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For this issue of *The Tablet* we wanted to bring you updates of research published this past year on topics in psychopharmacology. These selected research articles highlight areas of interest for clinicians. Many of these studies’ authors include psychologists and psychology graduate students.

**SSRIs and CNS Hemorrhage**


A meta-analysis of studies relating to the relationship between SSRIs and this risk of CNS hemorrhage was published in October in the journal *Neurology*. The authors included controlled observational studies that compared samples of patients receiving SSRI therapy and control groups not receiving SSRIs. It is important to note that the studies included in this meta-analysis were not prospective controlled studies that directly sought to determine a causal relationship between SSRIs and CVA. Nonetheless, meta-analyses are considered the gold standard for identifying relationships between variables that cannot be studied in randomized, controlled experiments due to inherent ethical or practical reasons. In short, the patients in the studies reviewed were not randomly assigned to an SSRI or no-SSRI group, but were prescribed SSRIs due to a condition that itself confounds the findings. The authors synthesized the epidemiologic evidence concerning selective serotonin reuptake inhibitor (SSRI) exposure and the risk of CNS hemorrhage. Using fixed effects models, the authors concluded that intracranial hemorrhage was related to SSRI exposure when risk ratios were unadjusted (1.48) and adjusted (1.51). The authors noted that the risk ratios for both hemorrhagic stroke and intracerebral hemorrhage increased when SSRIs were combined with anticoagulants. In addition, increased...
risks were noted across case studies, case controlled studies and cohort studies. Despite these findings, the authors indicate that although SSRI exposure is associated with an increased risk of intracerebral and intracranial hemorrhage, base-rates and absolute risks for these events are very low.

**Developments in Depression Research**


Research indicates coupling antidepressant medications can be advantageous for the treatment of depression. Caffeine and dietary creatine are also showing promise in depression research. According to a meta-analysis by researchers in Brazil, combining antidepressants is more efficient for the treatment of depression than just one antidepressant by itself (Rocha, Fuzikawa, Riera, & Hara, 2012). Furthermore, in two case studies at University Medicine Berlin, a combination of Tranylcypromine and Bupropion was found to be effective for addressing treatment-resistant depression, though the authors note significant risks associated with this combination of medications (Quante & Zeugmann, 2012). In animal research, researchers in Bulgaria found that long-term exposure to caffeine produced an antidepressant effect in rats subjected to chronic stress (Pechlivanova et al., 2012). And, a graduate student in psychology with her colleagues found that supplementing diets with creatine produced antidepressant-like improvements in female (but not male) rats (Allen, D’Anci, Kanarek, & Renshaw, 2012). They suggest this finding may lead to gender-specific strategies for treating depression in humans.

**Antipsychotic Medication and Suicidality**


Antipsychotic medications are currently used to treat a range of psychological disorders. The association be-
tween suicidal ideation and antipsychotic medication was analyzed within different diagnostic groups (schizophrenia, other psychosis and no psychosis), using cross-sectional data from the Northern Finland 1966 Birth Cohort. For people with schizophrenia or other forms of psychosis, there were no associations between the use of antipsychotics and suicidal ideation. In the non-psychotic group, however, higher antipsychotic doses were associated with more suicidal ideation, even after controlling for depression and anxiety (p < 0.05). These results indicate that the risk of suicidal ideation should be considered when prescribing antipsychotic medication for non-psychotic disorders, and clinicians should monitor patients for suicidal ideation.

**Metabolic Effects of Ziprasidone & Olanzapine**

This study compared the metabolic effects of ziprasidone and olanzapine treatment in 260 patients with first-episode schizophrenia who were randomly assigned to receive treatment over six weeks. The mean doses were 138.2 mg for ziprasidone and 19.0 mg for olanzapine. Both medications improved schizophrenia symptoms, but the olanzapine treatment showed more decreases in Positive and Negative Syndrome Scale scores. The ziprasidone treatment, on the other hand, showed superior change scores for weight, BMI, fasting plasma glucose, insulin, homeostasis model assessment 2-insulin resistance, low-density lipoprotein, total cholesterol, and triglycerides. These results suggest that ziprasidone could be considered as an alternative to improve antipsychotic-induced hyperglycemia or insulin resistance. The authors also note that some patients showed elevations in liver transaminases and suggest that practitioners monitor liver function throughout both olanzapine and ziprasidone treatments.

