

Integrating Psychology with Psychopharmacology

Special Section Editor: Joseph J. Zielinski, PhD

We will encounter diagnostic conundrums in our daily practice whether we know it or not. As psychologists, we need to answer for ourselves whether we are prepared to service patients who consult us with complex medical problems or medical problems presenting as “psychological” symptoms. The aging of our population will make this an increasing occurrence. Our psychiatrist colleagues sometimes overlook medical issues and ignore laboratory diagnostics, failing to inspire confidence from our patients. Primary care physicians readily admit that they are less than confident when prescribing psychotropic medications due to the necessary broadness of their training. Whether or not psychologists prescribe, and I think we should, we need appropriate training in both physical diagnosis and psychotropics in order to help diagnose previously undiagnosed medical illnesses. We also need to respond confidently when we encounter side effects in our patients already on medication. We have been living with a shared delusion that our patients do not have or do not develop medical illnesses while they are in psychotherapy with us.

We know that the DSM-IV is more a medical classification than a diagnostic system. However, its diagnostic flow chart has great utility. Its diagnostic algorithm is an explicit, sequential consideration of the following diagnostic entities: medical illness, substance abuse, and mood disorders, before considering other diagnoses. Chance favors the prepared mind. Consider the following cases from the author’s own practice.

A 50-year old office worker was suspected of substance abuse because of falling asleep after lunch. A comprehensive interview, including questions about sleep habits, led to the suspicion of nocturnal restless leg syndrome. I referred him to a neurologist who confirmed the diagnosis and prescribed a benzodiazepine, which successfully treated his difficulties and led to a full night’s sleep. Alas, suspected substance abuse treated with a tranquilizer.

An 8-year old third grader, considered odd by his teacher, was referred for a psychological evaluation. Interviewing of both the parent and teacher elicited the teacher’s surmised that the boy was experiencing auditory hallucinations, as he frequently turned his head to the left as if orienting to some auditory stimuli. A comprehensive developmental history concluded that this boy had had several treatment resistant exposures to strep infection and probably suffered from Pediatric Autoimmune Neuropsychiatric Disorder Associated with Strep (Swedo, et al., 1998). I referred the boy to his pediatrician for a strep titre, which was high, resulting in subsequent treatment with antibiotics and a diminution of his motor tics.

A bereaved elderly widow exhausted my armamentarium of psychodynamic and cognitive-behavioral strategies over the course of a year, including referral to and completion of a bereavement group. She had lost her husband three years previously. She completed her homework assignments, but continued to experience loss of élan, describing herself as “going through the motions of life.” Her primary care physician medicated her for depression, but a benign essential tremor led to a referral to a neuropsychiatrist who made the tremor diagnosis, but insisted that our patient suffered from “existential issues.” I maintained the position that something was medically wrong. This senior lady then suffered a brief delirium of indeterminate etiology and a brief hospitalization was unable to discern the cause. We terminated several months later on excellent terms when I ethically told her that I

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had taken her as far as I could. She expressed gratitude for my efforts. She later wrote to me and reported that her primary doctor had subsequently diagnosed her with temporal arteritis, the likely cause of her delirium, which was successfully treated with steroids. She reported that she was approaching her life with an enthusiasm and zest that she had not felt in years.

A 56-year old vice-principal lost her 12-year old job due to non-completion of paperwork. She was treated by a psychotherapist under a capitation agreement and medicated for depression. Her desperate husband called me and described bizarre, out of character behavior, such as talking to strangers in restaurants, poor overall hygiene, eating nothing but junk food, resulting in 12 dental caries. I completed comprehensive neuropsychological testing which found deficits consistent with a frontal dementia, which was confirmed by an MRI.

A post-hysterectomy patient on replacement progesterone was treated with Klonopin for post-MVA pain. She had consulted a number of different specialists including me, for pain management. She came to a session reporting confusion and fatigue, stating that she was "totally out of it." A computer check of drug interactions showed that her hormone replacement therapy increased the half-life of Klonopin several fold, effectively resulting in an overdose. This was promptly reported to the prescriber.

What would have happened without these diagnostic capabilities? We can only guess, but it is probably not good. This is because we see what we look for, and we look for what we know.

Our unique testing expertise is an additional strength because psychological testing is on par with medical testing in its accuracy. In a comprehensive meta-analysis, Meyer et al. (2001) concluded that psychological and neuropsychological test data are strong and compelling, and possess validity comparable to most medical tests. Additional findings were that they provide unique information for each distinct assessment method used and add critically important information to interview data. As psychologists, we also routinely spend significantly more interview time with our patients than physicians do, and thus benefit from the time honored saying, "Listen to your patients and they will tell you their diagnosis."

Given our expertise in psychodiagnostics, psychoeducational evaluation, and neuropsychological assessment, prescribing psychologists would be in a perfect position to offer comprehensive biopsychosocial diagnostic and treatment services. Prescriptive authority also includes the authority not to prescribe, and to order appropriate laboratory tests of thyroid and liver function, renal sufficiency, and any other bodily system of import. In their scare tactic article against psychologists prescribing, Robiner et al. (2002) list potential diagnostic medical pitfalls in prescribing psychotropics. Each potential disaster is specifically addressed and comprehensively taught in psychopharmacological training, making all of their objections red herrings. Also, as in my case examples, prescribing psychologists will collaborate with physicians in a dialogical fashion and, as a result, our status will only grow with prescriptive authority.

Furthermore, psychologists bring honed research skills to the table. As an example, Keith et al. (2002) demonstrate the relevance of neuropsychological assessment in medicine, i.e., the cognitive effects of cardiac bypass surgery. Incisive commentaries on and critical reviews of that study by Chelune (2002), Millis (2002), Sawrie (2002), and Smith (2002) collectively showcase the best that psychology has to offer in terms of patient sample collection strategies, methodology, and measurement theory. Psychology can and will bring these research skills to evidence-based medicine in psychopharmacology, and will serve as a gatekeeper of knowledge for both the professional and public community. Psychologists will do research independent of the pharmaceutical industry on the integration of psychotherapy and psychopharmacology (Levant & Sammons, 2003), despite arguments to the contrary (Healy, 2003). Such research will also address non-specific medication treatment effects, placebo response, and combined treatment interventions with specific disorders in line with current efforts on psychotherapy efficacy and effectiveness studies.

The following Special Series elucidates the importance of training in pathophysiology and psychopharmacology for today's psychologists in clinical practice. Each featured article espouses close collaboration with physicians, obviating the fear that psychologists will prescribe in a vacu-

um without access to medical providers. George Kapalka's article focuses on the practice of pediatric psychology. A teacher and a clinician, George works interactively with pediatricians to help them diagnose and treat children in need of psychotropic medication. His experience is consistent with what most psychopharmacologically-trained psychologists say about their increased ability to help patients after such training. Bruce Banford's and Ron Striano's articles highlight the diversity among psychologists in serving patients. Bruce specializes in doing psychotherapy, and advising physicians psychopharmacologically, with ventilator dependent patients. He exemplifies a market niche that can be filled by appropriately trained psychologists working collaboratively with physicians and other allied professionals. Ron brings hospital-based and private practice experience to his commentary on irritable bowel syndrome. He describes the multifaceted assessment and detailed medical knowledge necessary to ameliorate this difficult to treat disorder. Ron is sought out by physician colleagues to recommend psychotherapeutic and psychopharmacological interventions for shared patients, while filling another needed market niche. The last article by Sean Evers describes what psychologists should look for before undertaking post-doctoral psychopharmacology training. Sean has experience in both the Prescribing Psychologists' Register program and Fairleigh Dickinson University's post-doctoral psychopharmacology master's program. He outlines what has already been happening in our ranks and what we can expect for the future.

