In This Issue

Clinicians’ Corner
Antidepressant Augmentation: Evidence-Based and Clinically Driven Polypharmacy
Robert Perna

Renewal of APA Designation for Programs in Psychopharmacology

APA Recommended Postdoctoral Education and Training Program in Psychopharmacology for Prescriptive Authority

Perspectives
Onwards to the Future
Patrick DeLeon

From the Editor
Editing The Tablet
James D. Calvert
Major Depressive Disorder (MDD) is one of the most prevalent psychiatric conditions in the USA\(^1\) and has a lifetime prevalence of approximately 16\%. It is believed to afflict an estimated 350 million people worldwide. These figures do not account for cases in which no care is sought or those that go undiagnosed and subsequently untreated. MDD is characterized by significant impairments in one’s level of functioning and often leads to a disability in the ability to work or care for other health conditions. Depression is a leading cause of disability worldwide with wide-ranging social and economic costs\(^1,2,3\). Depression can involve a diverse array of symptoms involving multiple bodily systems. Pharmacotherapy as a sole treatment for depression yields response rates of 53\% versus 36\% for placebo\(^4\). These numbers suggest that many individuals with MDD do not experience full relief and many continue to suffer residual symptoms. Approximately one-third of people with MDD that are treated with medication fail to report a complete remission to antidepressant. While 60 to 70\% of people get clear benefit from the first agent tried, a full 15\% of MDD patients continue to have significant symptoms following the first medication trial\(^3\). Various studies including the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) study have found that the likelihood of achieving remission significantly decreases if an individual’s depression did not remit after two treatment strategies. Various treatment strategies, including augmentation with additional agents, have evolved to help effectively treat individuals who fail to respond to a single 1\(^{st}\) or 2\(^{nd}\) line medication.\(^3\)

A major problem posed to clinicians on a patient-to-patient level is that it can be very difficult to monitor, let alone attribute, incremental changes in benefits due to different medications. Therefore, it is prudent for prescribing clinicians to objectively monitor depression severity beginning at baseline by completing a...
brief depression measure (BDI-II, Hamilton Rating Scale for Depression, CES-D) and also serially throughout the course of treatment. In fact, it is not uncommon for patients to report symptoms on these questionnaires they might not otherwise report when asked by a clinician. Brent et al. found that when switching to another SSRI or Venlafaxine or adding Cognitive Behavior therapy all options significantly helped patient self-rated depression symptoms, though the venlafaxine group suffered more side effects. People who have been tried on two or more anti-depressants are often referred to as having treatment resistant depression. Individuals with this type of depression often require multiple psychotropic medications to experience significant relief. Some literature suggests that primary care clinicians may be more inclined to discontinue one medication and start another in its place, while mental health clinicians more inclined to add augmenting agents. Switching may be the preferred method for patients with MDD who experience intolerable side effects from a particular class of antidepressant medication or who show insignificant symptom improvement. In the case of the latter, it may be valuable to assess for medication compliance and that the trial of the antidepressant medication was of adequate length (6 to 8 weeks).

The biological etiology of depression remains unclear. However, medications that target serotonin, norepinephrine and dopamine have demonstrated efficacy in alleviating the symptoms of MDD. Specifically, most treatment algorithms suggest starting with an SSRI, SNRI, or NDRI then switching, not augmenting, to second-line treatments with a different mode of action. Augmentation, on the other hand, might begin with an SSRI and then add another agent such as the DNRI (Bupropion) or a mood-stabilizing agent. Most algorithms discourage SSRI augmentation with an SNRIs and vice-versa because of the risk of serotonin toxicity. Studies such as STAR*D highlight the fact that no single augmentation strategy shows across-the-board differences in the general population. Furthermore, augmentation strategies have rarely been compared with each other under similar conditions, thus the relative magnitude of their effects is unknown. This leaves most augmentation choices to be made by the prescriber based on their clinical experience. Nonetheless, antidepressant augmented can be performed in an empirical manner based on considerable research.

**Most MDD treatment algorithms suggest starting with an SSRI, SNRI, or NDRI followed by a switch to another antidepressant with a different mode of action (e.g., switch from an SSRI to an SNRI) should the first medication not be effective**

**Literature Review**

Randomized-controlled studies (RCTs) and meta-analyses lend support a stepwise, evidenced-based approach to augmentation. For example The Texas Medical Algorithm Project Manual provides a clear and explicit stepwise approach to treating MDD.
Lithium

There are decades of research supporting these strategies and probably the most evidence supports the efficacy of lithium as an augmentation agent for treatment-resistant depression. In fact, numerous RCT\(^{11}\) support lithium as the Gold Standard augmentation agent in terms of efficacy\(^{11}\) and the mechanism of action is believed secondary to a second messenger system involved in monoamine production. Some of the complexity and risk in choosing an augmentation agent is that many of these agents are not FDA approved to treat major depression, though are clearly evidence-based. Most of the lithium placebo-controlled studies use doses of 250 to 1200 mg/day for a minimum duration of two weeks and generally have an odds ratio of 3.31 suggesting lithium is about three times more effective than placebo as an augmenting agent. Some research suggests that lithium augmentation dramatically reduces the risk of suicide\(^{12}\). Lithium augmentation will require a baseline renal panel and would likely be more difficult in patient with renal disease. Bauer\(^{13}\) found that lithium showed an average responses rate of 45% compared to 18% in placebo. Unfortunately, much of the lithium augmentation research is with Tricyclic Antidepressants rather than SSRI’s or SNRI’s, and there are no specific guidelines on ideal patient characteristics for this strategy.

Antipsychotics as Antidepressant Augmenting Agents

Both first and second-generation antipsychotics (SGA) have been utilized as augmenting agents, but the second-generation agents have a mechanism of action that is highly serotonergic particularly involving 5-HT2A and show promise as augmentation agents. Though the SGAs carry a much lower risk of extrapyramidal symptoms, they do carry a great risk for components of metabolic syndrome. The prescriber will obviously have to order lipid panel and other labs and implement BMI measurement and waist circumference. Thus SGA augmentation may not be the best approach with patients who have metabolic syndrome or are high risk for it. ADA-APA consensus guidelines suggest baseline BMI, waist circumference, fasting glucose, and fasting lipids, at 12 weeks and essentially the same monitoring again at one year.

