of the territory's legislature held a hearing to consider testimony and vote on the measure, but the committee did not vote because it lacked a quorum. The Association of Virgin Islands Psychologists said the bill would expand the mental health care resources available for indigent residents with mental illness. The bill's requirements are considered stringent, including completion of postdoctoral training specializing in prescriptive practice and 300 hours of class-based instruction in neurosciences, biochemistry, psychopharmacology, and physiology. Candidates would have to treat a minimum of 100 patients in the clinical portion of the course, which would have to be approved by the Virgin Islands Board of Psychology. Finally, they would have to pass a certifying exam approved by the board. The bill did not restrict the categories of medications that certified psychologists could prescribe, although prescribed medications must be within "the scope of practice of psychology."

There was the usual litany of objections by psychiatrists, but apparently their was also

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a concern that the legislation lacked any requirement that a psychologist with a prescription certificate ever consult with the patient's primary physician, which one might assume was ethically mandatory in any event.

Psychologist prescribing legislation has been approved in three other U.S. jurisdictions--New Mexico, Louisiana, and Guam. The New Mexico legislation involved the state medical board in the rule making process, but the Louisiana measure contained no such provision.

NAPPP's position is at http://www.nappp.org/rxp.pdf ***The Importance of Prescriptive Authority*** by Jack G. Wiggins, Ph.D., Psy.D., ABPP, ***NAPPP*** board member.

This CP Editor hopes all psychologists stay informed of the larger picture of all efforts to expand psychologists scope of practice, to better serve the public, whether or not they are interested in that particular aspect for their clinical activities.

What do you think?

The Ph.D. Syndrome

Scott D. Wylie, Psy.D. and Tim Shea, M.S.

What is the "Ph.D. Syndrome"? We will give you a few hints; it is common amongst doctoral (Ph.D, Psy.D.) level psychologists, its' symptoms are most pronounced in medical settings, and even though there is a cure, very few psychologists have chosen to use it. We have adopted, "Ph.D. Syndrome" to describe how psychologists go from confident, assertive doctors of psychology into silent, deferential, and insecure lay-persons in the presence of a medical provider. We would like to outline why we believe this "Ph.D. Syndrome" exists, what effect it is having on the perception of psychologists in the medical arena and in our community; and most importantly what we can do about it.

While working exclusively in medical settings, we have seen first hand the detrimental effects of acute Ph.D. Syndrome in the field. One of the most obvious contributors to Ph.D. Syndrome is the inconsistent, and sometimes inadequate, clinical training that some clinicians receive. How many psychologists do you know who have had biochemistry, anatomy and physiology, clinical medicine, or pharmacology as a core part of their training? In general, psychologists have less medical training than nurses. We are all trained to practice with a bio-psycho-social model, though are limiting ourselves in the areas of the hard sciences. These limitations breed insecurity. There seems to be an underestimation of our ability to work in the hard sciences, and an overestimation of a physician's knowledge across all spectrums. This combination of under and over estimation is a breeding ground for a full blown case of Ph.D. Syndrome.

Modern day mental health care is experiencing a paradigm shift in provider roles. Psychiatry is moving out of the "mental health" world, and is being re-identified as strictly a medical specialty. Psychiatry has again embraced the biological basis view of mental illness, which aligns more closely with the medical model. Concurrently, psychologists are being marginalized by their inclusion in a more generic group of Masters level providers (LCSW, MFT, and LPC's,). This inclusion diminishes our standing in our field, and further encroaches on areas that not too long ago were solely held by clinicians.

PhD Syndrome has a daily reinforcing value that psychologists are not colleagues. In many work locations where PhD Syndrome runs rampant, psychologists have no authority over patient care, allow themselves to be called by their first name to patients, and are noticeably absent from any type of medical rounds. When psychologists engage in Ph.D. Syndrome behavior, medical providers view us as non-clinicians, and more like referral dependent therapists (IE. SLP, PT, OT). Although there has been a huge increase in scientific knowledge in regards to etiology and treatment of mental illness, including an explosion in the number of medications available, psychological training has not actively engaged this new knowledge. Also, with the expansion of psychology training to a plethora of professional schools, the field is being flooded with psychologist who are more prone to develop PhD Syndrome, and further degrade the perception of psychology in the medical realm.

There are a number of steps we can take to reverse our diminishing roles, and enhance our ability to provide services that are more reflective of our expertise. The steps are straight forward, but require a unified and persistent contribution from clinicians.

1. *Interact with medical providers as a colleague, and you will be treated as a colleague*. Medical providers are not coming to you with questions so you can defer back to them, they want an answer, a solution, a diagnosis. Provide an answer, and then be flexible to update your diagnosis when more information becomes available. Differentiate yourself from your "therapist" colleagues, and educate medical providers on your areas of expertise. Become a knowledge expert that is actively sought out by providing timely responses and proactive solutions. This can also provide a great opportunity to network, and build a referral network for your private practice.