Former APA President, Ted Blau once appealed to the "best and brightest" to move to the front in forensic psychology. In the same spirit, we appeal to our readers to raise the bar in psychological service delivery. Prescriptive authority for psychologists is not radical, but a natural evolution in the development of our profession, directly analogous to similar growth in medicine and other health professions (Sammons, Levant, & Paige, 2003). State licensing boards in six states and the District of Columbia have officially stated that it is within the scope of psychological practice to collaborate with physicians on medication issues for the welfare of our shared patients. The synergy of our diagnostic and research skills with prescriptive authority can make us the premier mental health providers. There is some evidence that combined psychotherapy and psychopharmacology with one clinician is better than split therapy, whether offered by a primary care physician and a therapist, or a psychiatrist and a therapist (Beitman et al., 2003). Why can't this be us? We owe it to ourselves and to our patients to prepare for the future of psychology. If we can meet this challenge, we will benefit from increased prestige in the eyes of medicine and the public, and in reimbursement rewards.

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Pediatrician/Psychologist Collaboration: A Model for Efficient and Effective Treatment of Children

by George M. Kapalka, PhD

The use of medications to treat psychological disorders is prevalent. While some argue that this is the result of society's efforts to find a "quick fix," most health professionals recognize that individuals, with many psychological disorders, exhibit significant structural and/or functional brain differences from normal controls. Thus, treatment of these disorders often involves the use of medications.

Because of a relative shortage of psychiatrists, long wait-times for initial appointments, and managed care's discouragement of family physicians from utilizing specialists, family doctors are pressured to prescribe psychotropic medications; consequently, more than two-thirds of all psychotropic medications are prescribed by them. However, most family doctors have little background in psychology or psychiatry and know little about psychotropics, and the disorders for which they are intended.

This dilemma of family doctors knowing little about psychotropics and psychological or psychiatric disorders is particularly commonplace in the treatment of children. Pediatric psychiatrists and neurologists are in short supply and have waiting lists that exceed those of their adult counterparts. Thus, most psychotropic medications are prescribed to children by their pediatricians. Psychostimulants, commonly used to treat the symptoms of ADHD, are the most often prescribed category of psychotropic medications used with children (Olfson, et al., 2002). Pediatricians most frequently prescribe these medications, although many do not have extensive knowledge about the pathophysiology and treatment of ADHD.

Pediatricians spend a limited amount of time with each patient and cannot perform in-depth reviews of personal, family, developmental, health, and social history necessary for proper diagnosis of most psychological disorders. Conversely, psychologists are trained in the diagnosis and treatment of mental disorders and traditionally see clients for one-hour appointments, usually weekly or bi-weekly. Thus, pediatricians can benefit from collaborative relationships with pediatric psychologists who can assist them in accurate diagnosis and make meaningful contributions to comprehensive treatment planning.

When patients are placed on medications, pediatricians need to monitor the patients' progress and side effects. Many pediatricians may not be aware of dose-response profiles and side effects involved in the use of psychotropics. In addition, pediatricians may not be able to see their patients frequently and long enough to accurately screen these issues. Consequently, opportunities exist for properly trained psychologists to assist pediatricians. Collaborative relationships between pediatric psychologists and pediatricians most likely develop when psychologists are familiar with medication response profiles, side effects, medical terminology and concepts. The collaborative model advocated herein is applicable to the assessment and treatment of many childhood disorders, e.g., ADHD.

Pediatricians use several methods to diagnose children with ADHD, including rating scales, a brief interview with a parent (typically, the mother), and a brief observation of the child. While these methods are sufficient to correctly diagnose some ADHD children, many children present with a complex pattern of symptoms. To perform a differential diagnosis requires an extensive review of family, school, social and developmental history, symptom-based questionnaires, and in-office observations. Some disorders may mimic the symptoms of ADHD. For example, children or adolescents presenting symptoms of agitation may also appear to be distractible, fidgety, and exhibit both poor control of emotional discharges and poor performance in school, all symptoms frequently seen in ADHD children. Such young patients may be misdiagnosed with ADHD whereas a mood disorder may be the accurate diagnosis.

Of all mood disorders, children with bipolar disorders are frequently initially diagnosed with ADHD (Bowring & Kovacs, 1992). The presenta-

tion of pediatric bipolar disorder often significantly resembles ADHD symptoms, with high activity level, impulsivity, distractibility, and poor judgment. Many children with bipolar disorder are initially diagnosed with ADHD and get worse when a treatment with psychostimulants is attempted (Biederman, 1998). An experienced psychologist may recognize that such children typically present with greater magnitude of mood swings, sleep disturbance, and explosiveness, and will be invaluable to a pediatrician in clarifying the diagnosis.

About 70 percent of ADHD children respond positively to the use of stimulant medications (Jadao, et al., 1999; Spencer, et al., 1996), while about 30 percent do not. Children with comorbid conditions are especially likely to have a poor response to psychostimulant medications. Studies suggest that about one-fifth of ADHD children have a comorbid depressive disorder (Biederman, et al., 1991). These disorders are easy to miss at first glance, as emotional dysregulation and agitation are often attributed to ADHD. However, such symptoms may signal a depressive disorder and require a different approach to treatment. When a child presents with a comorbid ADHD and depression, the use of psychostimulants may not be a preferred first-line treatment. Studies have shown that some antidepressants exhibit efficacy rates for ADHD similar to those of psychostimulants, while concurrently addressing the symptoms of depression. Tricyclic antidepressants have historically been known to improve ADHD symptoms (e.g., Higgins, 1999). However, the side-effect profiles of these medications (i.e., weight gain, sedation, possible cardiac problems, among others) are often difficult to tolerate. Newer antidepressants, including bupropion (Conners, et al., 1996) and a newly approved compound atomoxetine (Kratochvil, et al., 2002), have shown efficacy in the

treatment of both ADHD and depression with more favorable side effect profiles. When a pediatrician becomes aware that a child is presenting with a comorbid depressive disorder, he or she may choose to try one of these newer medications, or to refer the child to a psychiatrist.