**Antipsychotic Medication and Osteoporosis**

In this article, the authors found some evidence of reductions in bone mineral density for patients prescribed antipsychotic medications, at rates much higher than the normal population. The authors note that the evidence is insufficient to merit routine monitoring of bone mineral density for patients taking antipsychotic drugs, but they suggest that clinicians have a lower threshold for checking bone mineral density, especially for patients with risk factors like low BMI, corticosteroid users, women with a history of prolonged amenor-
rhea and those with a family history of osteoporosis or previous history of fractures. When low bone mineral density is detected in patients taking antipsychotics, suggested treatment is alendronic acid or oestrogen augmentation, which may also benefit negative symptoms.

**Celecoxib and Risperidone for Autism**


In this 10-week randomized double-blind placebo-controlled study, 40 outpatient children with autism were randomly assigned to receive celecoxib plus risperidone or placebo plus risperidone. The dose of risperidone and celecoxib were titrated up to 3 and 300 mg/day, respectively. There were no differences between the groups in hyperactivity, inappropriate speech, or adverse side effects. The combination of risperidone and celecoxib was superior to risperidone alone in treating symptoms of irritability, social withdrawal, and stereotypy.

**Balcofen for Binge Eating**


Balcofen was shown to reduce binge eating frequency by an average of 20% in this double blind, crossover study of 12 participants conducted at Penn State University. Baclofen also reduced the severity of binge eating behavior from severe to moderate levels, and cravings were reduced by 30%. The placebo also resulted in significant reductions in the severity of binges and of food cravings, but not in reducing the frequency of binge eating behavior. Overall, the larger effects were associated with Balcofen.

**Energy Drinks**


Energy drinks probably do not confer as much benefit as college students might think according to psychologists at Tufts University. To determine the relative effect of the ‘active ingredients’ in popular energy drinks, 48 subjects were divided among four groups receiving different combinations of ingredients including a pla-
cebo control group, a group receiving both caffeine and taurine, and two other groups, each with only one of the two ingredients. Taurine alone increased participants’ speed in decision making tasks, but in combination with caffeine appeared to reverse the invigorating effects of caffeine. They concluded that caffeine, not other ingredients, is probably responsible for most of the energizing effect of energy drinks.

**Vitamin C and Noise Exposure**


Vitamin C may reduce the negative impact of prolonged exposure to noise according to research coauthored by a psychologist in Northern Ireland. Long-term exposure to noise can result in sleep and eating disturbances, anxiety, and even increased aggression. However, in this study, mice treated with Vitamin C showed fewer signs of behavioral and physiological stress compared to mice exposed to noise without Vitamin C supplementation, and indeed, were more similar to mice which had not been exposed to noise.
During her Fiscal Year 2013 U.S. Senate Appropriations Committee testimony, the Director of the U.S. Navy Nurse Corps, Rear Admiral Elizabeth Niemyer, provided an exciting glimpse into the operational future of health care reform, with its emphasis upon patient-centered, holistic, and multi-disciplinary care – “The Navy Nurse Corps is comprised of 4,059 active and reserve component and 1,783 federal civilian registered nurses. Together, they are a unified and highly respected team of health care professionals known for their unwavering focus on delivering outstanding patient and family-centered care for our active duty forces, their families, and our retired community. The clinical expertise and leadership of Navy nurses ensures a fit and ready fighting force vital to the success of Navy and Marine Corps operational missions at sea and on the ground…. Navy nurses are ready to deploy anytime, anywhere, and they continue to set the standard for excellence as clinicians, patient advocates, mentors and leaders providing compassionate and holistic care even in the most austere conditions.”

Advancing the science of nursing practice through research and evidence-based care to improve the health of our patients is a vital strategic focus. Fundamental to the growth and development of nurse researchers is the availability of experienced mentors to guide and teach research novices throughout the process. Collaboration is absolutely essential in today’s environment of continued rising health care costs and limited financial resources. Joint and integrated work environments are now the “new order” of business. We are working on promoting, building, and strengthening strategic partnerships with our military, federal (especially the VA), and civilian counterparts to improve the health care of our beneficiaries.

