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NEWSLETTER OF DIVISION 55, AMERICAN SOCIETY FOR THE ADVANCEMENT OF PHARMACOTHERAPY

MARCH 2008

ASAP TABLET

Don’t Miss This One: Division 55’s Excellent Programs Scheduled for APA in Boston

Steven Tulkin, Ph.D. and Stanley Berman, Ph.D.

This is one convention that Division 55 members should not miss. There is something for everybody. Although the final schedule is not yet set, it looks like 2008 will be a banner year for psychopharmacology programs at the APA convention. Division 55 has been able to expand convention hours by co-sponsoring symposia with at least three other divisions: 28 (Psychopharmacology and Substance Abuse), 42 (Psychologists in Independent Practice), and 53 (Clinical Child and Adolescent Psychology). Our programming will include advanced courses that will qualify for CE credit, as well as presentations about integrating psychopharmacology with psychological interventions in a variety of settings. The tentative convention schedule includes the following:

- Evolution of Psychopharmacology Practice: Where Are We? Topics include:
  1. Evolving Practice for State-Licensed Psychologists (Elaine LeVine)
  2. Evolution of RxP Practice in Public Service Psychology (Pat DeLeon)
  3. Evolution and Challenges of RxP Advocacy (Beth Rom-Rymer)
  4. Evolution of Clinical Practice Guidelines and RxP Ethics (Bob McGrath)
  5. What We Need for RxP Growth (Morgan Sammons)
  6. DISCUSSANT: Russ Newman

- Advocacy and Legislative Update (Mario Marquez hosts this session, which will present an overview of accomplishments at Mid-Winter Conference, and an update on state-by-state advocacy)

CONTINUED ON PAGE 9
Mission over Ego

As we go to press in late January for the March issue, Missouri has introduced its RxP bill with an amazing start. They had 85 co-sponsors for their bill, something that may have never happened before in the state of Missouri. This is undoubtedly due to the hard work and cooperation of a number of psychologists, too many to mention here. A lot of relationships had to have been built up for this to happen. The midwinter conference gave the whole effort a significant boost. It is so impressive when a bunch of doctoral level professionals put ego aside and cooperate to move towards a goal that benefits the society we serve. I am reminded of my former co-worker Jim Fegan’s lessons about mission over ego (see previous issue of The Tablet: http://www.division55.org/Tablet/Vol7No2.pdf).

In this issue, we have our first presidential column from our new Division 55 President, E. Mario Marquez, Ph.D., ABMP. As most of you know, Mario was a key force (along with Elaine LeVine and others) in helping New Mexico to become the first state to gain prescriptive authority. Like the other leaders in New Mexico, Louisiana, and the military, Mario did not stop contributing once his jurisdiction won the right to prescribe and thereby provide increased access to patients in need of integrated mental health care. Like the other leaders whose mission is already accomplished in their own jurisdiction, Mario continues to give selflessly in other states, often at his own expense. I remember hearing the legislators in New Mexico say that it was the personal integrity of Mario, Elaine, and others that really swayed them over the big guns of the opposition.

What is happening with the Psychopharmacology Examination for Psychologists (PEP)? Jan Ciuccio, Assistant Executive Director of the APA Practice Organization, agreed to write a piece updating us on the PEP. It is helpful. Thanks, Jan. Please also see the accompanying information about Jan and what her office does.

Bret Moore, Ph.D., ABPP, will be presenting at APA in Boston in August. He agreed to contribute a column from Iraq for this issue.

Speaking of APA in Boston, Stan Berman, Ph.D., and Steve Tulkin, Ph.D., are co-chairs of the program committee and have outlined some of the offerings for this August. There will be more about the Boston offerings in the next Tablet.

International insomnia expert Charles Morin, Ph.D., agreed to an interview for this issue on treatments for insomnia. Dr. Morin has published numerous articles on insomnia in journals including JAMA and JCCP. Dr. Morin is based in the Canadian healthcare system and has served as a consultant to various pharmaceutical companies. He made an interesting comment towards the end of the interview: “If we took a 1% tax on hypnotic medications to support CBT, it would be greatly helpful and might even help the pharmaceutical companies because they would treat more people.”