Similarly, about one-sixth of ADHD children present with a comorbid anxiety disorder (Newcorn, et al., 2001). Childhood fears and sleep problems, common with anxiety disorders, may be attributed to ADHD symptoms, or normal childhood variation. Yet, ADHD children who present with tendencies toward fear, anxiety, and obsessive behavior, are often very difficult to properly medicate. Psychostimulants exert their psychotropic effect by increasing the activity in the dopaminergic, and to a lesser extent, noradrenergic, pathways. Increasing the availability of these neurotransmitters may exacerbate the symptoms of fear, anxiety, and obsessive behaviors. Consequently, psychostimulants are not the best choice of medications to use with an anxious or obsessive ADHD child. Instead, modafinil, an atypical stimulant, may be a good choice. Similarly, alpha-2 adrenergic agonists, such as clonidine or guanfacine, have also been shown to improve ADHD symptoms without increasing anxiety (Connor, et al, 1999). Pediatricians need to know about the comorbid anxiety symptoms in order to make the best judgment about which medication to try with a particular ADHD child.

A child with comorbid ADHD and a tic disorder also warrants discussion. For many years, conventional wisdom has been that psychostimulants may exacerbate tics. Thus, any ADHD child with a comorbid history of tic behaviors was not a candidate for stimulants. Recent research has shown that this approach may be erroneous. The comorbidity between Tourette's Disorder (TD) and ADHD is significant, with more than 50 percent of children with TD suffering comorbid ADHD (American Psychiatric Association, 2000). Both disorders are likely due to dopamine transporter gene anomalies. Several studies have shown that children with TD and ADHD do respond to stimulant medications (e.g., Gadow, et al., 1995). When stimulants are used with them, both the ADHD and TD symptoms diminish. So, a trial of stimulant medications may be warranted in ADHD children with comorbid tic problems.

Many parents are resistant to on-going mental health treatment and may not have the financial means or adequate insurance coverage to cover prolonged mental health care. Consequently, pediatricians may be reluctant to refer children to psychologists. However, parents may be

receptive to a referral for a two-session consultation when it is clear that the purpose is to clarify the diagnosis. I have had much success with an approach where the first session is spent with the parents alone to review the description of symptoms and relevant personal, family, school, health and social history. The second session includes an interview/observation of the child. Between the sessions, parents fill out behavioral rating scales, such as the Conner's Rating Scales or Barkley's Home/School Situations Questionnaires. This evaluation can be performed within two weeks of the referral and afford the physician and parents timely feedback about the diagnosis and available treatment choices. Many pediatricians who refer children for an evaluation with a pediatric neurologist currently use this referral model. Pediatric psychologists familiar with medical and psychopharmacological issues can also be a viable referral choice for these pediatricians. A two-session evaluation with a pediatric psychologist is likely to be similar in cost to a neurological evaluation and can usually be performed more expeditiously because most psychologists do not have wait times as long as pediatric neurologists.

Many pediatricians are not aware that some psychologists possess significant background in psychopharmacology. To educate physicians about psychologists' background and potential benefit to the physician and the patient/family, significant outreach efforts may be necessary. Psychologists need to make known their receptivity to the use of medications, as many perceive psychologists as being medication-unfriendly. A background in psychopharmacology, and a willingness to perform focused, time-limited services, will complement pediatrician's services. A collaborative pediatrician/pediatric psychologist treatment can be efficient, efficacious, cost-effective, and professionally rewarding.

Pediatricians can benefit from collaborative relationships with pediatric psychologists who can assist them in accurate diagnosis and make meaningful contributions to comprehensive treatment planning.

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Integrating Psychopharmacology into the Psychology Service on a Ventilator Unit

by Bruce T. Banford, PsyD

Patients with serious medical illnesses survive longer than before with the help of advances in biomedical technology. People with emphysema, chronic obstructive pulmonary disease (COPD), stroke, cerebral vascular accidents, and amyotrophic lateral sclerosis (ALS) are extending their physical lives when placed by their families on units where they receive 24-hour nursing care and mechanical ventilation. This presents a challenge to psychologists who work in these facilities in helping these patients enhance the quality of their emotional lives during their stay (Martin, 2002).

This article outlines both the major themes in the psychological care of ventilator patients, and the important clinical issues for the psychologist, who collaborates with physicians in developing a psychopharmacological treatment program.

Anxiety has the highest incidence of all psychological disorders on the ventilator unit. Imagine being conscious, with your air supply slowly cut off. It would be like drowning or smothering, and being fully aware. Increasing CO₂ levels in the blood, secondary to pulmonary disease, actually trigger anxiety and panic attacks. Some patients have a premonitory history of anxiety, others do not. A once highly-functioning, competent, productive person is reduced to infantile helplessness, while ruminating on the question, "What is to become of me?"

Many ventilator patients develop grief reactions as they become aware that their lives have forever changed. Agitation and oppositional behavior are common in some patients, while others regress to infantile dependency and claim that they are not able to do things for themselves that they are clearly able to do. Some patients go into a state of denial, assuring all of the staff that their stay is just temporary, and they will soon re-claim their former lives. Often their families collude with this idea, not wanting to confront the patient or themselves about the reality of the current situation, their mortality.

Patients on the ventilator unit must rely on visits from family and friends to satisfy their social needs. While some families rise to the occasion, others slowly forget about the patient or get too busy with their own lives.

There is a tremendous amount of loneliness on a ventilator unit. Grief turns into major depression. Active and passive suicidal ideations emerge. Some patients lose the motivation to participate in physical or occupational therapy. Others try to remove their life-sustaining equipment, e.g., ventilator tubing, and IV antibiotics. Because their life situation will not change, it is imperative to treat the depression as quickly and effectively as possible. Families who are aware of this often call the psychologist crying, "Please help my dad."

By the time we are 50 years of age, we may develop one major medical problem that requires medication. With each additional decade of life, major medical problems may increase by one per decade (Preston, 1997). In the case of COPD or emphysema, this risk is even greater. Chronic cigarette smoking frequently leads to coronary artery disease or lung cancer that may co-exist in the ventilator patient. Cardiac conduction problems, renal insufficiency and elevated liver enzymes are also common problems (Barbarash, et al., 1990).

Obesity, either pre-morbid or due to a lack of physical activity, is also common. Thyroid insufficiencies and insulin-dependent and non-insulin dependent diabetes are common endocrinological problems. Multiple medical problems, and multiple medications, pose a serious management challenge to any independent prescribing health care professional.

A patient's response to individual psychotherapy can vary greatly on the ventilator unit. Some patients are so angry that they are psychologically unavailable to engage in the process. Some are afraid of the psychologist and say, "I don't need a psychiatrist...I'm not crazy." Others would see the psychologist every day if it were possible. Generally, patients are very grateful for any attention they receive and willingly practice relaxation or cognitive therapy. These modalities are two of the main strategies that are useful on the ventilator unit. The patient's situation dictates how confrontational the psychologist should be. If the patient has extreme anxiety or panic, the psychologist should be supportive and help the patient build defenses. There

will be time, as therapy progresses, to challenge faulty cognitions such as, "My life is over." In this case, the patient is challenged to reframe his situation as, "serious, with eventual medical decline," while at the same time maximizing the time that is left. I have had more than one patient enroll in distance learning classes or receive funding from the Division of Vocational Rehabilitation for a computer to connect him to friends via the Internet.