Navy nurses serve in unique roles and environments supporting operational, humanitarian, and disaster relief missions. Our commitment to operational forces remains a top priority. A unique challenge at the Kandahar Role 3 Multinational Medical Unit is that about 25% of the complex trauma cases are infants and...
children. This necessitates a unique clinical knowledge base in which Navy nurse have shown exceptional adaptability and flexibility. In addition to providing cutting edge care to the wounded, Navy nurses are uniquely trained and qualified in illness prevention and health promotion. Navy nurses provide outstanding care and education that ensures long-term improvements in the health and quality of life by enhancing the partner nation’s capacity to provide care after we depart. Navy nurses trained coalition medics and lay health providers embedded with the military medical assets involved in joint training exercises for international nation building in the Philippines, Thailand, Korea, and Cambodia. On March 11, 2011 mainland Japan experienced a 9.1 magnitude earthquake. In its aftermath, a catastrophic tsunami and subsequent Fukushima nuclear meltdown devastated the Pacific coastline of Japan’s northern islands. We were again at the ready providing reassurance, advocacy, education, and compassionate care for local nationals, active duty and retirees and their family members during Operation TOMODACHI. When low levels of radiation were detected, a Navy Family Nurse Practitioner led one of the five potassium iodide distribution sites with fellow nurses providing educational counseling for the remaining 200 expectant mothers and over 2,800 parents with children under the age of five. For the first time, a Family Nurse Practitioner is filling the role as the First Marine Expeditionary Force Headquarters Group Surgeon in Camp Leatherneck, Afghanistan. Navy nurses personify the Navy’s slogan, “Whatever it takes. Wherever it takes us.”

Nationwide, psychology’s practitioners will increasingly be collaborating with Doctors of Nursing Practice (DNPs), who will typically possess three to four years of advanced practice education beyond the baccalaureate degree.

The Timeliness of a Mental Health Focus

On August 31, 2012 President Obama signed an Executive Order – Improving Access to Mental Health Services for Veterans, Service Members, and Military Families. Highlights: Long deployments and intense combat conditions require optimal support for the emotional and mental health needs of our service members and their families. The need for mental health services will only increase in the coming years as the Nation deals with the effects of more than a decade of conflict. Our public health approach must encompass the practices of disease prevention and the promotion of good health for all military populations throughout their lifespans. The Departments of Veterans Affairs and Defense shall jointly develop and implement a national suicide prevention campaign focused on connecting veterans and service members to mental health services. This 12 month campaign, which shall begin on September 1, 2012, will focus on the positive benefits of seeking care and encourage veterans and service members to proactively reach out to support services.
The lack of full understanding of the underlying mechanisms of Post-Traumatic Stress Disorder (PTSD), other mental health conditions, and Traumatic Brain Injury (TBI) has hampered progress in prevention, diagnosis, and treatment. In order to improve the coordination of agency research into these conditions and reduce the number of affected men and women through better prevention, diagnosis, and treatment the Departments of Defense, Veterans Affairs, Health and Human Services, and Education, in coordination with the Office of Science and Technology Policy, shall establish a National Research Action Plan within eight months of this order. There shall also be established an Interagency Task Force on Military and Veterans Mental Health to be co-chaired by the Secretaries of Defense, Veterans Affairs, and Health and Human Services, or their designated representatives. The mission of the task force shall be to review relevant statutes, policies, and agency training and guidance to identify reforms and take actions that facilitate implementation of the strategies outlined in this executive order.

Making a Difference

One of the most inspirational symposiums at this year’s Orlando convention was chaired by Kevin McGuinness of the U.S. Public Health Service Regular Corps, a Prescribing Psychologist and President of our Division. Christina Vento truly envisions the magnitude of change ahead – “Thoughts on Being/Becoming a psychologist who prescribes. I am sometimes asked by mental health colleagues why I went through the years of training and extra stress and liability to become a prescribing psychologist. I could have continued in the conventional clinical psychology path that I originally trained for. As with most big questions there are many answers: reducing health disparities in my rural and impoverished State of New Mexico; the intellectual challenge of new learning. But the one that has been on my mind lately is the importance of the therapeutic relationship with clients, especially those with more severe mental health challenges.