Beth Rom-Rymer, Ph.D., organized a smashing successful midwinter conference to help Missouri kick off their legislative campaign. See her concluding comments/reflections and a photo in this issue. Last, but not least, James Quillin, Ph.D., MP, ABMP, writes a reply to Steven Hayes from the interview in the January issue.

Sincerely,

Jeff Matranga, Ph.D., ABPP
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By the time you read this message in the spring of 2008, we will already know the fate of our efforts in Missouri relative to the RxP legislation and D55 Mid-Winter conference in January. It is interesting only because this column is being written in late December 2007. Thus, the rising anticipation from where I sit now. Being that this is the first of four Tablet write-ups, I would like to begin by thanking each one of you. Thank you for the opportunity to serve as ASAP President. It is an honor and a privilege to function in this role, and I pray that I am up to the challenge.

When I ran for president of D55 in 2006, I campaigned on a platform of unity. An excellent strategy, but very formidable task based on my efforts so far. As you are aware, many of our members are independent thinkers and leaders in their own right. This is a good thing, but on occasion makes for difficult times in reaching consensus on important decisions and policies. I want you all to know that I will continue to strive to bring us together no matter how difficult it becomes, and I welcome your assistance in this regard. Please, do not hesitate to provide me with your wise counsel at any time.

I want to thank and acknowledge the individuals that have given of themselves so selflessly over the past decade or so to make our Division what it is today. That is, one of the most dynamic, politically active, and debatable Divisions within the American Psychological Association. We have formally been in existence only about seven or eight years, yet our history is rich with accomplishments, thanks much in part to our former presidents, Dr. Jack Wiggins, Dr. Ron Fox, Dr. Anita Brown, Dr. Matt Nessetti, Dr. Beth Rom-Rymer, Dr. Bob McGrath, and Dr. Elaine LeVine. These leaders have helped to establish a solid foundation which has allowed us to endure past difficulties and prepared us to withstand the trials before us. Make no mistake about it, what we are trying to accomplish essentially amounts to “biopsychosocial” conflict on many fronts, and the resistance will continue. There is, however, a certain amount of security knowing that our “founding fathers” are still working with us, and active in our mission.

I also wish to thank and acknowledge our current Board members, whose reputations precede them; Dr. Morgan Sammons – President Elect, Dr. Robert McGrath – Past President (appointed to fill the slot vacated by Dr. Elaine LeVine who was elected to D55 APA Council Representative), Dr. Glenn Alley – Secretary, Dr. James Bray – Treasurer and APA President Elect, whose courage and perseverance is a testimony to us all, Dr. Elaine Orabona Mantell, Dr. Jim Quillen, Dr. Nancy Alford – Members at Large, and Dr. Beth Rom-Rymer, Dr. Elaine LeVine – Council Representatives.

One need only scan the lists of Past Presidents and current Board Members to envision the possibilities before us. They provide us with unwavering inspiration. If any of you do not know these men and women I urge you to get to know them. I can tell you first hand they are some of the most passionate, compassionate, and charitable individuals you will ever meet. My job will definitely be made easier as a result of their dedication, experience, and skills.

If I may, please also allow me to express my appreciation and recognize several other individuals, who have been instrumental to the Division’s RxP movement, as well as, all the Division Committee Chairs, who are listed in the Tablet. Dr. Elaine LeVine, my RxP soul mate, Dr. Pat DeLeon, who is considered by many, including myself, as the “father of RxP,” Dr. Michael Sullivan for all his efforts through the PD, and the man behind the scenes most responsible for our successful RxP effort in New Mexico, Dr. Russ Newman for his leadership in APA, Dr. John Caccavale for his efforts through NAPP, and Dr. Sam Feldman for his efforts through PPR. A special thanks to Dr. Beth Rom-Rymer who has worked relentlessly on the Mid-Winter Conference in Kansas City, Dr. Steve Tulkin and Dr. Stan Berman who are putting together one of the best Division Programs for the Convention in Boston, and Dr. Jeff Matranga who has taken the Tablet to new heights. Our sincere appreciation also goes out to Dr. Dan Abrahamsom, Deborah Baker and all the employees of the Practice Directorate who have been extremely supportive to D55.