Attention must be devoted to the patients' families if they are available to come in for therapy. The breach in the established relational fabric often devastates families (Lynn, et al., 1997). It may be necessary to actively pull in reluctant families in order to fortify a visitation schedule, lest the patient be left in isolation. At times, group therapy can play an important role in the armamentarium of the psychologist on the ventilator unit. Patients who do not have wheelchairs often do not know the other patients. The group process may encourage relationships among the patients. There is healing power in group feedback from those in the same situation. The patient realizes that he is not alone. The group is also a context in which to challenge faulty cognitions and to facilitate the grieving process.

Getting an accurate diagnosis can be a challenge, given the variety of medical problems, multiple medications, and lack of critical psychological data that should come with the patient. Is this a depression, or a prodromal expression of an evolving dementia? Is this an anxiety disorder or a difficulty with oxygenation? Is this patient's elevated blood urea nitrogen level causing mental status changes? The development of a professional consultative and collaborative relationship with the prescribing physician is extremely important.

Getting a current functional status of the major organ systems and blood work is very important for the prescriber. If a psychologist is going to recommend psychotropics to a physician for a particular patient, it is essential that the psychologist know the functional status of that patient's organ systems. This is the essence of the physician-psychologist collaboration. If a patient has renal or liver insufficiency, a much lower dose of psychotropic medication is required. Body mass, nutritional deficiencies, and anemia all reduce protein in the blood that affects the volume of distribution and transport of protein-bound medications.

Given their multiple medical problems, patients on ventilator units are treated on the average with 15 to 20 medications. Many of these medications have serious side effects that can alter the mental status of these patients. For example, anticholinergic medications that are used to "dry up" pulmonary secretions may create delirium and confusion. Even the use of SSRIs can stimulate visual hallucinations or stimulate a manic reaction in a small number of patients. When prescribing certain SSRIs for obsessive-compulsive disorder, depression, or panic disorder, one has to be watchful for blood thinning medications like Coumadin. Careful and frequent monitoring of the prothrombin clotting time is necessary to avoid causing patients to hemorrhage. The prescriber should avoid tricyclic antidepressants, atypical antidepressants, and some antipsychotics for ventilated patients with cardiac conduction concerns. This would also be true of lithium formulations. It is vitally important to review and cross-reference all medications that these patients are taking, when considering recommending an additional psychotropic medication. A comprehensive table of the cytochrome P450 enzyme system is useful in this regard. Such tables are readily available in hard copy and on-line. Additionally, a table referencing general medications that may produce psychiatric symptoms is extremely important to have in the armamentarium of a prescriber.

Anxiety has the highest incidence of all psychological disorders on the ventilator unit. Imagine being conscious with your air supply slowly cut off. It would be like drowning or smothering, and being fully aware.

Patients appreciate feeling empowered since they often feel their lives have been taken away. If they are competent, patients should be involved in making the decision to take psychotropic medications. If they are not competent to participate in this process, an interested family member or an appointed guardian should be involved. Practitioners should consult the Health Insurance Portability and Accountability Act for guidance in this process. The concept of informed consent to treatment is very important here. The patient and the family should be educated about the diagnosis, the type of psychotropic medication, alternative treatments, intended clinical effects, possible side effects, and the consequences of not treating. An acknowledgement of their understanding should be documented.

Quarterly psychotropic reviews are necessary as part of sound psychological and medical practice. An appropriate psychotropic review team consists of the physician, supervising nurse, psychologist, social worker, and a pharmacist, if available. All professionals share their observations and other data, in order to make critical judgments about continuing or altering the psychotropic regime. This presents a good opportunity to educate staff regarding the use, effectiveness, and side effects of the medications. Documentation of these joint consultations should be made in the patient record and on a psychotropic review sheet.

Consider the case of a 53 year-old man who was admitted with the medical diagnoses of COPD, seizure disorder, and type II diabetes. He also had the psychiatric diagnosis of schizoaffective disorder. When admitted, he was taking a variety of medicines including Prednisone, Albuterol, Glucophage, Dilantin, Zoloft, and Haldol. Severe agitation, cursing, and delusions centering on God removing his organs and replacing them with cash characterized this patient's thinking and behavior. The nursing staff was extremely disgruntled because this patient's behavior and psychosis were barriers to treatment. Haldol was titrated up, but did not help. There were too many side effects from a trial on Zyprexa. Other than the diagnosis, there were no psychiatric reports. A meeting was held with the daughter who reported that her father was hospitalized twice for depression following his wife's death. In speaking with the daughter, it became apparent that she herself had Bipolar Disorder. First, the psychologist and the physician discussed the diagnosis. It was likely that the patient also had Bipolar Disorder. Secondly, some of the currently prescribed medications could produce agitation. This was more than agitation, however; this was mania with psychosis. The first thing done was tapering off Zoloft as quickly as medically feasible. Concurrently, the Dilantin was replaced with Depakote, and an appropriate blood level was attained. Lastly, Seroquel was added. It became apparent that the Bipolar Diagnosis was correct. The Zoloft had actually fueled the mania and made the antipsychotic ineffective. Currently, the patient's psychosis and mania have remitted, and he is engaged in psychotherapy to work on grief, subsequent to both his medical condition and the death of his wife over ten years ago.

Psychologists practicing in nursing home settings are being asked to expand their services to the elderly and chronically ill. This may reflect a greater trend in the medical field to utilize psychologists' expertise in managing mental health matters associated with medical illnesses in a variety of settings. Comprehensive training in psychodiagnostics and psychotherapy makes the psychologist's contribution significant to a much underprovided and growing population. Out of necessity, psychologists need to become more medicalized, if they are going to meet this challenge. As one can see, the issues surrounding the psychological care of ventilator patients are complex. It is critical to have a comprehensive psychopharmacological program as an adjunct to psychological services in this setting. Moreover, it is critical to build collaborative and professional working relationships with our medical colleagues, for the sake of our patients and our profession.

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Behavioral Medicine Treatment Paradigm for Irritable Bowel Syndrome

by Ronald C. Striano, PhD

According to the Center for Disease Control, Irritable Bowel Syndrome (IBS) results in an estimated \$8 billion in direct medical costs annually, with IBS patients incurring 74% more direct healthcare costs, than all other patients combined. It is the second largest reason for lost work time, after the common cold. IBS is diagnosed more frequently in women (Borum, 2002), and it is also diagnosed in children (Zeiter & Hyams, 2002).

Diagnosis is exclusionary after work-ups of patient complaints yield no other explanation. The symptoms of IBS are cyclical. Patients report experiencing constipation, but feel an urge for a bowel movement. Bowel movements occur with great difficulty, often with straining, and produce pencil thin stools or pellets, without relief. The patient reports feeling bloated and experiences increasing abdominal pain in the two lower quadrants. Doubling-over and lower back pain occur as the pain becomes intense. Palpation of the lower abdomen elicits serious pain in the area corresponding to the large intestine. Watery diarrhea is followed by a period of relief, until the cycle recurs (Ahn, 2002). The location of the syndrome is the large intestine, beginning at the ileus, and including the ascending colon, transverse colon, descending colon, and the sigmoid colon (Gray, 1995). Spasms cause pain and the resulting irritation. When the colon tightens, the patient experiences a sensation of fullness and a desire to evacuate. It is the narrowness of the colon that results in pencil thin stools and pellets. When the delicate lining of the descending colon is irritated, it can no longer perform the function of water removal, so the stool cannot be well formed. The result is watery diarrhea. The extreme pain is a result of severe colon irritation. Medical tests, including colonoscopy, usually reveal no abnormality beyond the irritation of the lining of the large intestine.

