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Our Shared Commitment to Prescriptive Authority

Katherine C. Nordal, Ph.D.
APA Executive Director for Professional Practice

Greetings to my Div 55 colleagues! I am writing at the invitation of your Tablet editor, Jeff Matranga, with whom I have only recently discovered I have a Mississippi connection. I am very excited about my new role as the Executive Director for Professional Practice at APA. And I thank Dr. Norman Anderson, APA’s CEO, for giving me the opportunity to serve in this position. I come to my new position following 31 years in practice, with 28 of those years in full-time independent practice. What most of you do not know is that I was (Continued on page 6)

“This is an agenda which we will see through to the end in all states...”

Presidential Column

E. Mario Marquez, PhD, ABMP
July 15, 2008

Mark your calendars. It is time to start thinking about the Annual Division 55 2009 Mid-Winter Conference. President-Elect Dr. Morgan Sammons, Dr Micki Levin, and Dr’s. Keith Hulse and Lance Lawrence are heading up the planning committee. A two-day conference is scheduled for Monday February 9th and Tuesday February 10th in Nashville, Tennessee (TN). The Sheraton Hotel, a four star property directly across from the State Capitol has been reserved, and a $147.00 per night rate has been secured. On Sunday, February 8th a pre-conference Psychopharmacology Exam for Psychologists review program will be held. The conference committee will host a welcome reception Sunday evening. Monday, February 9th will be a full day of CE presentations and advocacy training. The CE focus will be on psychopharmacology and the endocrine system. There will be (Continued on page 15)
Greetings, psychopharmacologically informed psychologists!

The timing of this issue is a little unusual in that the electronic version will be available in early August but the hard copies will not be out until early September. So, pardon any confusion in tenses.

We have an exciting issue for a volunteer newsletter. There are some very interesting and worthwhile contributions in here. If you do see this prior to Boston and if you are going to APA in Boston, you might want to check out a couple of the articles by people who will present in Boston.

Dennis Girard agreed to write a short version of what he will be presenting (or just presented) in Boston on how to reduce use of opioids with psychotropics. Dr. Girard has an interesting role providing regular psychopharmacology consultation on the inpatient med-surg floors at New England Baptist Hospital in Boston. A Boston specialty neurologist once told me, candidly: “Dennis has saved our _es more than once!” She was referring to Dennis’ ability to catch and correct interactions and iatrogenically-induced delirium in post-surgical patients. Dennis’ presentation will be (was) part of a symposium on Friday morning, August 15, 8-10 am, in Room 253A at the Boston Convention Center.

David Antonuccio will be presenting as part of a symposium titled Integration of Psychotherapy and Psychopharmacology With Children and Adolescents on Thursday, August 14, 9-11 am, in Room 205B at the Boston Convention Center. Dr. Antonuccio agreed to an interview by Lauren Holleb on what is new about using antidepressant medications with children and adolescents.

At the same symposium on children you will hear or did hear George Kapalka. In this issue, George presents a thoughtful discussion on whether or not Psychology’s house is divided.

Well, Katherine Nordal can address George’s question in her role as APA’s new Executive Director for Professional Practice. Dr. Nordal has a stellar background and has some reassuring things to say about APA’s commitment to RxP.

Merla Arnold has recently published an important article on reducing polypharmacy in older adults in Professional Psychology: Research & Practice. Dr. Arnold agreed to an interview in this issue and she will be presenting a continuing education workshop on Wednesday, August 13 titled What Psychologists Should Know About Working With Older Adults.

Thank you to neuropsychopharmacologist Douglas Hoffman, Ph.D., for his technical input in proofreading part of this issue.

As usual, please see the Presidential column by Mario Marquez for an important update on RxP developments.

Michael Titus is a psychologist-officer in the U.S. Public Health Service, where there is an opportunity for prescribing psychologists to serve the public. This is an important development. Please see his article in this issue and also a longer version at our web site: division55.org/RxPinUSPHS.htm.

Coffee or tea? Ever wonder about the differences in effects? Isn’t it all caffeine? Apparently not. There is an amino acid in tea called theanine that you may be hearing more about in years to come. L-theanine resembles glutamate; several prior studies document impact on dopamine and serotonin levels in the brain. See the interview with Janet Bryan beginning on page 16. Dr. Bryan has published elsewhere an article reviewing the literature on the different effects of coffee and tea. She agreed to an interview in this issue.