I hope I haven’t bored you too much; however, I do want you to know where I stand in terms of the Division. The most important factor is the relationships we have developed over the years. Issues, policies, and efforts will come and go, but relationships will last a lifetime and beyond. As we proceed on this mission it is absolutely essential that we treat each other with complete respect. In the end this is what will get us to the promise land. Being an uncomplicated minded man, I have only one basic goal for the Division. I understand, however, that everything we do is important, and that is why we have Chairs and Committees doing the heavy lifting in each of the areas. With your permission my primary objective will be to unite our efforts to pass more bills in more states granting prescriptive authority to more trained psychologists to help more hurting people. It behooves us to make 2008 the best year ever for ASAP. Please respond to The Divisions’ calls to action when the times arise. We need each member to unite and stand together to reach our lofty goal of fifty states and the Canadian Provinces with RxP.
Prescribing Psychologists in Iraq: An Opportunity for a More Comprehensive Level of Care

Bret Moore, Psy.D., ABPP

I have found that the observations I made during my first deployment are still relevant. In particular, the issue of over-reliance on psychotropic medications for the treatment of psychological problems continues to be a significant issue.

During both of my tours, I have had the opportunity to work as the sole mental health provider, as mentioned above, and as part of a team which included psychiatrists and psychiatric nurse practitioners. In my experience, there are definite differences in approach when treating service members for various mental health problems. This should come as no surprise to the reader. As a consequence of more focused training in pharmacotherapy for psychiatrists, and psychiatric nurse practitioners to a lesser extent, over-reliance on medication is inevitable. However, it is my belief that this doesn’t have to be the case and that the psychologist trained and credentialed to provide psychotropic medications in the combat environment can expand the treatment options and overall level of care provided.

An exhaustive discussion of how psychologists with training in both skill sets would increase the level of mental health care in Iraq while decreasing the reliance on psychotropic medications is beyond the scope of this article. However, there are some examples that aptly make this point. For example, as one might expect, clinical presentations of posttraumatic stress symptoms within the contexts of acute stress disorder and posttraumatic stress disorder (PTSD) are relatively common. In my experience, psychiatric providers with limited training in psychological interventions are quick to initiate an SSRI such as sertraline (Zoloft) for the various PTSD symptom clusters and prazosin (Minipress) for nightmares. Although there is substantial evidence for the use of these medications for these particular issues, it is unfortunate that they are first-line treatments considering the potential unwanted side effects. Moreover, less invasive and equally (if not more) effective are various psychological therapies such as prolonged exposure and cognitive processing therapy for PTSD and imagery rehearsal therapy for nightmares.

Probably the single most common complaint heard by mental health providers in Iraq involves problems sleeping. Mission schedules, noisy living quarters, and worries about home and the job at hand can wreak havoc on sleep initiation and maintenance. As might be expected, medications such as zolpidem (Ambien), quetiapine (Seroquel), and trazodone are popular choices of intervention. However, the psychological and psychiatric literature is replete with evidence supporting the effectiveness of cognitive-behavioral interventions for insomnia (see Harvey, et. al., 2007; Jacobs, et. al., 2004; Sivertsen et. al., 2006). Furthermore, it is widely accepted that a psychological approach to treating sleep disturbances should be the first line of treatment.

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“National Unity: Putting it all Together for Missouri and Beyond in 2008”

Editor’s Note: The Midwinter Conference was strategic and inspiring. Below are closing comments from the chair, Beth Rom-Rymer, Ph.D.

“They said we couldn’t do it – but, in the Show Me State, we showed ‘em what we could do!”

“Our strength
Our commitment
Our presence”

“We sure showed ‘em what we can do!”

“We’ve been beaten down. Costs of practice have risen. Remuneration has plummeted. Yet, the ways in which we care for and provide for our patients, the ways in which we integrate psychotherapy and pharmacotherapy, have been demonstrated to be exceptionally effective.”

“More than 40 prescribing psychologists. More than 40,000 prescriptions written.”

“Last night, I heard from the State legislators that our timing was exquisite, that if we had waited one more week to lobby and to put on our dinner, we would have been competing with 6 – 8 other groups everyday.”

“And, so it is our time, NOW, for RxP in Missouri and Beyond! Throughout the country!”

“We go as a team: APA leaders, Division 55 leaders, State leaders.”