Several of the SGA have been researched as augmentation agents. Olanzapine augmented fluoxetine has been shown to be superior to fluoxetine in the treatment of treatment-resistant depression\(^{14}\). Risperidone has been shown in several studies to be an effective augmentation agent with several SSRI’s\(^{14}\). Hirose\(^{15}\) added risperidone (0.5 or 1 mg/day) to fluvoxamine and found a remission rate of 76 in the augmented group compared to 30% for the monotherapy group at six weeks. Rapaport and colleagues\(^{16}\) examined 386 individuals with Major Depressive Disorder who failed to experience sufficient symptom improvement following...
treatment with citalopram. These patients then received adjunctive treatment (open-label) with risperidone for 4–6 weeks. Of these patients, 241 (63%) experienced significant symptom improvement.

Berman and colleagues\textsuperscript{17} used aripiprazole augmentation for individuals who were treatment-resistant with to up to 1–3 retrospective antidepressant trials. To confirm treatment resistance, those patients underwent an 8-week, open-label trial with an SSRI (fluoxetine, sertraline, paroxetine or escitalopram) or an SNRI (venlafaxine). Individuals who experienced insufficient symptom improvement had either aripiprazole or placebo added to their SSRI or SNRI regimen, under double-blind conditions for 6 weeks. The aripiprazole group achieved a significantly superior remission rate (26%) compared to the placebo group (15.7%).

**Stimulants as Antidepressant Augmentation Agents**

Fatigue associated with depressant can very debilitating as can the difficulty in attention or focus that some people with depression experience. There is some evidence supporting the potential benefits of adding stimulants to antidepressants, in the context of fatigue. Much of the research suggests alleviation of fatigue and perhaps attention, but little or no benefit for other depression symptoms. Patkar and colleagues\textsuperscript{18} examined methylphenidate augmentation in 60 patients with Major Depressive Disorder who had been resistant to at least one trial with various antidepressants, primarily SSRIs. These individuals were randomly assigned to extended-release methylphenidate, 18–54 mg/day, or to placebo for a duration of 4 weeks. The response rates were 40% with methylphenidate and 23% with placebo.

Stimulants may be most effective with symptoms of fatigue

Not only has methylphenidate shown evidence of efficacy for depression based fatigue, but other activating agents such as modafinil have also shown some efficacy. A double blind placebo controlled study comparing people who were partial responders to an antidepressant, found that those receiving modafinil (100-400 mg daily) showed significantly improved fatigue and daytime wakefulness.\textsuperscript{19, 20} A double-blind study by Fava and colleagues\textsuperscript{21} with MDD patients who experienced a partial response to 8 weeks of SSRI monotherapy and had residual fatigue or sleepiness benefited from modafinil. The patients were randomized to modafinil or placebo for 8 weeks. Approximately 150 patients participated in each group and the patients receiving modafinil showed significantly greater improvement on the Clinical Global Impression (CGI) scale. Thase and colleagues\textsuperscript{5} performed a 12-week, open-label, dose-titration extension study of the study by Fava and colleagues\textsuperscript{21} Individuals who had received placebo in the randomized phase had the option to switch to modafinil. The response was sustained in patients, and some patients who had failed to respond to modafinil during the initial 8-week trial responded during the 12-week treatment with modafinil. It has thus far been used to treat specific residual symptoms. The usual dose has been 200–300 mg/day. A randomized trial by Fava and colleagues\textsuperscript{21} is one of the largest augmentation studies conducted and showed

**In addition to stimulants such as methylphenidate, modafinil has shown some efficacy as an augmenting agent**
modafinil to be quite effective for depression related fatigue. However, it is unclear whether modafinil is effective for antidepressant nonresponders who do not have sleepiness and for those who exhibit insomnia as a feature of their depression.

**Summary**

Many individuals only receive a partial therapeutic response from their first antidepressant trial. There are many agents that may effectively augment antidepressants. This process can be logical, sequential, and based on evidence. Much of the research on augmentation supports the utility of: adding an antidepressant of different mechanism, second generation antipsychotics, lithium, and stimulants for depression related fatigue.

**References**


Do you have a clinical review or grand-round case presentation? If so, we would like to consider it for publication in THE TABLET. Please contact Jim Calvert, Tablet editor, at jcalvert@calvertpartners.com to discuss your ideas.
The American Psychological Association (APA) recently renewed the designation of Alliant University and Fairleigh Dickinson University as meeting the APA guidelines for Postdoctoral Education and Training Programs in Psychopharmacology for Prescriptive Authority.

Dr. Steve Tulkin, Director of the Postdoctoral Master of Science Program in Clinical Psychopharmacology at Alliant University, reported: “The Postdoctoral Master of Science Program in Clinical Psychopharmacology at the California School of Professional Psychology at Alliant International University has received renewal of its designation by the APA RxP Designation Committee as meeting APA guidelines for Postdoctoral Education and Training Programs in Psychopharmacology for Prescriptive Authority. The Program has graduated over 440 psychologists from 40 states, and has 50 psychologists currently enrolled. A new cohort will begin the Program in January 2014, using a live interactive Distance Learning system that eliminates the requirement for face-to-face attendance. For further information, email psychopharm@alliant.edu”

Dr. Robert McGrath, Director of the Postdoctoral Master of Science Program in Clinical Psychopharmacology at Fairleigh Dickinson University, reported: “The Fairleigh Dickinson University M.S. Program in Clinical Psychopharmacology has been re-designated for five years by the APA Designation Committee for Postdoctoral Education and Training Programs in Psychopharmacology for Prescriptive Authority. This designation indicates the program is consistent with the APA’s (2009) Recommended Postdoctoral Education and Training Program in Psychopharmacology for Prescriptive Authority. Five years is the maximum permissible period for re-designation. For more information on the program visit http://rxpsychology.com”

In the following section we have included the entire 2009 APA Recommended Postdoctoral Education and Training Program in Psychopharmacology for Prescriptive Authority document so you can see the requirements that these programs must meet in order to receive designation and renewal as training programs in psychopharmacology.
INTRODUCTION

Education and training in psychopharmacology for prescriptive authority has evolved rapidly over the past two decades. As of the writing of this document, there were approximately 10 programs in a range of educational contexts offering this training on a postdoctoral basis. As more states pass laws authorizing properly trained psychologists to prescribe it will continue to be necessary to define what is meant by “properly trained psychologists.” Psychology’s ethical responsibility to the public requires that the profession be able to define the training needs and minimum competencies required for prescriptive authority. This document reflects the most current thinking in the field as to the nature of such education and training. It incorporates knowledge and experience derived since the 1996 version of this document, Recommended Postdoctoral Training in Psychopharmacology for Prescription Privileges, became APA policy.