My tenure as volunteer Editor will end in December. The goal has been the corollary of the Scouting principle to leave a campsite better than one found it, which is something that all the editors before me have done. I have confidence that the continuity will continue in January, when Laura Holcomb will be taking over as Editor. Please see the nice introduction of Dr. Holcomb by Dr. Marquez in his column. Laura has graciously helped with some of the proofreading for this issue. She is sharp and motivated!

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The Tablet, September, 2008
The RxP Movement: A House Divided?

George M. Kapalka, PhD, ABPP

Reprinted from the Newsletter of the New Jersey Chapter of the American Society for the Advancement of Pharmacotherapy

Spring, 2008

Nearly three years have elapsed since I last commented on our journey toward prescriptive authority (Kapalka, 2005). Much has happened since. I think it’s time to revisit where we stand.

We continue to make strides in our profession’s quest for prescriptive authority for properly trained psychologists (RxP). To date, two states, New Mexico and Louisiana, and the US territory of Guam, have authorized psychologists with post-doctoral training in psychopharmacology to prescribe medications. This is in addition to psychologists trained within the Department of Defense program who continue to prescribe medications to military personnel. Reviews of the practice of these prescribing psychologists are very encouraging – no serious adverse events have been reported. This is indeed good news and goes a long way toward proving once and for all that properly trained psychologists are able to competently prescribe medications.

RxP is supported by most practicing psychologists, and findings of research studies abound that confirm this conclusion. Within our own state, a study that sought feedback from all licensed psychologists revealed, with a respectable 41.4 % return rate, that 66.4 % support RxP (Kapalka, McGrath & Zielinski, 2004). Similar findings have now been obtained from research studies in many states across the country. It is clear that the RxP movement continues to gain momentum and is backed by the majority of psychologists.

Or is it? Recently, an editorial critical of RxP was published in a Missouri newspaper (Heiby, 2008). Heiby portrays herself as representing psychologists opposed to RxP. She argues that psychologists’ training to prescribe medications is substandard and psychologists with this training pose a risk to the public. She goes on to criticize the American Psychological Association (APA) training model as “substantially less rigorous and comprehensive than the training required for all other prescribing disciplines” (paragraph 5). She also attempts to invalidate some of the arguments that have long been forwarded to support RxP – like greater access to care in underserved areas and populations – and purports that psychology licensing boards are incapable of monitoring the practice of prescribing psychologists. She concludes by providing an address to the website of Psychologists Opposed to Prescription Privileges for Psychologists (POPPP), an organization for which she claims to speak.

Readers of this editorial may indeed get the impression that psychologists are deeply divided about RxP. But, what are the facts, and whom does Heiby really represent? It is not necessary here to analyze so, in the end, are we a house divided? Research indicates that the answer is no.

(Continued on page 4)
Heiby's arguments, since all of her claims are distortions that have successfully been invalidated many times. For example, the amount of hours devoted to psychopharmacology is comparable (or exceeds) the training of many professions that currently prescribe medications (for example, nurse clinicians); psychologists that already prescribe do so judiciously and safely; in rural areas there are indeed more psychologists than psychiatrists; and in the states where psychologists prescribe, the psychology licensing boards are able to manage and regulate RxP just fine. Yet, despite significant amount of evidence to the contrary, some psychologists want to continue to mislead legislators and the public.

Internal divisions among us are not new. More than a decade ago, the Association for the Advancement of Applied and Professional Psychology (AAAPP, a small group of academicians with few links to clinical practice) sent delegates to Hawaii to argue against an early RxP bill. AAAPP at one point became an affiliate of the American Psychological Society (APS), but gradually lost members and eventually disbanded. Then, there was the Committee Against Medicalizing Psychology (CAMP), and now POPPP. Who are these folks? Essentially, they are fringe extremists who appoint themselves to speak for the profession. They perceive themselves as crusaders who need to save the future of psychology from those of us, the misguided majority, who are trying to lead our profession astray. For example, Heiby apparently resides in Hawaii, but seeks out jurisdictions across the country (in this case, Missouri) that pursue RxP to voice her opposition.

What should organized psychology do to counter these claims? Some within our ranks feel that we should do nothing. After all, a few extremist opponents always exist (Luddites come to mind), and in the long run, they usually do not stop progress. So, if we let them be they will slowly become victims of attrition. But, this is risky. Because extremists often use unscrupulous methods to exaggerate the validity of their stance, those who are not knowledgeable about the issues at hand may become swayed. This can have a negative impact on popular opinion, and popular opinion does affect legislators.