“This is only the beginning and we have miles to go before we sleep.”

I want to thank my team:

Mario Marquez
Mark Skrade
Marci Manna
Elaine LeVine
Carolyn Talboys Smith
Ellen McLean
Kelly Lora Franklin
The Division 55 Board
MOPA
The Forest Institute

for their collegiality, the shared vision, the creativity, the commitment, the financial support, day in and day out, for an entire year, to pursue our goals.

And, I want to thank YOU for your commitment, your energy, your sacrifices.

We can’t do it alone.
New Business and Constituent Operations, APA Practice Organization

The New Business and Constituent Operations department is responsible for management of a variety of business and operational functions, including support for direct mail communications to practitioner constituents of the APA Practice Organization and research related to constituent demographics. The department is also responsible for supporting the advocacy goals of the APA Practice Organization with a variety of fundraising outreach programs. Additionally, the semi-autonomous College of Professional Psychology is housed within the department and promotes the profession of psychology by offering a variety of credentialing and credentials-related products on behalf of the APA Practice Organization, including the Certificate of Proficiency in the Treatment of Alcohol and Other Psychoactive Substance Use Disorders and the Psychopharmacology Examination for Psychologists (PEP).

From the College of Professional Psychology, APA Practice Organization

Jan Ciuccio,
Assistant Executive Director,
APA Practice Organization

PEP Accepted for Use by State Licensing Boards

The Psychopharmacology Examination for Psychologists (PEP) is accepted for use in awarding prescriptive authority by the New Mexico and Louisiana State Licensing Boards. The PEP has been offered since January, 2000 and, to date, 174 psychologists have taken it. The passing rate for 1st time test takers is 71%. According to Professional Examination Service (PES), APAPO’s testing firm, this passing rate demonstrates that the PEP is appropriately selective for use in a licensing process. Passing rates for 1st time test takers on licensing examinations typically fall between 65% and 75%.

Training Program Graduates Taking the PEP

Training programs whose graduates have taken the PEP include Alliant, Fairleigh-Dickinson, Georgia Psychological Association/University of Georgia, Illinois School of Professional Psychology, Massachusetts School of Professional Psychology, NOVA Southeastern, Prescribing Psychologist’s Register, Southwestern Institute for the Advancement of Psychotherapy, Texas A & M, and the Department of Defense Demonstration Project.

Since 2006, APAPO and PES have published the PEP Performance Report by Postdoctoral Training Programs, an annual report providing a comparison of the performance of candidates who have completed postdoctoral psychopharmacology training programs and have taken the PEP. The information provided includes the number of tests taken by graduates from each program, the mean and standard deviation for the overall scores, and the mean scores for each of the ten knowledge areas. Programs with less than three graduates taking the PEP are not included to maintain candidate confidentiality. The report of performance should prove useful to postdoctoral psychopharmacology training programs and to practicing psychologists considering training.

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Division 55 Fellow James H. Bray
Wins APA’s Presidential Race

James H. Bray, PhD

Members elected APA’s 2009 president: James H. Bray, PhD, a Baylor College of Medicine associate professor of family and community medicine and psychiatry.

Active in APA’s governance for over 15 years, Dr. Bray is perhaps best known for his clinical work and research on developmental and family factors in divorce, remarriage, adolescent substance use, and collaboration between physicians and psychologists. He was treasurer of Division 55.

Dr. Bray ran to advance psychology as a health profession and to be recognized as a partner and an equal in all the health professions. But being on the campaign trail, he shifted his priorities because in talking with hundreds of psychologists he learned that they are hurting. Practitioners in particular are hurting very badly in their practices. Their reimbursement is going down, not up. APA needs to do something to help by refocusing our energy on this issue.

Dr. Bray will also continue to fight for prescription privileges for appropriately trained psychologists. His goal is to have at least three more states pass legislation to allow psychologists to prescribe during his tenure. He will do everything he can to make that happen.

Dr. Bray also wants to shine a light on those who are homeless. Many homeless people are there because of psychological trauma, mental illness, or problems resulting from substance abuse, physical abuse, or sexual abuse. When you give them the help they need, they can become productive citizens. Homelessness is increasing. Dr. Bray would like to see what we can do to turn that around.