In accordance with Association Rule 30-8.3 requiring that all APA standards and guidelines be reviewed at least every 10 years, and in light of the advances that have been made in prescriptive authority education and training and legislation enacted since the document APA Recommended Postdoctoral Training in Psychopharmacology for Prescription Privileges (1996 Recommended Training) was approved in 1996, the Council of Representatives authorized a joint BEA-CAPP Task Force in February 2006 to review the current program requirements and recommend any necessary updates and revisions.

When the original model program standards were developed over a decade ago, few programs existed and no state legislation, enabling psychologists to prescribe, had been enacted. Since then, a number of new programs have developed operating under varying education and training models, and enabling legislation has been passed in two states and one U.S. territory (with legislation pending or planned in several others). These developments clearly called for revisions of the existing policy.
Contextual Framework

The program described in this document is a postdoctoral experience, which is intended to be an extension of doctoral education and training in psychological practice. Accordingly, the scientific basis of pharmacology and its application to clinical practices of prescribing must be viewed in the context of the total complex of factors influencing human psychology. Education and training should reflect the integration of research literature and practice experience on the relationship between psychopharmacological and psychological interventions.

Psychopharmacology education and training for psychologists, while building on training traditions in medicine, pharmacy, and nursing, should be conducted in a manner consistent with the education and training of psychologists. These standards are also designed specifically to meet the needs of practicing psychologists and their patients and are intended, in part, as a service to the public by describing the minimum requirements for this training.

Application for Psychologists Matriculating through the 1996 Recommended Training

A number of programs have emerged that included many, if not most, of the key elements of the 1996 Recommended Training, and many psychologists have completed significant portions of the 1996 Recommended Training through those programs. The revisions found in the present document reflect subsequent advances in learning models and methods of pedagogy, as well as feedback from psychologists who have completed a postdoctoral program in psychopharmacology. Inasmuch as the current document builds on the earlier model, those psychologists who completed programs based on that earlier model can be recognized as meeting the curriculum requirements relevant at the time of their matriculation. To address the needs of those psychologists who completed postdoctoral programs that did not meet all requirements of the 1996 Recommended Training, programs are encouraged to develop policies that would permit, on an individual case basis, the demonstration of competence to meet current program requirements.

Essential Elements

Postdoctoral Education and Training

These standards are intended to describe a postdoctoral experience. This program involves advanced training in a specific content area of psychology representing a significant expansion of scope of practice. The prerequisites for admission to a program continue to be (1) a doctoral degree in psychology; (2) current licensure as a psychologist, and (3) practice as a health services provider as defined by state law, where appli-
cable, or as defined by APA. The 1996 Recommended Postdoctoral Training Program includes didactic coursework prerequisites that are included now in these standards in the basic sciences and neurosciences domains of instruction. Training programs in psychopharmacology for prescriptive authority can award transfer credit for no more than twenty percent (20%) of the total curriculum hours. This twenty percent shall be limited to the basic science and neuroscience domains of the curriculum.

These standards include three components that reflect an evolution in instruction and assessment from the 1996 Recommended Training. These include integration of didactic instruction and supervised experience, the incorporation of competence based assessment, and incorporation of a capstone competency.

**Integrated Didactic Instruction and Supervised Clinical Experience**

Relevant supervised clinical experiences are now integrated into the sequence of courses. These standards allow psychologists to assimilate new knowledge as it is learned through its application.

The revised curriculum integrates supervised clinical experiences with coursework so that as each content area is addressed in the curriculum, supervised clinical experiences relating to the course content are provided to the participant. Supervised clinical experience remains an important aspect of training. By building such experiences into the sequence of didactic coursework, participants will be able to apply the concepts acquired through coursework at the time that is optimal for cementing learning.

The term “supervised clinical experience” is substituted for the term “practicum” used in the 1996 Recommended Training.

**Addition of Elements of a Competency Model**

The curriculum promotes the integration of knowledge, skills and attitudes fundamental to professional practice with psychopharmacologic interventions. In this context, movement to competency-based models to measure education and training outcomes is occurring across the health professions. These models include both formative (ongoing) and summative (end point) assessment approaches. Various entities within psychology (e.g., the APA Benchmark Competencies Initiative, the APA Policy on Education and Training Leading to Licensure, and the Practicum Working Group on Competencies) are focusing on the identification and assessment of competencies in education and training that have resulted in important changes in how educational outcomes are defined and evaluated. The APA Task Force on the Assessment of Competence in Professional Psychology articulated 15 principles that are a useful resource in this process. By focusing on necessary competencies, these standards are intended to allow maximum flexibility in program design within the parameters of ensuring an optimal educational experience.
Capstone Competency Evaluation

To be consistent with a model that emphasizes the mastery of essential competencies, training programs developed under these standards provide a capstone competency evaluation that requires integration of the knowledge, skills, and attitudes the psychologist is expected to master during their matriculation in the program. Two recommended components of this could be a review of a portfolio of cumulative supervised clinical experiences and the application of the knowledge, skills, and attitudes to unrehearsed clinical situations ranging from routine, uncomplicated cases to those of a more complex nature involving multiple medical comorbidities. This evaluation is distinct from any evaluation that focuses exclusively on mastery of information, such as the Psychopharmacology Examination for Psychologists. The capstone competency evaluation is summative and follows demonstration of mastery of multiple, foundational competencies throughout the training program.

Education and Training in Issues of Diversity

Programs developed under these standards will continue their commitment to providing training courses and experiences that encourage sensitivity to the interactions between pharmacological interventions with development across the lifespan, gender, health status, and ethnicity of patients. This focus is reflected in both the didactic and experiential components of the program so that psychologists will develop the appropriate skill-based competencies to address diversity in the population being served.