Treatment with medications such as Lev-Bid or other Bella Donna derivatives offers some relief, but incurs side effects like dry mouth and fatigue (Kamm, 2002). Some physicians utilize tricyclic antidepressants at sub-therapeutic dose levels from those used to treat depression. These take advantage of the anticholinergic side effects, which slow down motility and bring relief.

What parents refer to as "toilet training" involves the large intestine. Teaching children to willfully deposit bowel movements into a toilet involves physiological and psychological issues. The toddler needs to be physiologically ready to control colonic activity. They need to be psychologically prepared to agree to give control of feces production to the caretakers. Ultimately, the colon is behaviorally conditioned to perform at the will of its owner. Colon function will not be the well-controlled motility of moving feces along on the journey out of the body, unless the learning process is smooth. This is the pathophysiology of IBS (Whitehead, Palsson, & Jones, 2002).

A thorough psychological evaluation usually reveals patients who are generally anxious, with a tendency toward dysthymia. They demonstrate ambivalence, especially with issues of authority. Poor sleep and uneven eating habits are common. Depression is often present (Chang 2001). The IBS patient generally has a history of difficult relationships dating to childhood, including a life-long struggle with parents. As anticipated, these issues usually follow into adult romantic relationships.

The goal of IBS treatment is to retrain the large intestine, and to resolve psychological issues that contribute to colon spasms. A necessary part of treatment is empowering and encouraging the patient to take control of their illness (Gershon, 1999). The patient must be assured that they and

only they can cure their IBS. The psychologist is the instructor or "tour guide" throughout colon retraining.

The first step is to arrive at an accurate diagnosis. A thorough psychological evaluation by clinical interview needs to be completed. If the patient is of geriatric age, a cognitive screen must be done. If the patient was not referred by a gastroenterologist, a referral to this specialty must be made. A full GI workup is required with a report sent to the treating psychologist to confirm the diagnosis of IBS.

Once confirmed, psychoeducation begins, including drawings, diagrams, and anything to assist the patient to understand what is occurring physiologically. Explanations of neurological pathways and processes of digestion and elimination are necessary, since the patient will be making changes to the function of the large intestine. Images with relevance to the patient's experience can be helpful. For example, an electrician can be taught using a drawing of electrical circuits wired in series, to explain how the brain controls colon motility.

There are three aspects to treatment. Medication to address bowel dysfunction and provide symptom relief is the first step. Low doses of tricyclic antidepressants such as Doxepin or Pamelor, between 10mg and

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30mg, are usually helpful. If psychological problems such as depression, anxiety, or obsessive-compulsive behaviors are severe, an SSRI can be slowly introduced as IBS symptoms decrease (Sadock & Sadock, 2001). The second aspect of treatment is retraining the colon through direct, purposeful, and conscious use of the patient's thought processes. Just as psychologist Bernard Brucker, of the University of Miami, demonstrated, patients with CVAs and spinal cord injuries can use conscious thoughts to reprogram neurological signals; the IBS patient learns to take control of physiological processes, long believed to be out of conscious control. The process involves the patient lying on a comfortable couch, with eyes closed, and lights dimmed, as the psychologist provides training information. The process begins with the patient being asked to take a deep breath, hold it, and exhale. This is done three times, after which the patient is asked to "breathe evenly, please concentrate only on the sound of my voice, and ignore all other sounds." The patient is reassured that they are in complete control and the psychologist is only teaching the process. The patient is asked to focus his/her attention on "the muscles in your toes. Become aware, kinesthetically aware, that is, aware by the way they feel, of all of the muscles in all of your toes. Become aware of how the muscles lie, what they must look like beneath the surface of the skin, and how they attach." The patient is asked to "use the power of your mind to allow these muscles to become loose, limp, and relaxed," and advised, "This is a cumulative process. With each breath you take, and with each word I speak, the muscles in your toes are becoming more and more loose, limp, and

A thorough psychological evaluation usually reveals patients who are generally anxious, with a tendency toward dysthymia. They demonstrate ambivalence, especially with issues of authority

relaxed. Continue to breathe easily and listen only to my voice. Focus now, if you will, on the muscles in your feet." The process moves along to toes, feet, legs, and eventually through the entire body. There is an acceleration of muscle relaxation as these external muscles are addressed. The patient is made aware that this relaxation is only muscular, not emotional, and that our goal is to better utilize emotional energy by refocusing the energy toward a purposeful use. The patient is given an image of free-floating hands, which the patient now owns "forever," that will "perform massage of the external muscles." The patient is taken through a lesson in learning how to "use these hands to go beneath the surface of the skin."

Utilizing these hands and the power of the patient's mind, the inner organs are addressed, with the patient being directed to focus on the throat, esophagus, stomach, chest wall from the inside, small intestine, and, finally, the large intestine. Various imaging techniques are used to allow the patient to practice control of body parts. Through this process, the large intestine, which is already responding to anticholinergic medications, is also responding to the patient's own direction to retrain its function.

The third and very important part of IBS treatment is traditional psychotherapy to address the psychological issues related to the original maladaptive development and maintenance (Svedlund, 2002). Locus of control is the most important issue in pain perception and apperception, and in the treatment of IBS. Medication is a temporary necessity to help control IBS symptoms until the retraining process is complete.

Generally, once the large intestine is retrained, the symptoms of IBS no longer return. If the patient remains in psychotherapy and resolves issues with relationships and authority, the prognosis is usually excellent. Patients who return for later psychotherapy generally do not return with the IBS symptom profile.

The ability of psychologists to comprehend the physiological and psychological interaction, and the role of medication, requires training in psychopharmacology. The mechanism of action and side effect profile of various medications allows an understanding of organ functions to include physiological/biochemical and psychological correlates.

Medication alone (Kamm, 2002) and psychological interventions alone are not effective in treating IBS. This medical/psychological illness can be resolved with the use of combined medication and traditional psychological techniques, demonstrating further support for psychopharmacological training of psychologists. It is likely that a psychological perspective combined with psychopharmacological training will result in the discovery of further benefits for patients with other medical/psychological illnesses.

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Psychopharmacology Training for Psychologists

by Sean R. Evers, PhD

The choice to embark on formal training in psychopharmacology is one that requires several difficult decisions. These decisions relate not only to the type and level of training a person may choose, but also a willingness to expand and reconceptualize some forms of psychopathology. Psychopharmacological training specifically requires a commitment of two of the more rare commodities available to the practicing psychologist, time and money. However, it unexpectedly offers camaraderie, new professional friendships, and the excitement of engaging in a cutting edge endeavor.