*For more information, visit www.bcm.tmc.edu/familymed/jbray.*

APA PRACTICE ORGANIZATION CONTINUED FROM PAGE 6

The Practice PEP

In 2007, the Practice PEP was introduced. This practice exam can help candidates assess their level of knowledge in the 10 content areas on the PEP and expose them to the types of questions they will encounter on the PEP. The Practice PEP was developed by content experts, using test questions drawn from the same item bank as the items on the PEP. This practice exam is intended to familiarize candidates with the test questions. It is the closest practice examination to the “real thing” on the market today, since it is the only APAPO designed and developed practice examination.

Practice Analysis to be Updated in 2008

The 10-part knowledge base tested by the PEP was validated using a “practice analysis” conducted by PES and the College of Professional Psychology in 1999. The process used was typical of that used for other professional examinations (e.g., psychology, nursing, medicine, dentistry, and others). A diverse and representative panel of experts, under the guidance of PES, conducted an extensive study reaching out to more than 600 individuals, organizations, and related professions. The study identified 10 areas of knowledge psychologists must have to prescribe psychotropic medications safely and effectively. The study also determined the importance of each area of knowledge in relation to the others. Data was used to set the number of exam questions for each of the 10 knowledge areas covered by the PEP.

This extensive process resulted in an examination that is based on the knowledge that is required for the safe and effective practice of psychology involving prescribing of psychotropic medications. This kind of “validity” is necessary for fairness and defensibility when an examination is used in a licensing context.

The 2007 PEP Performance Report by Postdoctoral Training Programs contains a detailed description of the 10-part knowledge base tested by the PEP.

It has now been almost 8 years since that first and critical practice analysis was performed. In 2008, PES and the APAPO will guide a process to review and update the practice analysis. Any adjustments made as a result of this process will be reflected in the PEP in 2009.

To request application materials for the PEP email apapoc-college@apa.org, call 202-336-6100, or download an application at: http://www.apapractice.org/apo/pracorg/pep.html#. If you have problems downloading the application, give us a call at 202-336-6100. To review the 2007 PEP Performance Report by Postdoctoral Training Programs, go to: http://www.apapractice.org/apo/praccore/pep.html#. If you have problems locating the report, give us a call at 202-336-6100. To take the Practice PEP, go to: http://www.testrac.com/ps. If you have problems registering to take the Practice PEP, give us a call at 202-336-6100.
Reply to Hayes: On Values

James W. Quillin, PhD, MP, ABMP

Editor’s Note: This is a response to the interview done with Steven Hayes published in the December 2007 issue of The Tablet.

As a new clinical psychology student freshly admitted to a program promising to educate me in the science of psychology and clinical application of that science, my eagerness, looking back now, was naïve. My education and training started, well enough, with a thorough grounding in experimental methods, statistical analyses, learning theory and advanced psychophysiology but began to unwind as I moved into the “clinical core” of my education. As I read the interview with Dr. Hayes published in the December issue of The Tablet, his perspective and concerns with respect to the “values” underpinning our discipline superficially echoed some I had heard long before, and I found myself reflecting on my earliest experiences with the future prospects of psychologists prescribing medication.

Clinical Psychology I, intended as an introduction to the science and clinical practice of psychology, was taught by the Clinical Training Director and was required by all those yearning to one day formally enter the clinical sections of our education. The lectures were typically uninspiring and disappointingly simplistic, often focusing on the alleged inadequacies of the “medical model” as contrasted with the obviously superior psychological or “behavioral model” of patient care. (I should not have used the term “patient” as we were instructed to refer to those with whom we were to “consult” rather than “treat” as “clients” to insure that we avoided the insidious influences of the medical model). It became fairly apparent to me early on that the process underway was more akin to indoctrination than to education, and I began to ponder more deeply the philosophical basis of the profession to which I aspired.