So, what should we do to neutralize overzealous extremists? First, we need to change our mindset about these groups, how they operate, and how we should respond. Instead of viewing them as innocuous, we need to accept that they do matter, and they do make a difference that sometimes is small (and maybe inconsequential in the long run), but at times may be more significant and destructive. Yes, everyone is entitled to voice an opinion, as long as it is expressed responsibly. Herein lies the problem: groups like POPPP create an exaggerated perception of the size of their ranks, and distort facts in order to make their claims appear more alarming.

What can we do to confront these misrepresentations? Here are some preliminary suggestions: Are these groups made up of non-licensed non-clinicians who are trying to render opinions about the scope of practice of licensed clinicians? If so, isn't it true that they are overstepping their boundaries, and are committing an ethical violation? If they are employed by a professional or educational institution, would their superiors (supervisors, deans, provosts, etc.) be interested in these violations?

Regardless of whether the extremists are licensed clinicians, are they distorting data to fit their own agenda? Again, is this not an ethical violation? Are they exaggerating their ranks? Is this not unprofessional behavior? At this time, I get the impression that just about anyone can form a fringe group (that may even be limited to a single member, as was apparently the case with CAMP) and can then allege just about anything without any expectation of sanctions by organized psychology if his/her statements lack accuracy and integrity. Is this consistent with the philosophy of our profession? If not, it is time that we resolve to do something about it.

So, in the end, are we a house divided? Despite these extremist detractors, research findings indicate that when it comes to support of RxP, the answer is no, and as a profession, we need to send a strong signal to our opponents that we are prepared to defend the validity of the RxP quest with voracity and determination. Still, another related question must also be considered; are we a "house divided" about how to obtain RxP? Here, the answer is not so clear.

APA is the official body that speaks for all of psychology, and has been a proponent of RxP for a number of years. However, psychology is a broad science and is made up of many professional divisions that have little relation to clinical practice. APA is an organization that must represent all of these divisions, not just psychologist clinicians. Consequent...
frequently, other organizations have formed to exclusively support the interests of clinical practice (and RxP). Some of these are recent, like the National Alliance of Professional Psychology Providers (NAPPP), an association that in addition to its national members now also has some state chapters. Some of these are longstanding, like the Prescribing Psychologists Register, an organization that supported RxP even before APA got on board, and provided the earliest organized RxP training in the country. Some of these are state associations that, although mandated not to oppose official APA policy, exhibit varying levels of support for RxP. Psychology licensing boards are another crucial body that influence the pursuit of RxP.

In the ideal world, all of those entities would collaborate to accomplish our common goal. In the real world, however, there are sometimes important differences between these groups that have interfered with the progress of the RxP movement. For example, a recent, significant RxP effort in one state was hampered in part because the licensing board went on record to oppose it. Elsewhere, RxP bills are sometimes introduced by one of these entities without the support of the others, and a struggle subsequently ensues about who will retain control of the bill. Such developments are clearly not in the interest of RxP, and yet they do take place. So, with regard to how to obtain RxP, we indeed appear to be a house divided.

How do we remedy this problem? It should start with the recognition of the need to include all of these constituencies at the proverbial table when plans are initially drawn to pursue RxP within a state. If an entity is left out, its leadership and members may feel disempowered and may proceed to prove their influence even if it is at the cost of an RxP effort. Obviously, this is not in our best interest. Instead, state efforts should start with enlisting the support of all the major constituencies, and should only proceed with legislative action when internal differences have sufficiently been resolved so that a bill receives the support of all relevant entities. If we fail to do so, we give ammunition to our opponents who can clearly point to the division among our ranks as indicative of our lack of readiness to obtain (and manage) RxP. Is this the message we want to send?

I think it is clear to everyone that RxP is a major effort that requires time, effort, money and perseverance. While we seem to have concluded, as a profession, that we support the pursuit of RxP, we still need to unite about how to do so. Unless we start resolving any remaining differences within our ranks, and do so before we start legislative efforts, we will remain a house divided, and, as the corollary suggests, our efforts "will not stand."