Designation Process Requirement

Both the 1996 Recommended Training and these standards are exclusively relevant to the evaluation of programs, not individuals; they are not intended to be used for the evaluation of individuals’ qualifications to engage in any activities related to psychopharmacology. The policies do, however, have important implications for determining whether or not individual psychologists have completed an acceptable course of education and training. The shift to an emphasis on skills-based competencies and away from requirements presumed to be suggestive of the mastery of skills (such as the institutional location of the training, the number of hours allotted to each topic, or the type of credential awarded upon the completion of training) implies that it is the development of critical competencies that should decide whether or not the training is adequate. Experiences to date do not provide a convincing rationale for choosing any given training model over others. Furthermore, it seems prudent to encourage the development of viable alternative routes to training competent practitioners at this still early stage in the development of this area of practice.

The shift to include more of a competency-based model, the breadth of formats in which programs may op-
erate, the integration of didactic coursework and supervised clinical experience, and other significant changes in demonstration of competency and methods of assessment of competencies require a mechanism to ensure that programs are providing the recommended education and training outlined in these standards. Therefore, APA will establish a formal designation body that represents psychopharmacology education and training programs, educators, relevant basic scientists, relevant public interests and practitioners to establish processes and procedures to evaluate consistency with these standards that will provide a system for assuring that programs are providing education and training presumed necessary for responsible psychopharmacological practices. Although detailed recommendations for establishing an appropriate designation process were beyond the scope of the task force that developed these standards, such a system is important and the establishment of a designation body is critical to establishing and maintaining minimal standards of program quality.

Maintenance of Competencies through Lifelong Learning

Postdoctoral training programs in psychopharmacology for prescriptive authority are rigorous and comprehensive in didactic content, clinical experiences, and the integration of psychological and pharmacological principles. Programs developed under these standards place a special emphasis on preparing psychologists to evaluate future advances in psychopharmacological knowledge and on the critical importance of lifelong learning in psychopharmacological practice.

Summary

These policies and procedures represent changes inherent in a shift toward a competency-based model of learning and assessment in preparation for prescriptive authority, and are intended to set the context for the understanding of the curriculum as further described in this document. Given the rapid evolution of the field, these standards should be reviewed in five years. This review should include a review of the quality assurance systems.

PREREQUISITES FOR ADMISSION TO EDUCATION AND TRAINING PROGRAMS IN PSYCHOPHARMACOLOGY

To participate in postdoctoral education and training in psychopharmacology, programs must require that psychologists meet the following prerequisites:
1. be a graduate of a doctoral program in psychology;
2. hold a current state license as a psychologist; and
3. practice as a "health services provider" psychologist as defined by state law, where applicable, or as defined by APA.
PROGRAM CHARACTERISTICS

The entire program of education and training should be an organized and sequenced program of instruction at the postdoctoral level.

The program is responsible for determining and disseminating admissions standards. The program could develop policies for allowing credit from a previous graduate or postdoctoral education and training program(s). To ensure that the training experience is up-to-date, sequential, and cumulative, transfer of a limited number of credits as appropriate for previous coursework is not to exceed twenty percent (20%) of the postdoctoral curriculum and is to be limited to the basic science and neuroscience domains (Domains I & II). This does not preclude the development of program policies that would permit, on an individual case basis, the meeting of program requirements through a current demonstration of competence obtained through prior postdoctoral education and training. In such unusual cases, program policies should explicitly state the criteria for such decisions, and there should be an accompanying record of the specific competencies demonstrated by the psychologist and those yet to be acquired through the program.

The program is accountable for establishing and demonstrating evidence of appropriate quality assurance mechanisms. As such, the program will demonstrate the following characteristics:

*Ethical Standards*

The program administrators and faculty will abide by the current Ethical Principles of Psychologists and Code of Conduct of the American Psychological Association.

*Mission*

The program has a clear and comprehensive mission statement that guides it, is approved by the governing body, and is publicly communicated.

*Governance & Administration*

The program has sufficient financial resources and access to appropriate physical resources to support its mission.

The program has qualified and competent administrators, including a director, with appropriate administrative authority.
The legal authority and operating control of the program are clearly described.

**Program Characteristics**

The program is an integrated and organized program of study.

The program has an identifiable body of students.

The program is clearly identified and labeled as a postdoctoral education and training program in psychopharmacology for prescriptive authority.

The program ensures the quality of education and training, including any consortial relationships or contractual agreements.

The program protects the security, confidentiality, integrity, and availability of student records.

The program has due process and grievance procedures.

The program regularly engages in a process of self-evaluation.

The program ensures that students maintain licensure throughout the program.

**Faculty**

Faculty and supervisors are qualified and sufficient in number to accomplish the program’s education and training goals.

In addition to psychology, the program faculty and supervisors may come from a variety of appropriate disciplines. Faculty will participate in the program’s planning, implementation and evaluation.

**Learning Resources**

The program provides access to facilities, services, and learning/information resources that are appropriate to support its didactic and experiential teaching, research, and service mission. This may include access to facilities, library materials, and an appropriate array of learning resources.

Further, the program will offer an integrated and sequential program of instruction as evidenced through the
following:

1. An organized sequence of courses with relevant syllabi;
2. Frequent evaluation of students’ knowledge and application of that knowledge and feedback to students of outcomes;
3. Periodic program evaluation;
4. Certification of program completion upon demonstration of appropriate level of competence

DIDACTIC INSTRUCTION AND SUPERVISED CLINICAL EXPERIENCE

A competency-based approach entails educational objectives or defined competencies at each level of learning. Competences facilitate demonstration of the ability to perform defined tasks along a continuum with a wide range of possible outcomes. Competencies are conceived as holistic and represent:
· **knowledge** of subject matter concepts and procedures
· **performance** of behaviors that demonstrate specific skills and abilities
· **problem solving** strategies and capabilities that involve elements of critical thinking and ethical responsibility
· **self reflection** that focuses on knowing the limits of one’s knowledge; clarification of attitudes, beliefs, and values; and identification of self-perceptions and motivations in the context of prescriptive authority.

Assessment of the delineated competencies for prescriptive authority includes approaches that integrate evaluation that is both formative (i.e., ongoing corrective feedback that advises for further development) and summative (i.e., determines attainment of a specific competency). Assessment is developmentally informed and conducted using multiple reliable and valid methods and varied sources of information. This approach shifts the focus from exclusively documenting what is taught to one based on demonstrating what students have learned and how they effectively apply didactic instruction in integrated practice. Throughout the curriculum, students will demonstrate threshold performance levels at identified benchmarks of competence across the delineated competencies.