The day of philosophical reckoning for me came when our professor returned from a trip to Great Britain and mistakenly assumed that we had a burning desire to share the details of her vacation. The resulting unsolicited opinions that masqueraded as a lecture on the unique “values” of clinical psychology began with the proclamation that, in the more sophisticated countries, the term “professor” was held in much higher esteem than of “doctor,” the former denoting a learned profession while the latter was reserved for mere tradesmen in medicine. She followed this observation with a dramatic pause and an obvious sense of self-satisfaction. In psychology, practitioners, especially “private practitioners,” the ill-fitting polyester pantsuit leaning against the desk in the front of the classroom carefully added, were usually not suited to the higher calling of clinical research. To any of us so unwise as to contemplate such a future, she sternly warned that our efforts and, perhaps more importantly, our motives would be forever considered suspect and unsavory in the eyes of the scientific psychological establishment. One unique value of my soon-to-be profession, it seemed, was to devalue me.

My well-traveled but poorly dressed professor then mused aimlessly and vaguely about the value of psychology to humanity, never quite seeming to get to any substantive point. At last, she exhausted her thoughts for the day but, in closing, elected to punctuate her otherwise pointless remarks with an unexpected observation which I found astonishing. Erecting herself professorially, her brow theatrically furrowed with unmistakable disapproval, she shared the hope that she would not live to see the day that psychologists would be permitted to prescribe medications, a practice that was a complete rejection of and clearly antithetical to the values our learned profession.

Having already been pegged as intellectually and morally unfit, as I was a practitioner-yet-to-be, and having not much else to lose other than the safety of anonymity, I raised my hand and asked what societal ill-effects would result if psychologists were to some day acquire prescriptive capabilities. She responded slowly and simply, as if replying to the village idiot. Reaching for a prescription pad and writing for some medication, she explained, was just a simple, quick and relatively inexpensive way of alleviating symptoms of problems, not the problems themselves. Finding this reply odd coming from an avowed operant behaviorist and my future career already flashing before my eyes, I pressed further and asked how, as a profession, we were to respond if that which clinical psychological science offers is not particularly valued? She smirked, walked briskly out of the classroom, never bothering to answer. To me, the conclusion was inescapable: an arrogant indifference to biological treatment was a prized and highly valued cornerstone of my profession. I was expected to quietly accept the party line, and to look no farther into the future of possibilities than the myopic lens of sanctioned doctrine permitted.

Times have changed. My professor died long before medical psychologists began prescribing medications in the management of patients. Clinical psychological researchers are beginning to develop some very meaningful treatment protocols. Psychology may yet become truly relevant. Dr. Hayes worries about the cost to psychology of losing our “…professional, scientific and collegial values…” I worry about the cost of it not losing the ones taught to me.

“Psychology may yet become truly relevant.”
Adjustment disorders are also very common in the deployed setting. Service members are faced with numerous stressors both back at home and in the combat environment. These stressors may include the dissolution of a relationship, conflict with a peer or supervisor, and difficulty adjusting to being away from home. By nature, adjustment disorders are transient and should resolve once the stressor is removed or has been dealt with effectively. Many would argue that medication should rarely if ever be used for these disorders. However, in my experience this is not the case in Iraq. When psychiatric providers with limited training in psychological interventions are involved, medications such as SSRIs, benzodiazepines, and hypnotics are often times used. Once again, this is unfortunate considering the availability of evidence-based psychological treatments such as interpersonal psychotherapy and cognitive therapy for depressive symptoms and relaxation based therapies for anxiety symptoms.

The intent of this article was not to minimize the important role that psychiatrists and psychiatric nurse practitioners play in Iraq. I honestly believe it is unlikely that I will ever work with such dedicated, competent, and caring professionals at any other point in my career. My intent was to highlight the fact that psychologists trained in the provision of both psychological and psychopharmacological interventions are ideally suited for the task of providing effective, comprehensive, and tailored mental health services to the men and women of our Armed Forces. At a minimum, I believe that we owe this as professionals and as a profession.