2. *Do not allow yourself to be referred to by your first name in professional communications with patients, other doctors, or other staff at your facility.* You are the highest educated person in your field, and you have earned the right to be called doctor. Anything short of this is a disservice to your education and your clinical colleagues. *(continued on page 4)*

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3. Seek out additional education and training in the medical aspects of the patients you work with. We believe all psychologists should have at least an RN level of medical/science education, but that currently is not a reality. We have seen psychologists with no symptoms of PhD Syndrome who have never taken medical coursework officially, but have taken it upon themselves to be involved in the bio-aspects of treatment, and to learn the

Necessary aspects of treatment, and to learn the necessary medical aspects of their target population. There are a growing number of opportunities available for psychologists to improve their medical/ science education. With the increase in available courses (distance learning, Fly-In, and residential), it is easier today for psychologists to increase their knowledge base.

4. *Express yourself briefly and succinctly*. Medical providers are overworked, and have very little time for lengthy explanations of the complex intrapsychic workings, transferences, and life histories. There is no one behavior that signals PhD Syndrome more than lengthy rambling. Brevity is not only recommended, it is often required.

5. Engage your medical provider colleagues. Seek them out to talk about a shared patient, have lunch with them, attend CME programs, give CME talks to them, and make a concerted effort to move the culture of your facility to an understanding that psychologists are highly educated, confident, and effective doctors.

Borderline Personality And Cyclothymic-Bipolar II: Demystified Connection?

Vincent J. Nerviano, Ph.D. CP Associate Editor, *Vincent@Nerviano.net*

Hagop S. Akiskal, MD, a well known expert on mood disorders, brings us a fascinating account of borderline personality disorder (BPD) vs. mood disorders in ***Demystifying Borderline Personality: The Cyclothymic-Bipolar II Connection*** [http://www.medscape.com/ viewarticle/457151] . He points out that the DSM-IV criteria for BPD, within the *dramatic cluster* of personality disorders, are largely derived from Gunderson & Singer. Curiously, the relationship between mood and BPD has been downplayed despite Gunderson's own research reported BPD patients meeting criteria for dysthymia (80%) and/or major depressive disorders (100%) at some point in their life, and much other research indicating considerable overlap between BPD and affective disorders. Usually the affective illness of BPD patients is described as *atypical*. Dr. Akiskal argues ***"that the atypicality of the affective dysregulation of patients given borderline diagnoses can be more precisely delineated in terms of cyclothymic and bipolar II disorders."***

Akiskal rearranges the DSM-IV BPD characteristics in a chart to highlight affective loading, pairing *Unstable intense relationships* with splitting, object hunger and abandonment depression; *Affective instability* with mercurial moods, reactive dysphoria and angry outbursts; *Behavioral dyscontrol* with impulsivity, substance abuse, binge eating and suicidality; *Chronic emptiness* with boredom*; Unstable sense of self* with identity disturbances and *Micropsychosis* with paranoid sensitivity and dissociation. He expresses great concern that the DSM-IV BPD operational construct does not coincide with the original psychoanalytic meaning, e.g. Kernberg's pioneering contributions in delineating a vulnerable psychic structure, rather than a specific nosologic entity, that was *a "stably unstable" level between the classic neuroses and psychoses.* Initially, the concept was a dilute form of psychosis to exclude such patients "from the couch", but with clinicians like Stone reporting that these patients often came from families with manic-depressive and alcoholic members - the first to make a persuasive argument about the need to shift from borderline as a subschizophrenic to a subaffective disorder. Dr. Akiskal points out that he independently, contradicting his own original hypothesis re schizophrenicity, found BPD probands closest to affective – especially a bipolar comparison group – from a familial standpoint. He also notes "this familial-genetic bipolar link was reinforced by antidepressant associated switches into irritable-angry hypomanic and mixed states in 20% of our sample during prospective observation, also observed by others...*To summarize, the recurrent nature of affective disorder, coupled with familial bipolarity and spontaneous and pharmacologic excursions into brief periods of elation, places the affective pathology of borderline patients in the soft bipolar realm (that can be broadly defined as bipolar II)."*

Elaborating further on the *"atypicality"*, Dr. Akiskal points out that that there is a misconception that micropsychotic and dissociative episodes in BPD patients emanate from psychotic processes; grandiose or irritable forms of hypomania occur in a third of our borderline probands with affective diagnoses. Also, half of BPD patients "have transient drug-induced psychoses secondary to alcohol, sedative hypnotic, psychedelic or stimulant drug use, or withdrawal." For BPD patients with concurrent panic-agoraphobia, depersonalization-derealization, as well as brief reactive psychoses, were not uncommon. He believes there is a misconception in Gunderson and Phillips' work contrasting BPD "empty" depression with the more classical "guilt" depressions in "classical" affective disorder: that only classical affective disorder is "true" affective disorder. Thus BPD "unstable, hostile, and labile moods -- the unrelenting tension and irritability with superimposed paroxysms of rage -- are relegated by these authors back into the characterologic realm." He further points to the recent forensic work of Coid who "recently provided a compelling description of the affective storms of borderline patients (restlessness, irritability, explosive anger, tension, psychotic anxiety), which lead to -- and alternate with -- the deceptive "calm" and "emptiness" following self-mutilation." Akiskal sees his position that a large group of BPD patients "suffer -- and make their loved ones suffer -- as a result of temperamental dysregulation along dysthymic-irritable-cyclothymic lines.