The topics that should be addressed by the psychopharmacology curriculum must cover a broad range of both basic science and clinical content areas with sufficient specificity such that the learner is adequately prepared for the practical application of the knowledge and skills attained. All areas should also address cultural context, including variability due to development across the lifespan, gender, health status, and ethnicity. A foundation of knowledge should be laid so that the learner can continually develop an understanding of and ability to use emerging treatments. This foundation should include instruction in the core principles regarding the implementation and evaluation of research on psychoactive substances.
Didactic Content Areas

The approaches taken to the didactic instruction of content should make use of multiple pedagogical methods. In addition to the provision of knowledge via more traditional means such as readings, lecture and discussion, participants may make use of various means for applying, integrating and thereby broadening their knowledge via the analysis of clinical cases, problem based learning, computerized patients and simulations using layered decision models, and skills-based demonstrations throughout the curriculum.

Recognizing that this is a dynamic field and that subsequent revision may become necessary over time, 400 contact hours, at a minimum, of didactic instruction is expected in the following core content areas (I-VIII).

As programs may develop specific courses using different content integration approaches, these are not meant as specific courses and the contact hours are not broken down into each area. The program must demonstrate that all content is covered and that the students achieve clinical competency in all content areas. Italicized content represents examples of some of the clinical competencies that may be associated with the domain of instruction.

I. Basic Science
   A. Anatomy & Physiology
   B. Biochemistry

II. Neurosciences
   A. Neuroanatomy
   B. Neurophysiology
   C. Neurochemistry

III. Physical Assessment and Laboratory Exams
   A. Physical Assessment
   B. Laboratory and Radiological Assessment
   C. Medical Terminology and Documentation

Integration of A-C through supervised clinical experience or lab experience in conducting physical exam, ordering psychometric and laboratory tests, understanding results and interpretation

IV. Clinical Medicine and Pathophysiology
   A. Pathophysiology with particular emphasis on cardiac, renal, hepatic, neurologic, gastrointestinal, hematologic, dermatologic and endocrine systems.
   B. Clinical Medicine, with particular emphasis on signs, symptoms and treatment of disease states with be-
behavioral, cognitive and emotional manifestations or comorbidities
C. Differential Diagnosis
D. Clinical correlations-the illustration of the content of this domain through case study
E. Substance-Related and Co-Occurring Disorders
F. Chronic Pain Management

Integration of A-F through supervised clinical experience or lab experience in taking medical history, assessment for differential diagnosis, and review of systems

V. Clinical and Research Pharmacology and Psychopharmacology
A. Pharmacology
B. Clinical Pharmacology
C. Pharmacogenetics
D. Psychopharmacology
E. Developmental Psychopharmacology
F. Issues of diversity in pharmacological practice (e.g., sex/gender, racial/ethnic, and lifespan factors related to drug metabolism access, acceptance, and adherence)

Integration of A-F through supervised clinical experience or lab experience in Clinical Medicine and ongoing treatment monitoring and evaluation

VI. Clinical Pharmacotherapeutics
A. Combined therapies - Psychotherapy/pharmacotherapy interactions
B. Computer-based aids to practice
C. Pharmacoepidemiology

Integration of A-C through supervised clinical experience or lab experience in integrated treatment planning and consultation and implications of treatment

VII. Research
A. Methodology and Design of psychopharmacological research
B. Interpretation and Evaluation of research
C. FDA drug development and other regulatory processes

VIII. Professional, Ethical, and Legal Issues
A. Application of existing law, standards and guidelines to pharmacological practice
B. Relationships with pharmaceutical industry
   1. Conflict of interest
   2. Evaluation of pharmaceutical marketing practices
   3. Critical consumer
Supervised Clinical Experience

The supervised clinical experience should be an organized sequence of education and training that provides an integrative approach to learning as well as the opportunity to assess competencies in skills and applied knowledge. The intent of the supervised clinical experience is two-fold:

1. To provide ongoing integration of didactic and applied clinical knowledge throughout the learning sequence, including ample opportunities for practical learning and clinical application of skills.

2. To provide opportunity for programs to assess formative and summative clinical competency in skills and applied knowledge.

In addition to the didactic hours, the number of hours needed to achieve mastery of clinical competencies is expected to be substantial and will vary across individuals.

The supervised clinical experience is intended to be an intensive, closely supervised experience. The range of diagnostic categories, settings and characteristics such as development across the lifespan, gender, health status, and ethnicity reflected in the patients seen in connection with the supervised clinical experience should be appropriate to the current and anticipated practice of the trainee. It should allow the practitioner to gain exposure to acute, short-term, and maintenance medication strategies.

The trainee gains supervised clinical experience with a sufficient range and number of patients in order to demonstrate threshold performance levels for each of the competency areas. In order to achieve the complex clinical competency skills required for independent prescribing, a sufficient number of supervised patient contact hours must be completed. The supervised clinical training experiences must be approved by the training director prior to commencing that placement. The program must document the total number of supervised clinical experience hours that students experience. These must be broken out by face-to-face patient contacts versus other clinical experiences, and the clinical competencies employed.

In addition, the method and appropriate benchmarks for assuring each clinical competency must be described. These methods may include, for example, performing physical examinations and presenting cases based on actual and simulated patients. The trainee recommends/prescribes in consultation with or under a designated supervisor(s) with demonstrated skills and experience in clinical psychopharmacology and in accordance with the prevailing jurisdictional law.

The program is responsible for the approval and oversight of each supervised clinical experience.
Final approval of the supervised clinical experience must be provided by the program prior to initiation.

The supervised clinical experience may be integrated into each level of education and training, provided in a final summative practical experience or a combination of both according to the design of the program. The last item in *Domains of Instruction, Sections III-VI*, encompasses areas where clinical experience can be integrated with didactic instruction.

In either event, the trainee must demonstrate competency in his or her ability to integrate didactic learning and applied clinical skill in a capstone competency evaluation.

There is also a responsibility to maintain competency through continuing education over the lifespan of maintaining and practicing in prescriptive authority or collaborative activities with prescribing professionals.