References

APA BOSTON
CONTINUED FROM PAGE 1

-Conversation Hour on Guidelines for Funding from Pharma (Co-Chairs include David Antonuccio, Bob McGrath, Beth Rom-Rymer, Glenn Ally)
-Update on Drug-Drug Interaction (Michael Angelini, PharmD, jointly sponsored with Division 28)
-Update on Child and Adolescent Psychopharmacology (Ron Brown, Ph.D., Jointly Sponsored with Division 53)
-Psychopharmacology and Chronic Medical Conditions (Alice Van Alstine, MD; Jointly Sponsored with Division 42)
-Strategies and Algorithm for Treatment-Resistant Depression
-Integrated Psychological and Pharmacological Treatment for Returning Military Personnel
-Models of Psychopharmacology Practice in Primary Care
-Practice of Integrated Care Across Medical Settings (Presentations on chronic pain, eating disorders, movement disorders, rehab settings, HMO, and others)
-Assessing Treatment Response in Alcoholics using Computer Modeling (Jointly Sponsored with Division 28)
-Conversation Hour on Options for RxP Training (Hosted by Training Directors)
-Paper Session (including papers on research, increasing student participation, and other topics)
-Presidential Address, Awards Program, and Open Board Meeting

Our Division Social Hour will again feature interesting food and drinks, along with opportunities to see old friends and make new ones. We are looking forward to celebrating the election of Division 55 Treasurer James Bray as the incoming President Elect of the AMERICAN PSYCHOLOGICAL ASSOCIATION. We have good reason to celebrate.

Make your reservations soon, as convention hotels tend to fill up quickly. PLEASE NOTE—the more of you who attend APA, the more convention hours we get for next year’s meeting in Toronto.
Insomnia Treatments
Interview with Charles Morin, Ph.D.

Jeff Matranga Ph.D., APBB

Dr. Charles Morin is Professor of Psychology and Director of the Sleep Research Center at the Université Laval in Quebec City. He holds a Canada Research Chair on Sleep Disorders and is past President of the Canadian Sleep Society. He is Associate Editor for the journals Sleep and Behavioral Sleep Medicine and is on the editorial board of several other journals. He has published four books and 160 articles and chapters. His main contributions have been in the development, validation, and dissemination of psychological and behavioral approaches for treating insomnia. His research is funded by the National Institute of Mental Health and by the Canadian Institutes of Health Research.

Dr. Morin disclosed that he has provided consulting services for the following pharmaceutical companies: Sanofi-Aventis, Pfizer, Sepracor, and Takeda.

Dr. Morin was interviewed by telephone on December 20, 2007.

When are medications helpful and not so helpful for insomnia?

For acute insomnia, medication is probably indicated in many cases. If someone is under major stress, such as a death in the family, a hypnotic may be helpful. This is also true for coping with jet lag when crossing several time zones. Because CBT takes longer to produce benefits, I don’t think it will be very helpful in such situations.

When insomnia is occurring comorbidly with another condition, a combination approach of a hypnotic and CBT might be helpful but there is still limited evidence to support this practice. A first step, of course, would be to try to treat the primary condition. It might be helpful with chronic insomnia and chronic pain. We can do CBT and this will be helpful to improve sleep some but it might also be helpful to combine with medications.

Similarly, with depression, treating the depression successfully should be a first priority. But, as insomnia is a frequent residual symptom and may put the person at risk for relapse, adding a treatment for insomnia, whether medication or CBT, may be helpful.

What are the potential benefits and pitfalls of combined therapies (CBT + medications)?

If you treat someone with CBT alone, assuming that this treatment modality is acceptable to the patient, the patient is more likely to get involved in the treatment. The efficacy is dependent on the patient following the recommendations. If a patient has both options, there is a possibility that the patient may use the easier option – taking a pill — and not participate in the CBT as actively.

CBT vs. CBT+zolpidem. We are just starting to look at the data for a study comparing use of CBT vs. CBT+zolpidem. One of the secondary questions was: does adding medication to CBT reduce compliance? That was not found to be true in this particular study.

There is also some risk that if there is a combined treatment the patient might attribute the treatment gains to the medication and not put as much effort into changing important perpetuating factors such as maladaptive sleep habits and dysfunctional sleep cognitions.

Adding medications to CBT? Are there any gains in efficacy if one adds medication to CBT? There is good reason to believe that you will capitalize on the short-term benefits of medications and the long-term benefits of CBT. There are less than 10 studies looking at this question, however. Some of these studies suggest that the combination is superior in the short run but not in the long run. CBT alone produces better long-term sleep improvements than medication alone, or CBT combined with medication.

Adding CBT to medications? Adding CBT to medications does add to the treatment effect over medications alone.