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Mood lability and hostile emotional avalanches, which characterize borderline patients, seem to derive from such temperamental dysregulation, which is quintessentially affective in nature."

Akiskal further expresses the belief that three recent studies have clarified the "complex interface of volatile affective temperament and atypical affective states" and how they relate to major depressive states with reverse vegetative (atypical) signs. Pisa showed 72% of 80 depressive patients with DSM-IV atypical features simultaneously met the criteria for bipolar II, with 60% having antecedent cyclothymic temperament. For DSM-IV axis II both cluster B (borderline-histrionic) and cluster C (avoidant) personality disorders were prevalent. Deltito et. al studied 20 consecutive BPD patients. Rated by descending order of established (conservative) bipolarity (bipolar I + bipolar II) was 44%; taking the most liberal definition of bipolarity (including pharmacologic-hypomania, cyclothymic temperament, and family history for bipolar disorder), 81% of borderline patients could be considered lying on the border of within the bipolar spectrum.

Akiskal's own part in *NIMH's Collaborative Study of Depression* has shown that clinical features reminiscent of borderline features (SADS Item 12) were strongly predictive of which major depressives would, over a prospective observation period of 11 years, switch to bipolar II (younger onset, high depressive recurrence, greater marital disruptions, higher phobic anxiety, more BPD clinical features, higher interpersonal sensitivity, high trait energy-activity and daydreaming, high trait mood lability). This was believed to underscore the importance of temperamental factors in borderline psychopathology, as well as their value in predicting bipolar outcome. "Stated more tersely, borderline personality, interpersonal sensitivity, mood labile temperamental traits, and bipolar II seem to represent overlapping expressions of the same diathesis." He also notes that mood lability is not pathognomonic for borderline personality, and occurs in bipolar II as well, as has been replicated by Henry et al.

Dr. Akiskal makes a major point that BPD is a casualty of the DSM Axis I-Axis II Distinction. He cites O'Connell et al who point out that structured interviews tend to misclassify subthreshold affective disturbances as dramatic personality disorders, with subsequent research by Levitt et al actually showing overlap of cyclothymic temperament and BPD. Akiskal believes there is an error in characterizing the ongoing functioning of patients with major mood disorders in "characterologic" language (Axis II in DSM-IV), which is conceptually removed from the "temperamental" language of classical European psychiatry; e.g. "bipolar patients are often described as "dramatic," "erratic," "unstable," impulsive," "passive-aggressive," "histrionic," "narcissistic," or "borderline," as if affective temperaments had little to contribute to our understanding of these personality disorders." Akiskal emphasizes the "advantages to returning to the more natural affective temperamental language of describing the premorbid, intermorbid, and postmorbid phases of major affective disorders where affective temperaments represent the substrate from which the more florid episodes develop."

Borderline as the "Darker Side" of Cyclothymia

Akiskal quotes his own group's work as demonstrating "that the temperamental terrain between depression and manic-depression is bridged by a spectrum of subtle bipolar disorders with an extremely variable course." There are recurrent, biphasic and abrupt mood switches; some may be seasonal and sometimes exacerbated by antidepressants. Rarely euthymic, but "explosive" in the abruptness of the affective changes with phases lasting for hours, days, and, sometimes, weeks. Mood shifts are often in a circadian pattern (i.e., waking up convinced of the futility of existence), but also are reactive to interpersonal altercations which may be trivial but emotionally charged for the patient. An endogenous propensity to extreme emotional reactivity in these patients is therefore inferred such that most clyclothymes accumulate an extreme array of social disturbances by their mid-20s (repeated romantic failure, episodic promiscuity, financial extravagance, uneven work or school record, dilettantism, geographic instability, polysubstance abuse, and joining various eschatologic cults.) He concludes such instability is secondary to lifelong biphasic mood swings below the threshold for full-blown bipolar disorder. Cyclothymics with predominantly irritable traits have this instability especially accentuated. "In brief, the morose temperamentality of the irritable cyclothymic provides the unstable base from which interpersonal tempests arise."