The clinical competencies targeted by this experience include the following:

1. **PHYSICAL EXAM AND MENTAL STATUS**
   Knowledge and execution of elements and sequence of both comprehensive and focused physical examination and mental status evaluation, proper use of instruments used in physical examination (e.g., stethoscope, blood pressure measurement devices, etc.), and scope of knowledge gained from physical examination and mental status examination recognizing variation associated with developmental stage and diversity.

2. **REVIEW OF SYSTEMS**
   Knowledge and ability to systematically describe the process of integrating information learned from patient reports, signs, symptoms, and a review of each of the major body systems recognizing normal developmental variations.

3. **MEDICAL HISTORY INTERVIEW AND DOCUMENTATION**
   Ability to systematically conduct a patient or parent/caregiver clinical interview producing a patient’s medical, surgical, and psychiatric (if any) history and medication history in cultural context as well as a family medical and psychiatric history, and to communicate the findings in written and verbal form.

4. **ASSESSMENT: INDICATIONS AND INTERPRETATION**
   Ability to order and interpret appropriate tests (e.g., psychometric, laboratory and radiological) for the purpose of making a differential diagnosis and for monitoring therapeutic and adverse effects of treatment.

5. **DIFFERENTIAL DIAGNOSIS**
   Use of appropriate processes, including established diagnostic criteria (e.g., ICD-9, DSM-IV), to determine pri-
mary and alternate diagnoses

6. INTEGRATED TREATMENT PLANNING
Ability to identify and select, using all available data, the most appropriate treatment alternatives, including medication, psychosocial and combined treatments and to sequence treatment within the larger biopsychosocial context

7. CONSULTATION AND COLLABORATION
Understanding of the parameters of the role of the prescribing psychologist or medical psychologist and working with other professionals in an advisory or collaborative manner to effect treatment of a patient

8. TREATMENT MANAGEMENT
Application, monitoring and modification, as needed, of treatments and the writing of valid and complete prescriptions

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**Division 55 — 2013 Board of Directors**

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<th>Position</th>
<th>Name</th>
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As Steve Ragusea recently pointed out when agreeing to reinvigorate the Florida Psychological Association (FPA) prescriptive authority initiative (RxP), it has been quite a while since one of our state psychological associations successfully enacted RxP legislation. Over the past decade a number of states have made considerable progress with both Hawaii and Oregon getting as far as having their bill ultimately vetoed by their Governor. This year Illinois and New Jersey have made considerable progress, each having passed one of the Houses of their respective legislatures, and with both of their efforts remaining alive in their two year legislative cycles. Patience, persistence, and personal presence will always be the key to ultimate success. Collectively, how do we encourage our colleagues to keep inching forward at the state level until the next generation of psychologists believes that their profession has “always prescribed,” as it has clearly been in the best interests of its patients? Merely writing e-mails to each other simply does not work.

Prescribing colleagues in the Department of Defense (DoD) and the U.S. Public Health Service (particularly, the Indian Health Service) have clearly demonstrated that psychologists can learn this clinical skill and can apply it admirably. And, it would be quite helpful in convincing those in administrative and policy positions to expand these important initiatives if our research colleagues would take a closer look at what has been accomplished, including the extent to which behavioral approaches might have been superior to utilizing medication. For example, research in psychotherapeutic techniques has repeatedly shown Panic Attacks can be successfully treated in less than 10 sessions. If prescribing psychologists are eliminating the long term costs of anxiolytics and antidepressants by using cognitive behavioral therapy, the monetary savings and reduction in human suffering would be demonstrably substantial. Bob McGrath, head of the Fairleigh Dickinson psychopharmacology training program, estimates that there are currently 1750 psychologists...
who have completed their advanced RxP training and with 60 percent of psychotropic medications currently being ordered by primary care providers, there is a pressing societal need. Incidentally, Bob was just voted Psychologist of the Year by his New Jersey colleagues – a well-deserved honor.

**Obtaining RxP in the VA system would be a major breakthrough**

The Department of Veterans Affairs (VA) is the largest employer of psychologists and Advance Practice Nurses (APNs). Obtaining RxP authority within the VA would be a major breakthrough for psychology. The VA serves approximately 49.3 million beneficiaries, constituting 15.5 percent of the nation. It operates the largest Federal health care delivery system in the country, with 152 hospitals, 107 domiciliary residential rehabilitation treatment programs, 133 nursing homes, 300 Vet Centers, and 821 outpatient clinics. It is estimated that 6.5 million patients will be treated in the coming year. The VA has proposed utilizing its federal supremacy authority to establish a system-wide, national nurse practice standard which would allow these practitioners to function to the fullest extent of their training, pursuant to recommendations by the Institute of Medicine (IOM). Under the leadership of Cathy Rick, then-Chief Nursing Services Officer, the new VHA [Veterans Health Administration] Nursing Handbook, provides APNs with the authority for independent practice, regardless of individual state licensure limitations, unless an individual VA facility limits their scope within that facility. This visionary document has been “cleared” by the relevant legal authorities who will be reminding hesitant states about the federal government’s supremacy powers within federal facilities. Two underlying values enumerated are that the patient owns and drives their care based on the information available and that nursing interventions are based on the best available evidence and accepted standards of practice.

Specifically the handbook proposes: “Clinical nursing practice varies widely among the States. To ensure safe and appropriate health care to the nation’s Veterans, VA has standardized the elements of practice, within VA, for clinical nursing practice other than the prescribing of controlled substances, without regard to individual State Practice Acts. This ensures a consistent standard of nursing care throughout VA’s national health care system.... Under the Federal Controlled Substances Act... a health care practitioner may prescribe controlled substances only if the practitioner’s State license authorizes such prescribing. Accordingly, APRNs, including NPs, may prescribe controlled substances within VA only if they are authorized to do so by their State of licensure or registration and comply with the limitations and restrictions on that prescribing authority. Where VA establishes elements of nursing practice that are more expansive or otherwise inconsistent with State practice standards, VA’s practice standards control. VA nurses must follow the VA nursing practice standards established in VA rules, regulations, and policies.”