“By bringing a person-centered focus and placing a high value on listening to the clients’ stories and concerns, I was able to forge treatment relationships unlike any they had had with a mental health prescriber.”

“I have been a psychologist for more than a decade and terminated with numerous clients in the course of my practice. I was profoundly touched by the reactions of my clients with more severe mental illness – mostly combinations of Bipolar/Schizoaffective, PTSD and various addictions – when I left the Albuquerque community mental health center where I was the primary prescriber this August. By bringing a person-centered focus and placing a high value on listening to the clients’ stories and concerns, I was able to forge treatment relationships unlike any they had had with a mental health prescriber. Coming from the assembly line of Medicaid psychiatric care, they expected me to be much like their past prescribers. They expected ‘drive by prescribing’ with brief assessments and cursory follow ups at 3-6 month intervals. When
I began asking things like which symptoms they wanted to focus on first and how they thought their medications were working, they tentatively began exploring a new type of relationship with someone who seemed genuinely interested in their life experiences and struggles with symptoms.

“In my practice, I used a collaborative, shared decision making model for deciding on how to proceed with treatment. After doing my initial assessment I would present two or three options for changing the medications, summarize the pros and cons, and then asked what the client would like to do. This occurred not in the preferred prescribing psychology model (integrated 50 minute psychotherapy/med management hour) but in a 90 minute intake/20 minute follow up model, with a referral to a separate therapist. At first introduction this paradigm was greeted by clients with shock and confusion but clients rapidly embraced having more input into what happened to their bodies. Another important area was that by collaborating with primary care I was sometimes able to improve the relationship between the client and their provider, as in many cases there had been much mistrust and mutual frustration.

Collaborating with primary care improved the relationship between the client and their provider

“What happened with a client-centered approach was that ‘no show’ rates improved and many began to get better due to some combination of improved adherence, renewed hope and feeling connected to the process, and the treatment relationship we established. When I decided to leave to take a position as the training director for the New Mexico State University Psychopharmacology Program this fall, my clients were frightened, discouraged, and in some cases devastated by the idea of returning to psychiatry as usual. I experienced as outpouring of emotion, baked goods, artwork and cards from clients and their case managers. What I did was not anything any other psychologist could not do but it was something few psychiatrists, especially those working with the severely mentally ill, seem interested in trying.”

Being There Makes All the Difference

“I am sure you recall that when I was Navy Surgeon General (1995-1998), my theme was ‘Take Health Care to the Deckplates.’ Telehealth technologies were a key part of this. I recall our first attempts at mental health interventions for forces at sea. We provided them to a carrier battle group deployed to the North Atlantic and Mediterranean. During the six month deployment we did not have a single sailor medevaced for mental health issues. A first. Back then technology was expensive and connectivity limited. Today technology is cheap and connectivity is ubiquitous. The time has come. Now we must get this administrative licensure obstacle removed [i.e., licensure mobility] (Harold Koenig).”

A slightly different perspective from Hawaii’s John Myhre : “The curmudgeon in me needs to share a defining experience: You haven’t lived until a patient becomes suicidal during a tele-psychiatry visit.... I found it pretty darn hard to control against patient harm over the TV!!!”
Challenges are never easy. “The services have been struggling with this since I was Army Surgeon General (2004-2007)! I was co-chairman of the DoD Mental Health Task Force and the same themes held true then as I just read in the Time magazine article on ‘A Suicide Every Day.’ I know the Army Vice Chief of Staff worked it hard but could not turn the numbers around I am told. Maybe some of our assumptions are wrong (contract with the patient to not harm themselves or alcohol, weapons, ‘Dear John letters’ and impulse may not be explaining it). One would think if you throw enough resources in time, money and people at this issue you could control it, but I am reminded of being a Medical Battalion Commander in the 10th Mountain Division in 1985-1988 and the concept in the Army at that point was ‘if you as a BC, you know everyone of your soldiers well enough, their checkbook account, their living quarters, employment of spouse, how the kids are doing in school, etc. – then you can spot impending suicide and stop it!’ The standard was zero defects on this. NO SUICIDES! It did not work! My Division Psychiatrist once told me – ‘Sir if they commit themselves to ending their life, they will!’ Pretty pessimistic view. So, I feel for the service medical and line leadership trying to sort this out. I am assuming they are calling conferences, trending and tracking, etc! (Kevin Kiley).”