Nationwide, approximately 10,000 psychologists are, or have been, involved in training in psychopharmacology (Wiggins & Egli, 1998), but only four to five hundred have completed Level II training (Caccavale, 2003). A decade ago there were no formal training programs in psychopharmacology for psychologists. Today there are more than a dozen programs spread across the country. A 1990 survey of APA members showed that 70% of clinicians and 64% of non-clinicians supported legislation to authorize prescriptive authority for psychologists (RxP). Recent surveys conducted between 1995 and 1998 showed between 55% and 77% of psychologists in surveyed states were in favor of prescriptive authority for psychologists (APA Practice Directorate, 2002).

In 1995, an APA Council Resolution directed the establishment of a model curriculum for psychopharmacology training for psychologists. This resolution resulted in the work group document, "Recommended Postdoctoral Training in Psychopharmacology for Prescription Privileges." This document was adopted by the Council as APA policy in 1996. This model has been amplified by the Committee for the Advancement of

Professional Practice (CAPP) and the APA College of Professional Psychology. It now has three distinct levels: Level 1: Basic Psychopharmacology (for graduate students), Level 2: Collaborative Practice with Medical Providers, and Level 3: Education for Independent Prescribing Authority (Williams, 2000).

CAPP identified the prerequisites to participate in postdoctoral training in psychopharmacology as a doctoral degree in psychology, state licensure, and five years of practice as a "health services provider." Level 3 was recommended to include a minimum of 300 contact hours of didactic instruction in the following areas: neuroscience, clinical and research phar-

macology and psychopharmacology, physiology and pathophysiology, physical and laboratory assessment, and clinical pharmacotherapeutics, cultural competence, and ethnopharmacology. Level 3 training also includes a clinical practicum that involves a minimum of 100 patients with appropriate didactic instruction and supervision. This supervision is defined as two hours per week. The APA College of Professional Psychology also constructed an exam to measure psychopharmacological competence. The Psychopharmacology Exam for

Psychologists (PEP) tests competence in the following areas: integrating clinical psychopharmacology with the practice of psychology, neuroscience, nervous system pathology, physiology and pathophysiology, biopsychosocial and pharmacological assessment and monitoring, differential diagnosis, pharmacology, clinical psychopharmacology research and professional, legal, ethical and inter-professional issues (Williams, 2000).

Formal psychopharmacology training requires a significant commitment of time. The APA minimum recommended training in didactic training is 300 hours plus supervision of 100 cases. Yet the first state that has approved prescribing by psychologists, New Mexico, requires the more exhaustive 450 hours of course work and a 400 hour/100 patient practicum under physician supervision (American Psychological Association, 2002).

Different training programs address this commitment of time in different ways. The University of Georgia's Psychopharmacology training program for psychologists presents their training in a formal graduate school style on campus, with structured lectures and coursework similar to a traditional graduate program, but scheduled on Fridays and Saturdays to fit into the schedule of working professionals. There are also innovative programs, such as that offered by Fairleigh Dickinson University, which includes ten courses with on-campus meetings, videotaped lectures, on-line meetings, discussions, case presentations, and testing. The Psychopharmacology Institute's postdoctoral program is totally internet based. This program consists of 28 courses including 492 hours of didactic training. Finally there is now an Internet based offering by the Prescribing Psychologists' Register, in association with New Mexico State University, that includes 450 hours of didactic training. The Prescribing Psychologists' Register was the first recognized training program for Psychologists to prescribe, and claims to have 11,000 members (Prescribing Psychologists Register, 2003).

The cost of psychopharmacology training must be evaluated on two levels. First, there is the direct cost of the training. It is estimated that the didactic training to fulfill the APA and New Mexico requirements can cost in excess of \$10,000, over a period of two to three years. This cost estimate is based upon the Fairleigh Dickinson Program, and does not include the cost of supervision for the preceptorship portion of the training. Second, is the indirect cost of time lost for practicing psychologists.

I have been invited to write this article about psychopharmacology training programs for psychologists because I have had the experience of attending two different programs. I was a member of the first cohort of psy-

It is estimated that the didactic training to fulfill the APA and New Mexico requirements can cost in excess of \$10,000, over a period of two to three years.

chologists to take the training offered by the Prescribing Psychologists' Register, and completed their initial training. More recently, I have completed the Fairleigh Dickinson University Postdoctoral Master's Program in Clinical Psychopharmacology. These two programs attempted to cover the same material, but did so in very different ways. There is one caveat, before I compare the two programs. I was a member of the first cohort group to attend both training programs and, therefore, they were still in their embryonic stages.

The program of the Prescribing Psychologists' Register can well be described as intellectual boot camp. The program consisted of a series of weekend presentations. Each weekend included two days of eight to nine hours of lecture, and each weekend ended with a test that assessed knowledge of the materials presented. The intensity of the presentations and the volume of the information are demanding. The initial program was designed for 150 hours of training, but when the APA drafted their guidelines, the program was expanded to 300 hours. A variety of interesting lecturers with various backgrounds and levels of expertise staff the program. The entire program was well above the average CEU presentation. The drawback to this program was its lack of printed materials and textbooks, and the fact that it required no preparation prior to the weekend workshop. Attendees were expected to complete readings provided after the workshop.

The Fairleigh Dickinson University Postdoctoral Master's of Science in Psychopharmacology program was both unique and traditional. The program involved ten courses. Each course required readings from one or more text books, written assignments, written case presentations, video taped lectures, and weekly on-line interaction sessions with a facilitator. Each course had a face-to-face weekend meeting with the entire class, and a facilitator to present and discuss cases. While the feeling of PPR was intellectual boot camp, the feeling of FDU's program was more like an endless marathon. The courses, for the most part, were exhaustive and the text materials excellent. Lecturers ranged from excellent to average, but the ability to fast forward or rewind and review the videotaped lectures was a great benefit. Online quizzes and exams acted as the mediums to structure and evaluate the materials learned. To complete the Postdoctoral Masters a candidate also had to pass the PEP Exam. Completing this program takes about two to two and a half years, and is a challenge. While the variety of lecturers offered a great opportunity to learn from different experts in the field, the videotape format did not allow for direct questioning. Although the group facilitator was available for questions and answers, on line and in the live interactions sessions, the process lacked the spontaneity of the classroom, or the benefit gained from direct interaction with the professors.

The commitment in time and money to attain Level II or Level III training in psychopharmacology offers direct and indirect benefits. There is an increased understanding of pathophysiology that allows for more effective consultation with referring and referred to physicians. This results in improved patient care and increased coordination of treatment between mental and physical healthcare providers (Foxhall, 2001). It indirectly challenges our preconceived notions about psychopathology and connects the practice of psychology with neurophysiology. This creates a new understanding. Combining the skills and theories that are the basis of clinical psychology with an expanded appreciation of biology creates a more holistic view of the patient.

Psychopharmacology training can take many different forms. Whether traditional or internet-based, it requires a significant commitment of time and money. It also requires an affinity for academic learning. In choosing a program, it is important to consider individual learning style. The availability of a variety of programs allows psychologists to match a program to their individual style and time availability. Anecdotal reports consistently

underscore participant satisfaction with the training and tangible benefit to practice enjoyment and challenge. It is necessary to understand that psychopharmacology training for psychologists is still evolving. As individual states pass enabling legislation, there may be state specific changes in the model curriculum and other requirements.