Akiskal cites a recent French national collaborative study which does display the notion of cyclothymia and hypomania as positive "sunny" traits and behaviors but he sees this as just one facet of soft bipolarity: "a driven-euphoric facet should be contrasted with the irritable-tempestuous or "darker" side of bipolarity." "In brief, depressions arising from a cyclothymic baseline are often characterized by dysphoric hypomanic periods, and are likely to be misdiagnosed as erratic personality disorders. Their high familial load for affective (including bipolar) disorder support their inclusion as a more unstable variant of bipolar II that can be best be characterized as "cyclothymic depressions."

In a yet unpublished collaborative study, Akiskal reports more data relevant to the "darker" side of bipolarity based upon 107 atypical major depressive patients where cyclothymic temperament accounted for much of the relationship between atypicality and borderline personality, indicating "support for the contention that atypical depression, borderline personality, cyclothymia, and bipolar II represent overlapping manifestations of a common underlying psychobiologic diathesis." He points out clinicians can be baffled unless the temperamental vulnerabilities are understood properly regarding the comorbid and erratic clinical presentations of BPD patients. He fears that these misunderstandings have resulted in some researchers preferring to characterize these vulnerabilities along the lines of sociopathy and related personality disorders rather than to the true complex picture represented by this work.

Akiskal asserts that the affective framework for borderline personality, as a soft bipolar variant described here, has major implications for clinical management both psychopharmacologically and in terms of formal psychotherapy. The "affective reconceptualization of borderline pathology may substantially reduce the therapists' countertransference because now the patient is viewed as affectively ill, rather than "character flawed." Clearly there is a requisite competence and confidence for

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treatment as a serious mental / mood disorder, with suicide risk. This potentially fatal consequence of the intense affective dysregulation needs to be conceptualized and clinically managed as rigorously as in any patient with serious mood disorder. One vital public health priority could be, in principle, treating the affective dysregulation and the impulsivity that underlies such risk as potentially preventable with the use of mood stabilizers including carbamazepine and divalproex.

Overall, clinicians need to remember these patients often come from disturbed families and are at risk for instability due to both genetic and developmental factors. Akiskal warns clinicians against assuming that the parents of BPD patients are or were "monsters" since the negative affectivity of BPD patients often lead to the development of malevolent object representations of significant others. "Parents' guidance is often crucial to these patients' mastery of maturational tasks. On the other hand, Kurt Schneider's wise admonition should not be forgotten*: "On their bad days, keep out of their way as far as possible."*

This CP Editor finds this a complex and fascinating topic, which might also provide good reasons for some psychologist practitioners to consider further the role of RxP in their future.

What do you think?

NAPPP Announces More Organizational Affiliations

CAPP

Two more groups have voted to affiliate with NAPPP. **The Board of Directors of the California Association of Psychology Providers (CAPP V. Rank)** has officially agreed to affiliate with NAPPP. This important association, which led the fight for hospital privileges and many other important issues for practitioners, is a very welcome addition to NAPPP. We will be collaborating with CAPP on a variety of issues advocating for practice and a better environment for professional psychologists. Members of CAPP and NAPPP will receive discounted dues for being part of the two organizations. We expect California psychologists to view this affiliation another step in the direction to bring strength to advocacy for their rights and the profession as a whole.

VeriCare

VeriCare is the **largest employer of psychologists** in senior care. Through the affiliation agreement, **VeriCare employees will become NAPPP members and NAPPP** will work with VeriCare to advocate for practitioners and patients involved in **senior care facilities**. VeriCare will join Dr. Paula Hartment-Stein's committee to develop objective quality care measures and performance outcomes. As long term providers of mental health in senior care, NAPPP will have the expertise of a solid group of professionals to help us justify higher reimbursement rates for practitioners. Another benefit for NAPPP members pertains to access to employment opportunities with VeriCare. They offer full time and part time positions nationally to psychologists.

NAPPP Members

Get CEUs By Completing The Test On Page 16!

It Doesn't Take Many Votes to Win!

Following are the **rates of return for the APA President-elect and apportionment ballot elections over the past 6 years. United practitioners could easily dominate elections in most psychology elections by becoming a cohesive voting block rather than breaking their vote up in sub-factions!**

President-elect

2006	87,457 sent	16,836 returned (19.25%)
2005	86,927 sent	14,506 returned (16.7%)
2004	86,831 sent	16,245 returned (18.7%)
2003	86,272 sent	17,956 returned (20.8%)
2002	85,298 sent	17,094 returned (20%)
2001	85,037 sent	17,930 returned (21.1%)

Apportionment Ballot

2006	87,753 sent	16,084 returned (18.3%)
2005	87,351 sent	16,622 returned (19%)
2004	86,958 sent	17,672 returned (20.3%)
2003	86,473 sent	19,045 returned (22%)
2002	85,702 sent	19,520 returned (22.8%)
2001	85,300 sent	17,753 returned (20.8%)

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Rockport Insurance Associates

The Importance of State Psychological Associations

By Jerry Morris, PsyD, MBA, ABPP

State psychological associations have been a conundrum for practitioners! They are often conceptualized by those in practice as a strange gaggle of diverse mini-APA's or APA extensions to the states. In actuality these organizations reflect APA, but are actually corporations with individualized corporate and local interests that sometimes parallel APA's interests and sometimes don't.