The New Zealand Ministry of Health is currently working with psychologists in New Zealand to develop plans for prescribing rights for clinical psychologists. We have been in contact with the New Zealand College of Clinical Psychologists about this exciting initiative. Caroline Grieg, Executive Director of the New Zealand College of Clinical Psychologists, writes:

“At the invitation of Health Workforce NZ (the NZ Ministry of Health workforce development agency) the Executive of the NZ College of Clinical Psychologists (NZCCP) has been working on developing a consultation document discussing the potential for prescribing rights for clinical psychologists. This document is now in the first round of consultation conducted with Health Workforce NZ, the Psychologists Regulatory Authority, the Executive of the Psychological Society and the NZCCP membership. It is envisaged that the consultative document will be finalised and distributed once again to other stakeholder groups and the general public for further comment shortly.”
New Division 55 Treasurer

**E. Alessandra Strada, Ph.D.** has agreed to serve as the Treasurer of Division 55. Dr. Strada will be filling the position for the remainder of 2012 and continue as Treasurer for 2013. Dr. Strada is adjunct associate professor at the California Institute of Integral Studies in San Francisco and adjunct faculty in the psychopharmacology at Alliant University, San Francisco. She is a primary care, pain and palliative care psychologist at the Mendocino Coast District Hospital in Fort Bragg. We welcome Dr. Strada to the Board of Division 55.

2012 Edwardo Caraveo National Service Award

**Michael Tilus, Psy.D., MP**, Commander in the U.S. Public Health Service and Director of Behavioral Health at Ft. Belknap IHS Public Health Service Hospital has been awarded the 2012 Edwardo Caraveo National Service Award. This award is bestowed upon a psychologist with prescriptive authority who demonstrates outstanding service in helping under-served populations. Your dedication to serving the under-served in frontier America and moving the prescriptive authority agenda in the U.S. Public Health Service and the Indian Health Service is exemplary of Major Caraveo's legacy. Congratulations and thank you for your service.

Division 55 — 2012 Board of Directors

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Greetings all. As this is my final column as President of the American Society for the Advancement of Pharmacotherapy (Division 55), I want to express my gratitude to our members and our Board of Directors for their support during the year. It has been a pleasure to serve as your president for 2012 and I look forward to supporting President-Elect Gil Sanders as he leads our division in 2013.

In my first presidential column some months ago, I acknowledged the frustration expressed by many of our members who seemed to be experiencing a weakening of both morale and optimism regarding the RxP movement, as the flow of information regarding states' progress towards RxP legislation appeared to be dwindling. I offered words of encouragement as I pointed to the RxP movement’s growing sophistication and to the strategic value of silence and information control in a high-stakes and politically charged legislative process. Also, in my first presidential column I laid out my plan to strengthen our Division by addressing several core organizational issues, emphasizing our need to grow our membership and to improve organizational communication. In this column I will share with you some of our progress this year with respect to that plan and our view to the future. There is cause for much optimism!

We have examined our membership recruitment methods to improve processes and procedures to improve recruitment and renewal.

Early in the year, led by Dr. Jeff Matranga, we began to study our Division's membership recruitment and renewal patterns in order to understand and improve the procedures associated with both. We discovered along the way that we needed to develop more effective methods to identify Division needs, develop plans to meet those needs, implement those plans and maintain consistency from year to year and across presidential terms of office. This process of organizational self-evaluation led to a decision to develop a Division 55 Policy and Procedures (P&P) Manual. Such an effort had been initiated in the past, but despite hav-
ing a presidential continuum including a President-Elect, President, and Past-President, none of those efforts seem to have survived the annual transition as one presidential term ended and another began. This year, however, I have begun the process with the expressed commitments of incoming President Gil Sanders and President-Elect James Bray to develop a practical P&P Manual as a living document that will reflect the flexibility of our membership and survive for many years to come.