Combining the skills and theories that are the basis of clinical psychology with an expanded appreciation of biology creates a more holistic view of the patient.

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Ethics in Brief

by Judith M. Glassgold, PsyD
Chair, Ethics Committee

The news that Martha Stewart is being charged for insider trading has flooded news outlets. Insider trading is defined as making stock trades based on information that is not available to the public. The principle is that there should be a level playing field based on similar information to ensure that all could equally profit. Psychologists and other mental health and medical professionals can become involved in insider trading when non-public information is disclosed in sessions with clients.

This could take the form of a direct stock tip: "Now is a good time to buy" or hearing

information about a business that could affect stock price: "We're on the verge of a new product." "Next week the FDA will announce our new drug is approved." "My company is going to be sold." Making trades on the basis of this information could be considered insider trading as well as potentially placing the client in jeopardy. The professional needs to wait, as do others, until the information is public, or confirm that the information is in the public domain. The Security and Exchange Commission enforces insider trading and can file civil or criminal charges depending on the offense.

The American Psychological Association's Ethics Code does not apply to psychologists' actions outside of professional practice and does not specifically address personal financial behaviors. However, using information from patient confidential treatment for illegal profit or harming the client through one's actions is sanctioned under the Ethics Code standards: 3.06 Conflict of Interest and 3.08 Exploitative Relationships. This situation would also come under the regulations of the State Board of Psychological Examiners, 13-42 10:13 Conflicts Of Interest (e) "A licensee shall not exploit the client's trust and dependency"

Countertransference and Ethnicity¹

by Ruth M. Lijtmaer, PhD

INTRODUCTION

It is impossible to think of identity without its ethnic nature. Being that culture is a highly variable set of meanings learned and shared by a group of people (Rohner, 1984), these basic belief systems and specific ways of relating are programmed and provide the foundation for the development of identity. Ethnicity is part of our cultural identity.

Individuals whose self-identity has been influenced by a society that demands levels of interaction and values that differ from Western culture will present therapeutic issues involving transference-countertransference dynamics that are affected by these factors. The more dissimilar the respective worlds of the members of the therapeutic dyad, the more work is involved in creating a joint search for understanding. The analyst needs to exercise particular caution in applying his or her personal assumptions and metapsychology about people and their respective culture. A clinical case involving a Chinese patient with a Latino therapist will be presented. But first, let us get a sense of some of the basic tenets of Chinese culture.

THE CHINESE CULTURE AND THE CHINESE SELF

Confucius (551-478 BC) was the most important of the Chinese philosophers who set the tone for the development of this culture. He believed that clear lines of authority, respect for the status of others, and the subordination of self to the good of the family, would increase peace and riches (Tang, 1992). Emotional expression is discouraged because it signifies not only the response of a given individual, but also implies an infringement on others. Being at the mercy of one's feelings is seen as promoting poor judgement. The noble person has control over his or her feelings, and therefore, self-restraint is highly encouraged.

It is viewed as an achievement to agree publicly with something with which one privately disagrees. Therefore, assertiveness is discouraged, in particular, if the opinions involved are not in agreement with the authority in the family. As such the family is

the center of a person's life. The ideal person places the family's needs above his or her own, recognizes and fulfills duties of his role within the family, and pursues knowledge to the best of his ability with the goal of developing his/her character.

CLINICAL EXAMPLE

Mary is a Chinese lawyer in her thirties. She has been married to a middle-level executive American man for about six years and had a five year-old daughter. Mary was referred to me because of a symbiotic relationship with her daughter. A Western therapist who evaluated the daughter told me that the girl had separation anxiety and some somatic complaints. I remember being somewhat anxious before Mary came to her initial session. It was from the referral source that I remembered that she was Chinese and that I did not know much about her culture. My anxiety manifested itself in my need to find out about her culture as I found myself looking for references. What was happening to me that was different from my approach to other new patients? I thought of the popular stereotype of Asian patients being more reserved and difficult to reach emotionally and I wondered if those perceptions were the source of my anxiety.

During the first session I questioned Mary about her family history. She migrated to the USA with her parents and her younger brothers when she was 17 years old. She worked and studied to obtain her law degree. Her brothers are also professionals and successful in their careers. Mary was also successful in her job, but was unhappy feeling that her husband did not help her raise and discipline their daughter. She stated that during the weekends which were to be "together time" he would spend a lot of time on the computer leaving little time for them. Mary described him as cold, distant, and critical of her, and as appearing to be disinterested in doing things together. As a result, Mary spent time doing things with their daughter. Other social relationships were similarly limited and she blamed her husband for this as well.

From the onset, Mary was quite ambivalent about treatment. On the one side, according to her cultural standards, she was supposed to solve her problems all by herself. On the other side, she felt she needed contact with someone in order to work out her problems with her daughter and husband. At that point I questioned myself about her possible feelings of family disloyalty by coming to see me and to talk to a stranger, someone outside her family circle. Because of this, I was afraid of making mistakes that would push her away. I was being cautious with her in the same way I felt she was being cautious with me.

In the initial sessions, Mary's posture was rigid and she appeared controlled. She talked about her stressful life: commuting to the city to work in a full-time job, picking up her daughter from the baby-sitter, coming home and making dinner and starting the next day in the same way. She had difficulty accepting that she might need more help in her everyday life. I wondered then, if that difficulty was an allusion to me (difficulty asking for help), but I felt it was too early to make that suggestion.

I had asked her about her expectations of treatment. She responded that her belief about therapy was that I was going to tell her what to do. I explained to her that we were going to work together to understand her problems. She appeared to be somewhat surprised about my response but did not say much.

We worked with specific and practical issues associated with her everyday life. I realized that my role with her was different than with other patients. I was more active and didactic which at first, I did unconsciously. I later realized that I became the teacher that she wanted. I questioned myself: Is my stance of giving her suggestions coming out of my anxiety to fulfill her expectations? I also became aware that she was not committed to therapy. I felt that Mary was complying with the referral's suggestion (an authority figure) and that I was complying with the role she had instilled in me in order that she stay in treatment. At that point I wondered: "Can I help her? Can she overcome her resistance?"

Mary finally asked her husband to be involved in their life. Her concerns were that he would not do many chores around the house, would not finish what he was supposed to do, and did not discipline their daughter the way she wanted him to. I asked myself: "This time I behaved like a teacher and told her what to do and that intervention did not work. Will she blame me for this?" She did not. Still, I wondered if she was angry with me and thought that she might leave treatment because of her disappointment that "my teachings" did not work. I also wondered if my thoughts were influenced by my experiences with other patients and, being influenced by Western worldview, created a unique type of transference. I also wondered if I could ask her about her disappointment that my suggestions did not work for her, which, after gaining more courage, I did. Mary denied any such feelings or thoughts, helping me realize that I had to be cautious with my interventions. Scrutinizing my feelings once more, I saw that my relationship was quite different with her than with my other patients! I attributed this to my anxiety about working with somebody whose cultural background was so different from mine.