Like APA on can expect that these state associations represent a trend toward feminization. APA is now over 53% women and that trend is likely to increase (http://research.apa.org/members.html, Table 1). Ray Fowler once noted that in 1985, 34% of APA were women, and by 1993 this figure rose to 42%, and by 2000 it was 49% (Fowler, 2002). By the next few years the trend increased by 15% and Fowler predicted that women would make up 60% of the organization's membership by 2010 and noted the writings and discussion about the dramatic change in culture and nature of the organization that would be occurring.

This means that state psychological associations are likely to be led by women leaders in psychology and that their tenor is likely to change with regard to valuing relationships and nurturance, positive emoting, socialization, and to eschew more aggressive, guild oriented, and battle-ground engagement activities more characteristic of male dominated and guild oriented associations. These are over generalizations of course, as attempting to understand any very broad social or cultural frame naturally entails, but still it is likely that the nature and culture of state psychological associations and their norms and values and related styles of interaction will change based on the association's changing demographics.

It may be harder in the future for these associations to tolerate aggressive guild task orientations which begat confrontation, battle oriented political confrontation, PAC arm twisting and downright pressuring of constituents to raise substantial amounts of money necessary to finance practice oriented legislative initiative. Such demanding and aggressive actions with open airing of conflicts and challenges within state associations may become cast as "disruptive" or even "unethical" rather than a necessary part of the struggles for market share and boundary maintenance that industries go through! The state association culture may reward those who "socialize pleasantly", "are supportive and nurturant", or who "resolve conflict through acceptance and compromise" (all important characteristics at times), but select against aggressive task

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oriented actions based on acceptance of conflict and open battling for boundary maintenance or territory and asset accumulation (also important traits in those growth industries that are defending and battling for market share)!
If state psychological associations become shifted to the point that they don't equally value, select leaders for, and reinforce both sets of traits, then there is likely to be a decline in their importance in the over all defense and extension of practice. The failure to develop and support sufficient numbers of aggressive and action oriented leaders who are revered and held up as exemplars and role models found and moved to the very top leadership in state psychological associations would render future state psychological associations to the future of a "book club", "social hour specialty group", or a haven for academics who need to demonstrate community and association involvement and leadership to achieve promotion and advancement.

One can not doubt that in this emergent culture men and women who are nurturing, focus on relational marketing rather than taking on battles with externalities, and who maintain the homogeneity of the association environment by discouraging risk taking and airing and aggressively understanding and reorganizing based on what has learned in conflict will be the favored leaders and will increasingly move into power. They will adopt and encourage "safe", "minimally challenging", and "feel good" initiatives that already have consensus and mass support. Thus, the organization will increasingly disdain the disruptive, conflicted, demanding, and aggressive action oriented application of organizational leadership and resources to address increasing psychologist practitioner market share, boundary defense, and directly attack conflicts with externalities.

State psychological associations have another important trend emerging. In addition to the feminization of psychology and a change of trait reinforcement and leadership selection (and the reader should remember that many good women leaders have these traits of conflict tolerance, aggression, love of battle over boundaries and boundary extensions, etc.), the state psychological associations have another driving dynamic. State psychological associations do not represent the majority of psychologists in most states. Many states have less than 25% of their state psychologists as members of the state psychological association, and of the members listed in the rolls of state associations, many are affiliate, retired or emeritus, or non-psychologist members of some form or another (thus inflating membership data).

This dynamic (psychologists generally don't join state psychological associations) undermines the state association's credibility when they attempt to speak for and negotiate for psychologists in their state. In essence, you have a small minority of psychology state advocates speaking for psychology in states. Many in legislatures and certain factions in psychology realize this phenomena and use it strategically to undermine state association political, legislative, and administrative efforts. It is widely known that some academics use this dynamic (and have openly used it repeatedly) to oppose practitioner legislative efforts by rallying extra psychological association opposition to legislative efforts and pointing out to legislators that "the state psychological association's position is actually not the position of psychologists and that many oppose them"! This is blatant and aggressive use of the fact that state psychological associations do not represent the majority of psychologists in a given state.

State psychological associations do not represent the majority of psychologists in most states.

Some state associations have noticed this dynamic and have tried (and repeatedly tried) to resolve it with "membership drives"! Those actives are doomed by the nature of psychologists (independent and somewhat introversive), and by the fact that the "book club", or "socialization society" image of state psychological associations do not attract more guild minded and action oriented psychologists who pick and choose the investment of their scare resources and only support "action oriented" and "aggressive" organizations that specifically take on and address their practice and guild needs! These types won't be attracted by membership drives and invites to join "book clubs" and "socialization societies"! They are business types with pressing business conflicts and needs! They are pragmatic and are looking for investment of dues and contributions where they will directly attack their business and industry problems. They won't be impressed by pretty brochures, loving interactions, or nurturant newsletters and mugs! They have arranged to get these needs met amply in their private lives and without drain on their business resources.