Creating a P&P manual to help Division leaders communicate more efficiently and consistently is an important step, but we must also improve communication between the Board and the membership that we serve. To that end we have increased our efforts to alert our members in a timelier manner, of events and news relevant to our mission.

One of the most important activities for Division 55 members is voting in APA and Division 55 elections.

This month we vote for representatives to the APA Council of Representatives in the annual apportionment election. The importance of voting in this election cannot be overstated. Very early in my presidency, I learned that our Division had lost a seat on APA's Council of Representatives (Council). APA Council, for those of us unfamiliar with the term, is the legislative body of APA and has full power and authority over the affairs and funds of the association in accord with its bylaws. Council is composed of representatives of divisions, representatives of state, provincial and territorial psychological associations (SPTAs) and the members of the APA Board of Directors. This year our membership will receive several messages reminding us of, among other things, elections and of their importance to our profession as voting members of APA and/or Division 55.

Another vehicle for communication with our members is the Division 55 Tablet Newsletter. This year we have enhanced service to our members, broadened the audience for the Tablet, and the expanded the public presence of the Division by offering continuing education opportunities in association with Mensana Publications. Likewise, we have taken advantage of an invitation by PsycInfo to make Tablet content available through PsycExtra, one of APA’s electronic databases. I want to thank Dr. James Calvert, Tablet’s editor, for his support of these opportunities and for his personal effort to solicit content submissions to Tablet from a diverse base of relevant viewpoints.

In addition to our efforts to strengthen our organization, we have continued our endeavor to support the healthcare needs of underserved Americans across our nation. With respect to our military veterans, we continue to face challenges to our efforts to provide services within the Veteran's Administration (VA); this despite a critical shortage of prescribing mental health practitioners in that agency. Earlier this year our Division responded to an invitation to share with the U.S. Senate, Committee on Veterans' Affairs (Committee),
prepared testimony illustrating our commitment to our nation's veterans and our willingness to support the
VA as it faces a critical shortage of prescribing mental health professionals. That testimony and all associated
attachments may be found on the Committee's website at http://www.gpo.gov/fdsys/pkg/CHRG-
112shrg74334/pdf/CHRG-112shrg74334.pdf.

We continue to work toward expanding prescriptive authority across our nation at the state level. At
this writing, several state legislatures have very strong RxP bills before them. I encourage all Division mem-
bers to take the time to explore available public information and participate actively in our Division. Involvement in Division 55 and in your state is the best way to get the timeliest information about RxP. Division 55 is now planning to have a ‘Mid-Winter’ conference in 2013, which, in consideration of venue and weather, may actually take place in the Early Spring 2013. Division 55 conference participation is a very good way to get the most current update on state RxP progress. I'm confident that you will see that the RxP movement is strong, moving forward and gaining ground. I truly expect to see more than one state pass RxP very soon. Please look for messages about the Conference and plan to participate.

Once again, thank you for your support of professional psychology through our American Society for the Advancement of Pharmacotherapy.

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**Become a Member of the American Society for the Advancement of Pharmacotherapy (Division 55)**

Available membership categories and associated dues are:
- Full Member/Fellow: $40/year
- Professional Affiliate: $40/year
- International Affiliate: $40/year
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**Special Offer:** First-year rate of $20 for new Members and Associates

For more information on Division 55 membership, please contact Amber Frausto, at afrausto.rw@gmail.com

Please submit an application available online at [www.division55.org](http://www.division55.org) to:

American Psychological Association

Division 55

PO Box 1448

Cedar Park, TX 78630

Phone: (512) 788-0207

Fax: (800) 784-9034
The announcement from New Zealand about the NZ Health Ministry’s interest in exploring prescription privileges for psychologists is an exciting development. We will be following the developments of RxP in New Zealand closely and hope to offer support and collaboration as they move forward.

I was rereading past issues of The Tablet over the last five or six years and noticed how the number of announcements for RxP legislation and new initiatives across the U.S. have dwindled. Initiatives were being discussed excitedly and the RxP movement was highly visible. But things seem to have gone quiet on the RxP front. This news from New Zealand may help pick up excitement, but it is important to note that there is still a lot of work going on for RxP.