So, how do we make a choice between the treatments? In an insomnia clinic, we are often faced with 1 of 2 scenarios: People have been on medications for a long time and the medications are not working. Here the question is not whether to try a new medication. Instead, we should work with these people to get them off of their sleeping pills. If they have never been exposed to CBT, we should try that.

People who do not want to be on medications. If the individuals have never used medications, some would benefit from CBT but sometimes CBT is just not enough or they might not be willing or able to use CBT. Then, medication could be of benefit to these people.

All patients should be informed of all the different treatment options. People should be able to make a responsible, informed choice.

There is a belief amongst healthcare professionals that once a patient has been on a benzodiazepine for a long time, that it is nearly impossible to get that individual off of the medication. Your research has indicated otherwise, with benzodiazepines (2004 article), with hypnotics in general (2007, JCCP), and I believe with benzodiazepines in GAD. Any comment or advice?

For those who are willing to try the taper, there is about a 75% chance of succeeding. Readiness to change is important. We don’t want to attempt a taper if there is severe stress occurring – if they are going through a divorce or if there has been a death in the family. On the other hand, there may never be an easy time.

We have found that we don’t always need to do psychotherapy or CBT with those patients; sometimes, the structured fol-
INSOMNIA TREATMENTS CONTINUED FROM PAGE 10

low-ups can be enough. Other times, a structured CBT protocol may be helpful.

In some cases, it is very difficult to get people off of medications. They may perceive that they are sleeping okay but they may not be. Most benzodiazepines produceanterograde amnesia. As such, medicated patients may simply forget the extended periods of wakefulness occurring even when they are on medication.

There may be some people for whom we may not be doing a service by getting them off of the medication. For example, individuals with severe anxiety symptoms or with a prior history of depression may be at greater risk for relapse following hypnotic discontinuation.

By and large, however, most of those who have used sedative-hypnotics for a long period of time can come off of those medications.

Tapering schedule?

These individuals can usually decrease their sleep medications by 25% every 2 weeks. The first couple of steps down in dosage are relatively easy. The later decreases are typically more difficult. At some point we need to introduce drug holidays. The patients picks 1 or 2 nights when they are not so concerned about their functioning the next day. Gradually, they would add more drug-free nights. The emphasis is on following the schedule – a schedule contingent plan versus a symptom-contingent plan.

Any comment on the use of drugs like quetiapine (Seroquel) and mirtazapine (Remeron) as hypnotics? Is there any usefulness beyond the ability of these drugs block H1 receptors (antihistaminic)?

I think that Remeron (mirtazapine) is a very sedating drug. The problem is that it is so sedating that the next day it leaves people still sedated. I think that when we are using antipsychotics for hypnotics, we are in trouble.

According to an NIH State-of-the Science conference held in 2005, there are only 2 treatments validated for the treatment of insomnia: CBT and Benzodiazepine-receptor agonists.

Trazodone (Desyrel; serotonin-2 antagonist/uptake inhibitor) was (and maybe is) the 2nd most commonly prescribed medication for sleep in the U.S. Any comment?

Trazodone can have some benefit but the evidence is really limited.

What is your view of how business interests influence prescribing of medications in comparison to both other medications and in comparison to other methods with proven efficacy, such as CBT?

That is a big problem we are facing. Is there a business interest for CBT? No.

If we took a 1% tax on hypnotic medications to support CBT, it would be greatly helpful and might even help the pharmaceutical companies because they would probably treat more people. People might be more receptive to medication treatment if it were combined with an abbreviated CBT program.

There are good behavioral programs with smoking cessation medications, but too often the behavioral part of the program gets diluted.

The bottom line is that we have 2 effective treatment options:

CBT: most helpful for chronic insomnia.
Hypnotic medications: most helpful for acute insomnia.

Do you see any advantage to having psychologists trained to the point of being able to prescribe medications?

Typically, if the treating professional is a physician, medications are used. If the treating professional is a psychologist, CBT is typically used. It may be that psychologists with both tools might be able to make a better decision. There are advantages and also risks to having psychologists being able to use both sets of tools.

What are the risks to being able to use both sets of tools?

If one has both sets of tools, it might be tempting to resort to use of medications despite lower effectiveness for chronic insomnia since CBT involves more work.

Further Reading


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