Practitioners have historically cyclically deserted state psychological associations, only to come back when practitioner interests are neglected or threatened by unresponsive leadership. This cyclical practitioner membership often causes a situation in which practitioner groups must set up political campaigns and re-establish control of state associations repetitively (through elections, and reorganization of associations). Thus, many states are in a state of cyclical flux, political turmoil, and wasted resources. Practitioner, who must give up thousands of dollars of personal income to volunteer while academics and state and federal agency psychologists maintain their income and in some cases get paid for state association service hours, resent the situation and sometimes can't afford the volunteerism (depending the state of their business).

Practitioners must realize that if they don't get involved in state associations that they will increasingly become book clubs with nurturant socialization, but will be inept and reluctant to aggressively attack practitioner issues. They will errantly be perceived by many as "representing psychology in the state", or as "arms of APA"! They will not get help with the important business issues and guild issues that affect practice in their state, and they will be at a distinct disadvantage when the state asks their state association for opinions related to the regulation of their practice and appointment of psychologists to regulatory and licensure boards.

What needs to be done! Most practitioners don't realize their power and potential influence! The APA elections find less than

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20% of members voting and the major elections in APA are won with less than 18,000 (of the over 125,000 members) votes. A small but voting block controls APA. This situation is amplified in the state psychological associations.

In some states less than 100 votes are cast for the winner of Presidential and Board elections. A handful of practitioners could take over the state association and influence the culture, where it focuses it's resources and what committees and work products are produced. Practitioners have no concept of what it would mean to be able to "get a sensible practitioner" appointed to replace an academic on the state licensure committee that hears potential practitioner issues, or what state association input into the state Medicaid plan can mean. They don't realize that the state association is looked to by government to help formulate rules for how reimbursement, documentation, and criminal investigation related to practice are handled. Practitioners need control of state psychological associations or to form a practitioner association that is viewed as representing practitioners in their states (like some states have done parallel to their state association, Louisiana, Kansas, California, etc.). Practitioners could easily form chapters of NAPPP, or set up NAPPP chapters affiliated with their state psychological association. Other ways to organize practice in your state would be to set up a "practice committee" within your state association.

The long and short of this message is that practitioner can and should take over their state psychological associations and should recognize the small numbers of cohesive practice voting block members it would take to do so! Practitioners are neglecting the influence, culture, and value of their state psychological association, and how easy it would be to get them shifted to an aggressive guild organization with real value for practice in the state.

In some states less than 100 votes are cast for the winner of Presidential and Board elections.

Men and women practitioners who reject the idea that doctors who never challenge the status quo, challenge the organization to enter into leadership engagement in conflicted and high risk practice situations need to emerge as the leadership in state psychological associations. They need to reject the idea that association activities and leadership must only pass to friendly and safe exchanges with no real core impact on the core values and top priority guild and business issues. These men and women must elucidate the folly of only recruiting and electing leaders that "make us feel good, and only do things that are fully consensual"! They must appreciate nurturance, warmth, and friendliness, but must also appreciate the needs for fighters, entrepreneurial practitioners who will move the organization toward redress of essential guild issues and taking more market share! The must move the state association's agenda to listen to practitioners and to hoist practice's core issue in every program, publication, activity and event, and resource investment of the state psychological association. They must gain control of state associations for practice and reorganize them around the infrastructure that can address practice priorities and issues.

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Ivan Boszormenyi-Nagy Dies

Ivan Boszormenyi-Nagy, was 86 at the time of his death in late January. He was an Innovator of Family Therapy, trained as a psychiatrist, and resided in Glenside, Pa.

Dr. Nagy in the 1950s and 1960s began to look beyond individual psychology to understand and try to treat severe mental disorders, particularly schizophrenia. Dr. Nagy noticed that destructive patterns of family interaction and related values and thoughts often spanned generations. He often brought patients' grandparents, parents, siblings, and children into therapy sessions. He found that by working to balance loyalties and ethical obligations among family members, he could help soothe patients' symptoms, and sometimes cure them.

Nagy, and his psychiatrist contemporaries (Murray Bowen and Lyman Wynne) became convinced that medications and genetics were not the answer to treating people with severe mental disorders Nagy felt that people with mental disorders often fell prey to dysfunctional relational ethics and harbor related grudges and negative affects and relational expectations that drive them to settle the books or balance the score. He felt that by restoring relational ethics and creating a relational atmosphere of fairness, understanding, and justice that much of the mental disorder would eventually dissipate.