As I have talked with psychologists involved with RxP at the state level, what I am hearing most from those involved legislatively is that they are working quietly with committees to develop legislation. They report that while letting people know about legislative activity is exciting for those of us interested in RxP, it can be counterproductive to be too loud. Opposition forces get fired up when they hear things.

While we need legislation to make RxP a reality, it’s important that we continue to build a strong base of training in psychopharmacology. Two years ago I developed a new graduate class in psychopharmacology for the clinical psychology program at Southern Methodist University. I will be offering it again next year at the request of the students. The students have been telling us that while working at their practicum placements and on internship they are repeatedly required to know about psychotropic medications. None of our students have said they want to become prescribing psychologists (they just want to get their Ph.D.’s right now), but they all want more training about medications. Those who have been on internship report that
knowing about medications gave them a leg up and a better sense of competence when working with clients and other health disciplines. Unfortunately, psychopharmacology isn’t a required class. In fact, it is somewhat rare for doctoral programs in the U.S. to have a psychopharmacology requirement.

Although we have all argued that training towards prescription privileges should be a postdoctoral program of study, we need to focus more energy on basic training at the doctoral level. I taught at a number of Masters-level counseling programs where a class in psychopharmacology is required. Those programs do not plan on training students to become prescribers, but they recognize the need to have a well-grounded knowledge in psychotropic medications. Although doctoral programs in psychology have training in biological bases of behavior, it is important that we develop more introductory courses in psychopharmacology. There is really no excuse for Masters-level counseling programs to have a required course in psychopharmacology, while doctoral programs in psychology don’t.

As an internship site visitor for APA, I have the opportunity to talk with professionals from different disciplines (e.g., psychiatry, social work, nursing) about their views of psychology interns. Invariably they tell me how well trained psychology interns are in psychological assessment and therapy. They are always impressed about how much energy and knowledge interns bring to the treatment teams. Imagine the impact if they also remarked about how knowledgeable interns were about medications. Being seen on internship as well trained in an area of mental health makes it easier for other professionals to begin seeing psychologists as experts in all area of mental health, ranging from clinical assessment to psychotherapy to pharmacotherapy.

I once had a pediatrician who wanted to refer a client to me for medication ask, “Can’t you guys (i.e., psychologists) already prescribe?” That was 15 years ago, and I wasn’t able to prescribe then. He was surprised because he had been talking with me and other psychologists for years about how to help his clients with ADHD. It’s a lot easier to try to get prescribing privileges when you go from “Can’t you guys already prescribe?” than from “What do you know about medication?”

Even if students don’t want to continue postdoctoral training, knowledge of psychotropic medications is simply a requirement these days. And well-trained students help build the groundwork for people to ask incredulously, “Why can’t those guys prescribe already?”

Have you written an article about psychopharmacology or would you like to write one? We are looking for articles and legislative updates. Contact Jim Calvert, Ph.D., Tablet editor, at jcalvert@calvertpartners.com to discuss your ideas or to submit an article.
The Society for General Psychology

American Psychological Association

Call for Nominations for Awards for Year 2013
Deadline: February 15, 2013

The Society for General Psychology, Division One of the American Psychological Association is conducting its Year 2013 awards competition, including the William James Book Award for a recent book that serves to integrate material across psychological subfields or to provide coherence to the diverse subfield of psychology, the Ernest R. Hilgard Award for a Lifetime Career Contribution to General Psychology, the George A. Miller Award for an Outstanding Recent Article on General Psychology, and the Arthur W. Staats Lecture for Unifying Psychology, which is an American Psychological Foundation Award managed by the Society for General Psychology.

In addition, there are two student awards: The Anne Anastasi Student Poster Award for the best poster presented in the Division One poster session, and The Anne Anastasi General Psychology Graduate Student Award, based on the student’s past performance and proposed research.

All nominations and supporting materials for each award must be received on or before February 15, 2013.

There are no restrictions on nominees, and self-nominations as well as nominations by others are encouraged for these awards.