Not surprisingly, medicine (the President-elect of the American Society of Anesthesiologists, who herself possesses a nursing degree and was trained as a nurse anesthetist), has expressed objections, based upon the commonly used “public health hazard” argument. She said of the proposed policy: “This document
effectively eliminates the gold standard, physician-led, team-based coordinated care in anesthesiology. The VHA intends this to be the policy for all its hospitals, superseding state law, where currently more than half of states require physician supervision of nurse anesthetists.... (L)ocal chiefs of anesthesiology will no longer have the authority to set policies they deem best for the patients they serve.” The proposal policies “raise significant safety concerns in our sickest population.” “The length and depth of training are dramatically different. As physician anesthesiologists we trained for 12 to 14 years rather than 5 to 7. Nursing education and training did not prepare me for the level of care needed in the perioperative environment when seconds matter.” Despite her statement, all of the objective evidence that we have seen over the years indicates that nurse anesthetists are extraordinarily safe, including a recent review of approximately 500,000 cases. In rural America their services are crucial as they are the primary provider of anesthesia.

We were very pleased to learn that Heather Kelly, who for the past 15 years has addressed legislative and administrative issues for the Science Directorate regarding the importance of psychological research at the VA, NSF, and DoD, has now become the APA point person on their team effort on all military and veteran-related issues, including the clinical portfolio. Obtaining RxP for interested VA employees will become one of her agendas. Accordingly, the research that Steve Ragusea has proposed would indeed be most timely, as well as extraordinarily useful to Heather, in countering medicine’s ongoing emotional “public health hazard” arguments against the expansion of non-physician scopes of practice and particularly, against RxP. And, we should remember that obtaining RxP provides clinicians with the authority to modify or stop ineffective medication decisions. Fred Frese, a longtime advocate for individuals challenged by chronic mental health issues, reports on a 7-year follow-up study published in JAMA-Psychiatry finding that individuals with schizophrenia who are on reduced or no doses of antipsychotic medications do better than those on medications. Other research Fred has highlighted suggests that those on antipsychotic medications live 15 to 25 years less than would be normally expected.

Recent research suggests that people with schizophrenia who are not on antipsychotic medication may do better than those on medications

The Alliance for Health Reform: One of the most enjoyable aspects of having retired from the U.S. Senate staff after 38+ years is that I have the time (and willing friends) to host a psychology-nursing health policy seminar at the Uniformed Services University of the Health Sciences (USUHS) (DoD). Each week we invite a colleague who is, or has been, active within the public policy process to discuss their personal journey. Recently Toni Zeiss addressed the class (generally 7 to 10 students and faculty) about her experience serving as the first woman and first non-physician to be appointed as Chief Consultant for Mental Health Services at the VA Central Office. At our annual APA convention in Honolulu, President Don Bersoff presented her with a special Lifetime Achievement Award. A previous guest was twice former VA Secretary Tony Principi.
Ed Howard, another speaker, and I used to work together when he was on the staff of then-Representative Spark Matsunaga, who was elected to the U.S. Senate in 1977. Ed is currently the Executive Vice President of the bipartisan Alliance for Health Reform, which is chaired by Senators Jay Rockefeller and Roy Blunt. Ed suggested that our nation’s health policy experts might finally be appreciating the importance of mental health care to our nation’s overall health care system and our citizens’ quality of life. Interestingly, Ken Pope has shared a similar view noting that in 2009, public and private mental health spending totaled approximately $150 billion, more than double its level in inflation-adjusted terms in 1986. The Accountable Care Act (ACA) will provide the largest expansion of mental health and substance use disorder coverage in a generation, with 32.1 million Americans gaining access to these services, while another 30.4 million currently with some coverage will gain federal parity protection.

### About 26% of adults in the U.S. suffer from a mental disorder in any given year

Highlights of the information which Ed presented: *An estimated 26.2 percent of Americans ages 18 and older – about one in four adults – suffer from a diagnosable mental disorder in a given year. * In 2008, just over half (58.7 percent) of adults in the U.S. with a serious mental illness received treatment for a mental health problem. * Approximately 38,000 people committed suicide in 2010. * Over 8.9 million individuals have co-occurring mental illness and substance use disorders. Only 7.4 percent of these individuals receive treatment for both disorders, while 55.8 percent receive no treatment at all. Minorities with mental health disorders have less contact with specialists. More than half of disabled Medicaid enrollees with psychiatric conditions also had claims for diabetes, cardiovascular disease, or pulmonary disease. People with mental illnesses and addiction disorders are at much greater risk than the general public for homelessness, poverty, poor nutrition, and lack of health care.

**The All Important “Bigger Picture”:** Community Health -- David Derauf, Executive Director of the Kokuia Kalihi Valley (KKV) Community Health Center in Honolulu, Hawaii, recently shared with us the cogent observations of one of his medical colleagues: “A few months ago, I was sitting across from Dr. Robert Jesse, Principal Deputy Under Secretary for Health in the VA, in a meeting when he asked a provocative question, ‘Why is it when we talk about personalized medicine, we only talk about genetics? Why wouldn’t we talk about a patient’s social circumstances and how we can ‘personalize’ medical care for them?’ He is totally right. In this country, 50 million people are hungry, while 26 million have heart disease and 26 million have diabetes. Those numbers cannot be mutually exclusive. Many people with heart disease and diabetes must be hungry at some point each month, which has been shown to result in worse health and higher rates of health care utilization.
Yet despite this knowledge, we do not typically ‘personalize’ healthcare to ask patients a simple two-question scale validated by Children’s HealthWatch to detect food insecurity, even when we know they are at a higher risk based on their zip code and where they receive their health care. Think for a second about the inefficiency of a doctor asking a woman to come back to the hospital each month to check her blood pressure when that woman regularly skips meals, worries about paying bills and potentially cuts her pills in half since she can’t afford them? Before we progress to expensive genetic testing to see if a patient processes drugs differently, wouldn’t it be more ‘personalized’ and more effective to screen for a common modifiable factor like hunger, and then make sure eligible patients are getting all the food subsidy programs for which they are eligible?

In many ways the VHA, the Nation’s largest integrated health care system, already ‘personalizes’ its care in important ways. It pays for Supportive Services for Veteran Families (SSVF), including help with job training and childcare, and it has begun to bring legal services onsite at VA facilities as part of medical-legal partnerships [such as with the University of Hawaii William S. Richardson School of Law] to address many civil legal needs that interfere with getting and staying healthy. I look forward to a future when ‘personalized medicine’ means less high tech care, and more ‘patient centered’ inter-professional teams addressing the full spectrum of social determinants of health.”