One of his most influential books, "Invisible Loyalties" (Harper & Row, 1973), written with Geraldine M. Spark, inspired a generation of therapists to think more broadly about mental health as part of a family system, dependent on hidden loyalties and commitments.

Ivan Boszormenyi-Nagy was born in 1920 in Budapest, into a family of prominent judges. He graduated from Peter Pazmany University with a degree in psychiatry in 1948 and moved to the University of Budapest. In 1950 he moved to Chicago, where he completed his medical residency, and later took a position at the Eastern Pennsylvania Psychiatric Institute in Philadelphia for 20 years.

He later became chief of the family therapy department at Hahnemann University, now Drexel.

Practitioner Focus

Joseph M. Casciani, PhD, is a clinical psychologist and a co-founder and head of clinical affairs for VeriCare (http://www.vericare.com/), formerly Senior Psychology Services.

Since VeriCare's outset in 1991, he has been responsible for the coordination and delivery of clinical services, provider training protocols, and program development. The company is a provider of behavioral health services, primarily for older adults in residential and long term care facilities, that employs over 300 psychologists, psychiatrists, clinical social workers and advance practice nurses, and contracts with over 1,000 client facilities in eight states.

Dr. Casciani has worked in the area of geropsychology since the early 1980's, when he was awarded several contracts by the CA Dept. of Aging to develop aging and mental health training programs for nursing home staff. He is licensed in three states.

Medication Side Effects: Do We Need Tailored Drugs or A Broader Conceptualization of Mental Disorder

Researchers to explain why drugs for the treatment of mental disorders may cause patients to gain a lot of weight. These powerful tranquilizers logically would be expected to lower inhibitions of some drives and dampen others just as street tranquilizers have done for years.

However, the biomechanization of mental illness seeks to focus on finding a magic drug that will stop symptoms we don't want while alleviating side effects. Certainly, that is an over simplified view of the mental disorders, but would improve medications and really be a sales advantage.

Antipsychotic medications can increase the activity of an enzyme called AMPK in cells in the part of the brain that regulates eating behavior. Even small amounts of the medication can cause large increases in the enzyme activity. Zyprexa's use has been plagued by concerns over weight gains, as has Clozapine, Seroquel, Respirdone (in descending order of prevalence) and other medication. It is felt that weight gain is at the heart of increased risk for serious complications including diabetes and heart disease.

Patients often are non-compliant or discontinue these medications due to rapid and noticeable weight gain. They begin to eat too much from increased appetite.

Zyprexa, the favored agent seems to potentiate the worst weight gain, along with clozapine, the parent drug in the class. However, Seroquel and Respirdone have this side effect associated with them.

Researchers have shown that AMPK's increase was because the antipsychotic drugs were interfering with the important protein histamine. Histamine is implicated in allergy symptoms and is suspected for a role in weight control. The problem with tailoring these major tranquilizers to change their effect on AMPK is the possible side effects of that action. There is no free lunch, and there are limitations to looking at the control of a syndrome like psychosis solely with medications.

Practitioner Focus

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Here's some web sites that clinicians may want to peruse and see if they are useful:

NIMH Outreach (http://www.nimh.nih.gov/outreach/index.cfm)

NIMH Announces New Outreach Partners http://www.nimh.nih.gov/outreach/partners/newpartnersjan07.cfm

Publications (http://www.nimh.nih.gov/publicat/index.cfm)

Medline Plus: Information on thousands of prescription and over-the-counter medications is provided through two drug resources -- MedMaster™†, a product of the American Society of Health-System Pharmacists (ASHP), and the USP DI® Advice for the Patient® ‡, a product of the United States Pharmacopeia (USP).

Press Room (http://www.nimh.nih.gov/press/index.cfm)

Gene Variant Linked to Schizophrenia http://www.nimh.nih.gov/press/childhood-schiz-onset-NGR-1.cfm

U.S.-born Children of Immigrants May Have Higher Risk for Mental Disorders Than Parents http://www.nimh.nih.gov/press/immigrant_mentalhealth.cfm

Different Families, Different Characteristics -- Different Kinds of Bipolar Disorder? http://www.nimh.nih.gov/press/bp-familiality.cfm

History of Childhood Abuse or Neglect Increases Risk of Major Depression http://www.nimh.nih.gov/press/abuse-depression.cfm

http://www.dbsalliance.org/site/PageServer?pagename=home

http://www.bipolarbrain.com/

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Get CEs for The Suicide Article in Our Current Issue

Complete the questions below and email your answers to Dr. John Caccavale at ceprogram@nappp.org

CE Credit Test: Articles in the entire issue.