The Society for General Psychology encourages the integration of knowledge across the subfields of psychology and the incorporation of contributions from other disciplines. The Society is looking for creative synthesis, the building of novel conceptual approaches, and a reach for new, integrated wholes. A match between the goals of the Society and the nominated work or person will be an important evaluation criterion. Consequently, for all of these awards, the focus is on the quality of the contribution and the linkages made between diverse fields of psychological theory and research.

Winners of the William James Book Award, the Ernest R. Hilgard Award, and the George A. Miller Award will be announced at the annual convention of the American Psychological Association the year of submission. They will be expected to give an invited presentation at the subsequent APA convention and also to provide a copy of the award presentation for inclusion in the newsletter of the Society (The General Psychologist). They will receive a certificate and a cash prize of $1000 to help defray travel expenses for that convention.

I. For the William James Book Award, nominations materials should include: a) three copies of the book (dated post-2007 and available in print; b) the vitae of the author(s); and c) a one-page statement that explains the strengths of the submission as an integrative work and how it meets criteria established by the Society. Specific criteria can be found on the Society’s website (http://www.apadivisions.org/division-1/awards/james/index.aspx). Textbooks, analytic reviews, biographies, and examples of applications are generally discouraged. Nomination letters and supporting materials should be sent to Janet Sigal, PhD, 888-8th Avenue, New York, NY 10019. (janet222@anl.com)

II. For the Ernest R. Hilgard Award, nominations packets should include the candidate’s vitae along with a detailed statement indicating why the nominee is a worthy candidate for the award and supporting letters from others who endorse the nomination. Nomination letters and supporting materials should be
sent electronically to Dean Keith Simonton, PhD, (dksimonton@ucdavis.edu). More information on the Hilgard award can be found at http://www.apadivisions.org/division-1/awards/hilgard/index.aspx.

III. For the George A. Miller award, nominations packets should include four copies of: a) the article being considered (which can be of any length but must be in print and have a post-2007 publication date); b) the curriculum vitae of the author(s); and c) a statement detailing the strength of the candidate article as an outstanding contribution to General Psychology. They should be sent electronically to Wade Pickren, PhD, (wadepickren@gmail.com). More information on the Miller award can be found at http://www.apadivisions.org/division-1/awards/miller/index.aspx.

IV. The 2014 Arthur W. Staats Lecture for Unifying Psychology is to be announced in 2013 and given at APA’s 2014 Annual convention. Nominations materials should include the nominee's curriculum vitae along with a detailed statement indicating why the nominee is a worthy candidate for the award including evidence that the nominee would give a good lecture. Nomination letters and supporting materials should be sent electronically to Nancy Felipe Russo, PhD (NANCY_RUSSO@asu.edu). More information on the Staats award can be found at http://www.apadivisions.org/division-1/awards/staats/index.aspx.

V. Nomination for The Anne Anastasi Student Poster Award nominations should be submitted for the Division One Posters upon call for the APA Convention Programs. More information on the Anastasi poster award can be found at http://www.apadivisions.org/division-1/awards/poster/index.aspx.

VI. The Anne Anastasi Graduate Student Research Award Nomination must be submitted electronically to the 2013 chair of the committee, Harold Takashishin, PhD (takashishin@ael.com) or Vincent Havern, PhD (havern@lemoyne.edu). Please send the following materials:

I. The Following Cover Sheet
Candidates for the Anne Anastasi General Psychology Graduate Student Award should submit the following:

1. There are 2 levels of the Anastasi Award: Students with 2 years or less of graduate study and those with more than 2 years of graduate study. Circle the one that best applies to you:
   a. Two years or less of study beyond the baccalaureate.
   b. More than two years beyond the baccalaureate.

2. I completed my masters' degree in year: ______ Did not complete a masters' degree ______

3. Include:
   a. Name + email:
   b. Institution:
   c. A mentor - email:
   d. Focus of research, title:

II. Send the next three as attachments:
1. Research statement on your past/present/future work (2-3 pages, with limited number of important citations)
2. Your Curriculum Vitae
3. Supporting letter from one mentor, either attached or sent separately

More information on the Anastasi research award can be found at http://www.apadivisions.org/division-1/awards/research/index.aspx.
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