A “Retiree’s” Journey – “A long time ago, ten years ago, I retired from the VA. And time and technology are passing by me so quickly. I can see it in my grandchildren, now starting college, who know so much more and can access so many things so quickly – compared to what I was like when I was graduating from high school. I was typing only 40 words a minute by the time I left high school, compared to two of my grandchildren, one still in high school, who repair computers and design software and create computer systems for their prep-schools. I stand in complete awe, as I work with Student Veterans, returning home from war, now enrolling in college. How outstanding they were in combat and now how outstanding they are in college. Like, what’s happening now, as I consult with the Office of the Dean of Students at the University of Texas at Austin, in the Student Veterans Center. I see first-hand the mastery of so many skills, so that Student Veterans are achieving so much…. Reminds me of my days as a teenager, attending a residential prep-school, adjacent to the UT Austin campus, 1947-1953. I was awed by World War II combat veterans enrolling in college, worked with them as we nailed up signs for Lyndon Baines Johnson (LBJ) running for the U.S. Senate in the Democratic primaries of 1948. World War II Student Veterans were awesome then, as OIF/OEF/OND Student Veterans are so now! Plus, older veterans – Korean and Vietnam era – are retiring and returning to school! There is so much more we must do to help veterans return to school.

Sad, now, that political leadership has changed so much in Texas. LBJ filled his politics with Pro-Life for living, improving education, enhancing health, helping businesses change from war to peace…. Nowadays, though, current Texas politicians are practicing Pro-Death. Refusing federal dollars for healthcare al-
ready paid for by Texas tax-payers; refusing federal dollars for Education already paid for by Texas tax-
payers, etc., etc. It’s Pro-Death in Texas and Pro-Life in Massachusetts... and all you have to do is compare
the life expectancies in the State of Texas with that of the Commonwealth of Massachusetts. Citizens are
living much longer in Pro-Life Massachusetts than in Pro-Death Texas. Similarly, it’s not just life expectancies
being shorter in Texas, it’s also Infant Mortality is higher in Texas. And, it’s not only due to lack of healthcare
in Texas... some portion of the higher death rate may be associated with greater use and excellent aims in
using firearms and weapons here in Texas. Sad. But we can not focus on what is Wrong. We must aspire to
doing what is Right... [Walter Penk].”

A Personal Perspective – It is important for psychology remember its history as we focus on future
agendas. The Center for the History of Psychology, located at the University of Akron in Akron, Ohio, is a
unique institution that cares for, provides access to, and interprets the historical record of psychology and
related human sciences. Under the leadership of David Baker, the Center houses a museum of psychology as
well as the Archives of the History of American Psychology and provides a variety of educational programs
for the public. The Center houses and makes available the personal papers of more than 200 psycholo-
gists. The collections include personal and professional correspondence, sound recording and moving imag-
es, artifacts, photographs, unpublished papers and presentations, and other kinds of material that tell the
story of psychology. The Center, a 501(c) 3 organization, is supported primarily through gifts from visitors,
foundations, and other donors. The gifts provide support for processing collections, creating exhibits, and
providing public programming. Individuals interested in donating materials should contact Cathy Fay
[cfaye@uakron.edu].

From the Editor

Editing The Tablet

Just a very brief note for this issue. I want to thank Division 55 for the opportunity to edit
The Tablet for the past three years. I am taking over as the CE Director for the Division and
passing the editorship to our next editor. The final decision on the next editor has not been
made, but I know our division leadership would like to hear from you if you have an interest
in editing the newsletter or would like to help out in some way. You can contact our current
President, Gil Sanders, or our incoming President, James Bray, about interest you have in
working on The Tablet. Feel free to contact me if you have any questions about The Tablet.

Jim Calvert
<table>
<thead>
<tr>
<th>Committee Name</th>
<th>Chair(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABPP</td>
<td>Beth Rom-Rymer, Ph.D.</td>
</tr>
<tr>
<td>CAPP Liaison</td>
<td>Neal Morris, Ph.D.</td>
</tr>
<tr>
<td>APA Convention Program of 2011</td>
<td>Massi Wyatt, Psy.D.</td>
</tr>
<tr>
<td>Evidence-Based Research Committee</td>
<td>Beth Rom-Rymer, Ph.D.</td>
</tr>
<tr>
<td>Gerontology Psychopharmacology Committee</td>
<td>Merla Arnold, Ph.D.</td>
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<tr>
<td></td>
<td>Beth Rom-Rymer, Ph.D.</td>
</tr>
<tr>
<td>Media</td>
<td>Nina Tocci, Ph.D.</td>
</tr>
<tr>
<td>Practice Guidelines Committee and Council Rep.</td>
<td>Bob McGrath, Ph.D.</td>
</tr>
<tr>
<td>S.W.A.A.T. Committee</td>
<td>Owen Nichols, Psy.D.</td>
</tr>
<tr>
<td>Awards Committee</td>
<td></td>
</tr>
<tr>
<td>Chapter Chairs</td>
<td>Nancy Alford, Psy.D.</td>
</tr>
<tr>
<td>Early Career Psychologist</td>
<td>E. Alessandra Strada, Ph.D.</td>
</tr>
<tr>
<td>Federal Advocacy Coordinator</td>
<td>Gilbert Sanders, Ph.D.</td>
</tr>
<tr>
<td>International Psychology Committee</td>
<td>Elizabeth Carll, Ph.D.</td>
</tr>
<tr>
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<td>Brian Bigelow, Ph.D.</td>
</tr>
<tr>
<td>Membership Committee</td>
<td>Massi Wyatt, Psy.D.</td>
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<tr>
<td>RxP National Task Force</td>
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<tr>
<td>Canadian Psychology Committee</td>
<td>Brian Bigelow, Ph.D.</td>
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</tr>
<tr>
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</tr>
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<td>Fellows Committee</td>
<td>Ray Folen, Ph.D.</td>
</tr>
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<td>Michael Schwarzchild, Ph.D.</td>
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<tr>
<td>Listserv Monitor</td>
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<td>Special Populations Committee</td>
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<td>Webmaster</td>
<td>David White</td>
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**S.W.A.A.T. Committee**
Owen Nichols, Psy.D.