*This test is for the articles that were **printed in this edition of The Clinical Practitioner.** Please read the articles and then answer the following questions. When you are finished email your test with answers to Dr. John Caccavale at ceprogram@nappp.org. You must have this test submitted within the next 30 days. You will get 1 hour or 2 CE credit for this exercise if you score more than 69% correct.*

1. Conngress has indicated a commitment to universal healthcare:
   A. Yes
   B. No
   C. For only Medicaid populations
   D. For only the disabled

2. The practice model that will have the most leverage in the new universal health system will be the:
   A. Solo practitioner private practice
   B. Psychologist in a hospital setting
   C. The group practice
   D. Tall handsome men

3. The Virgin Islands RxP Bill sponsor was:
   A. Senator Joe Johnson.
   B. Senator Pat Deleon.
   C. Sen. Usie Richards.
   D. None of the above.

4. What are the effects of acute Ph.D. Syndrome:
   A. Inadequate and inconsistent training
   B. Our training breeds insecurity
   C. An understatement of our ability to work in the hard sciences.
   D. All of the above.

5. Wylie and Shea recommend that the psychologist:
   A. Refrain from letting patients and other refer to them by their first name.
   B. Drop out of the health professions and study basic science.
   C. Both A and B above..
   D. None of the above.

6. One of the great mistakes that Wylie and Shea think that psychologists make based on insecurity is:
   A. They should have gotten a two year RN before going to graduate school.
      To graduate school.
   B. They don't have the confidence to engage and Actively collaborate with physicians.
   C. They could easily get into medical school and should do so.
   D. None of the above.

7. Akiskas holds that :
   A. Bipolar Patients should be avoided by all psychologists.
   B. half of BPD patients "have transient drug-induced psychoses secondary to alcohol, sedative hypnotic, psychedelic or stimulant drug use, or withdrawal."
   C. Both of the above
   D. None of the above.

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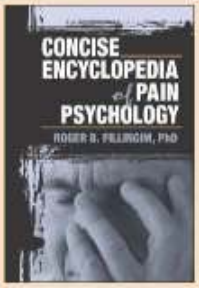

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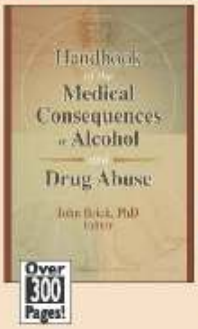

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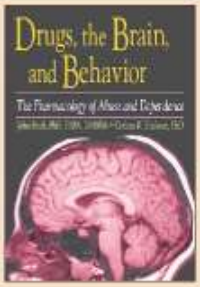

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The Past Issue Picture: Dr. Jerry Morris on his MO Office Patio!
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PAST ISSUES INDEX: THE CLINICAL PRACTITIONER

To Get Your Past Clinical Practitioner (Aug, Sept, Oct, Nov, Dec, Jan) Click

Editor's Comment: Jerry Morris, PsyD, MBA, ABPP

Colleagues,

I hope you are continuing to enjoy *The Clinical Practitioner* (click here to see back issues). This is your practitioner oriented newsletter and we can't succeed without you. Please consider doing informational, practice, or scientific articles and sending them to me at morris49@ipa.net or to one of our editors.

As you notice in this edition, increasingly psychology practice oriented credentialing, service delivery, and educational organizations are affiliating with the national practitioner organization. Dr. John Caccavale and our practitioner board have articulated a clear organizational vision that is practitioner focused and which keeps our organization lean, responsive, and action oriented. We are not here to squander our scarce resources on semi-meaningless socialization or poster presentations, but rather want to strategically take on those core problems and core activities that affect the daily lives, businesses, and clinical service delivery of practitioners. Because we are the other kid on the block and because we have a unique nature and core practitioner structure we add an important and fresh practice perspective that has intense loyalty and attachment to a very specific group within the broad body psychology. We are not for everyone, and don't want everyone in our organization. We are not about sub-grouping and fractionation but recognize our constituents only by their mantel "Practitioner"! Our members can count on our focused and dogged dedication to practice and anyone who makes their living by using psychology to heal disease and treat human health care problems. If you are looking for a focused, unique, and action oriented "practitioner home" you should be with us!

Psychology is changing! If you answer the questions of "who are psychologists", "what do they do when they treat illness", "where do psychologists work", "what type of people become psychologists", "how does the public view psychologists", and "what does it take to become a practitioner of psychology" you get very different answers than you did 20 years ago (or even 10 years ago). We, and the practice of health care psychology has changed dramatically! Some of our views of psychology and ourselves are so archaic that they sound silly to those who have moved forward at the grass roots of practice. Grass roots practitioners often find old psychological institutions more or less in tune with what the new psychology actually is when viewed from the front lines of practice and at the grass roots level. It will be up to these institutions to reinvent or invent themselves by entering the grass roots dialogue and listening to the doctor in the trenches. Some psychological institutions will do a good job of this and will show the flexibility and evolutionary thrust to do so and some won't! NAPPP will collaborate with any organization or group of practitioners who listen to and act in the best interests of the grass roots doctor/practitioner of psychology.