Finally, during one session, she verbalized anger towards her husband. However, she did it, in a monotone voice. When I carefully questioned about her lack of emotional response, Mary stated, "You cannot express your anger." She said that she did not want to be angry like her father and denied any angry feelings towards her father or me. It was then that I took the opportunity to ask her what would be her response if her daughter expressed any angry feelings towards her or other situations. Her response followed the Chinese tradition of discipline and restrained emotions as she told me about the importance of the child's respect towards adults and teaching a child to contain strong emotions. It is worth noting that the child frequently had physical complaints before going to school. I then realized she was raising her daughter in the "Chinese way." Perhaps that was the reason the child was having difficulties in separating from a "secure physical environment" and "fight" on her own in the Kindergarten where the children were raised differently. I also thought about the girl's struggles being in a school where the rules and expectations were dif-

ferent from the ones she was accustomed to follow. I also wondered if Mary wanted her husband to behave like a "Chinese father" towards the daughter. I questioned Mary as to whether she saw any connection between her daughter's difficulties in separating and her child rearing practices. She accepted that as a possibility. Then I suggested that her attachment to her daughter might be related to her lack of contact with her husband. Mary's response was positive. She stated that she had not conceptualized it in that way. I thought: "Perhaps I am reaching her here! Intellectual understanding works!"

It is worth noting that at different times during the sessions I had asked Mary to educate me about aspects of her culture that were new to me. She appeared pleased to hear my interest. In hindsight, I believe that my curiosity in her being different from me was important and helped the working alliance develop.

One day Mary started to tell me some events of her childhood and as such I assumed our working alliance had become stronger. Mary remembered her father as being very harsh with her. Whatever she did was not good enough. She remembered one time that her father physically punished her for not being sure of something. Another time, she felt shame and embarrassment when he scolded her in front of other relatives. I wondered if her father's responses to her had something to do with his disappointment of having a first-born female instead of a male child. Mary told me how much she tried to behave like a boy to please her father. She stated that her brothers were treated differently; her father was more severe with her than he was with them. Mary justified her father's behavior as an excessive response to discipline and that it was her father's strong rules that made her strong and successful. However, when talking about it later in treatment, she did not seem so convinced of that explanation which she had given herself most of her life.

Mary described her mother as submissive and passive and someone who did everything to keep her husband happy. I wondered if she too was struggling not to be passive like her mother. I thought perhaps she felt trapped in an "in-between space." With this information I realized that her husband was a transference figure for her father and that

she may see me that way too. When I suggested that, Mary denied any of those feelings. Nevertheless, she expressed ambivalence about her husband's role in the marriage. One more time, Mary "reminded" me through her negative response, that transference interpretations were not working. I had to use another approach to help her understand how she was repeating her early experiences with other people in her life. When I explained that to her, her response was a mixture of puzzlement and agreement. At that point I thought: "I am making it here with her." I realized that the teaching and explaining approach was a place where I could reach her emotionally.

Feelings of shame and guilt began to surface. Themes revolved around being Americanized and breaking the Chinese rules. Her parents lived in New York City's Chinatown and she left her parents there and moved to New Jersey. She married an American, not a Chinese man. She was a woman not a man. Her sense of identity was shaken by the new roles that she had assumed.

It is worth noting that Mary visited her parents once a week, many times after work or during her lunch hour. Other times she would invite them to her home and take them to New Jersey although they were frequently reluctant to accept the invitation. When I questioned her about those visits, Mary said that her parents did not like her husband because he did not speak Chinese.

When Mary expressed her shame and guilt more intensely, although still in a reserved way, it was a precious time (at least for me). We came to understand her symbiotic relationship with her daughter as her way of not letting go of her Chinese identity. She was holding on to the Chinese child rearing precepts with her daughter so that she did not feel estranged from her family by losing her Chinese sense of self. At the same time, she married an American and lived in New Jersey, away from her family. This conflict revived her relationship with her parents. Losing her Chinese identity brought shame to her parents and shame and guilt to her. When all those experiences started to surface, I encouraged her to talk about them. With other patients I might have stressed the transference: i.e. I was not her father and whatever she said to me was totally accept-

ed. However, with Mary I learned to be less interpretative of any possible transference manifestations. I started to feel comfortable when I was more direct in my interventions. Mary was still cautious, using her "face" to cover up her intense feelings. I discovered that even though I only saw the surface, perhaps that was the best I would get from her. Furthermore, I started to accept that I was going to be her teacher, an authority figure, with Mary my student.

Treatment lasted almost two years. Mary felt that she had learned enough to be content with her life. She said she was able to accept her daughter's needs as being different from hers. She felt that she stopped using her daughter to fill the gap in her relationship with her husband. Mary was developing some friendships, which were helping her to be liked by others. She said that she had to accept her husband the way he was.

In hindsight, if our work together had continued, the road ahead of us would still be a difficult one. I would have to remind myself of our cultural differences, review my expectations of her, and accept that our working alliance had to be constantly strengthened.

COUNTERTRANSFERENCE CHANGES

What changed in me? I think that my initial anxiety gave me a clue that something different was happening with this patient. Mary was my first Asian patient. I had worked with patients from many diverse cultural groups, all of whom were Westerners. My anxiety made me feel cautious and afraid to make a mistake. What helped me most was my honesty in questioning what was happening to me in my relationship with Mary. I believe that being naive at times and asking her to educate me about her culture were also important ingredients in our relationship. It took me some time to allow and accept whatever transference manifestations developed in any way or form. It also took me time to accept a more authoritarian and powerful role in the therapeutic relationship than I normally assume. Eventually, I learned to accept whatever she gave of herself to me.

THE LATINO THERAPIST AND THE CHINESE PATIENT

As a Latino therapist and closer to the Western values, some additional observations are necessary to understand the dynamics of the dyad.

When writing this paper I realized how difficult it is to separate my Latino self from my Western self. Thinking of my Latino self, the patient's fear of her father and her dependency, reminded me of the Latino stereotype of men and women based on the concepts of Machismo and Marianismo. As a Latino woman therapist, I was frustrated at times by my patient's lack of affect. I see myself more passionate about life and I think that this was the most difficult juncture for me. Later, when I was able to accept her lack of expressive emotions, I felt sad for my patient's inability to express her emotions more openly. This is the aspect of treatment that reflected my own personal background and biased me.

In terms of the technical stance of being trained in the psychodynamic culture, I had to be more concrete in my interventions. When I started seeing this patient I was biased by my generalized assumptions that Asian patients were more reserved. In addition to that, I felt I was totally ignorant of her culture. My initial response was anxiety and a fear of making mistakes. Technically, I was more didactic than usual and took more personal responsibility for the outcome of treatment, even though I view the therapeutic process as a combined effort. Another technical change was my use of more intellectual explanations than emotionally loaded interpretations in an attempt to induce feedback.

CONCLUSION

In situations such as the one described here, where there are great disparities between the patient's and the analyst's ethnocultural experience, it may be useful to consider the mirroring function of the patient for the analyst. Looking at the patient enables the analyst to find reflections of his or her ethno-cultural self that ordinarily do not enter into awareness. This in turn can facilitate the search for optimal distance that is required to understand the patient's psychic reality, including aspects of the self that are cultural derivatives (Akhtar & Kramer, 1998).

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