References


Dr. Kapalka holds board certifications in clinical psychology, psychopharmacology, and learning disabilities, and he is school-certified and licensed in four states. Dr. Kapalka is a member of medical staff at Meridian Health, Brick Hospital Division, and he is the director of the Center for Behavior Modification in Brick, NJ. He also holds a graduate faculty appointment as Associate Professor at Monmouth University. As a researcher, Dr. Kapalka authored a book and some 100 publications and professional presentations. Dr. Kapalka is an active member of Division 55. He chairs the Committee on Pediatric Psychopharmacology, and he chairs the New Jersey chapter of ASAP. In the past, Dr. Kapalka also held the position of the chair of Continuing Education.

Announcement:

The National Council of Schools and Programs of Professional Psychology Passes Resolution Supporting RxP

For more details, contact Mark Skrade, Ph.D.:

MSkrade@Forest.edu
Nordal & APA’s commitment to RxP continued

(Continued from page 1)

enrolled in the RxP training program at Nova University at the time that I came to APA. I had planned to complete RxP training and then return to public service psychology in an underserved rural area as a prescribing psychologist with a special interest in child/adolescent psychopharmacology within the next 3-4 years. I had envisioned working 3-4 days per week as a prescribing psychologist in an integrated health care system and sharpening my golf game, which needs a lot of work, during my off time. It was a very difficult and carefully deliberated decision to abandon that course and accept the position at APA. I love treating patients, as do all of you, but believe that in my new role and with your help, we have the ability to make an even bigger impact on patient care during this new chapter of my professional life.

I want all of you to know that I am absolutely committed to prescriptive authority for appropriately trained psychologists! The RxP agenda is very high on my priority list and on the Practice Organization’s agenda. This is an agenda which we will see through to the end, until appropriately trained psychologists in all states, and in both public and private practice settings, are authorized to prescribe.

That includes psychologists in independent practice, community health centers, mental health centers, state hospitals, prisons, the DOD, VA, Indian Health Service, University Counseling Centers, and any other setting in which psychologists practice.

Our agenda has always had and will continue to have its challenges, both from within and particularly from outside the profession. It is an agenda which has commanded a paradigm shift regarding both the practice of psychology and the training of psychologists for prescriptive authority. Paradigm shifts take time and a commitment to the long haul. There are victories along the way, and there are setbacks. But we can never forget what we are about is bringing the best possible behavioral health care to our patients, and to underserved populations, so there is no turning back.

A little history is in order here. Did you know that RxP first made it on the radar screen when Senator Daniel Inouye, at the 1984 Hawaii Psychological Convention, challenged HPA’s members to seek prescriptive authority as a way to address the unmet needs of Hawaii’s underserved populations, and that HPA introduced the very first RxP bill in 1985, some 23 years ago? In 1989 the Practice Directorate participated in the DoD Blue Ribbon panel to create the curricula for the Psychopharmacology Demonstration Project (PDP). PDP training for two Navy psychologists began in 1991. During 1995-96, three states introduced RxP bills and in 1996, APA adopted Model Legislation for Prescriptive Authority and the Recommended Postdoctoral Training in Psychopharmacology for Prescription Privileges. In 1997, six prescribing bills were introduced, the fourth PDP class graduated, and the APA Council authorized the College to develop the Psychopharmacology Examination for Psychologists (PEP). Six states introduced bills in 1998 and 1999, and in Dec. 1999, Guam granted psychologists limited prescriptive authority. Six states introduced bills in 2000 and the APA College’s PEP became available. Bills have been introduced every year since and to date, 21 different states have introduced RxP bills. New Mexico’s bill was passed in March 2002 and Louisiana’s bill in May 2004. New Mexico’s and Louisiana’s regulations became effective in January 2005.

Our movement continues with a lot of enthusiasm and momentum despite disappointing recent outcomes in both Hawaii and Missouri where we were so close to a legislative victory.

I am pleased to serve on the Division’s task force which is addressing a national strategy for implementing RxP. You have had and continue to have excellent leadership with whom I have had the pleasure to work. I attended your Div. 55 Advocacy Summit in 2006 in Santa Fe and the 2007 Summit in Missouri. They were very exciting conferences! I wish we could bottle your contagious enthusiasm for advocacy and give a dose to our colleagues outside of the RxP movement. I will see you all on the ground in Nashville in February 2009...and challenge those of you who have not been able to attend the two prior summits to make plans to be in Nashville. I bet we could even find some good music if there is any energy left over for evening activities. I have also had the pleasure in my role as a Committee for the Advancement of Professional Practice (CAPP) member and chair to serve with prescribing psychologists Glenn Ally and Elaine Mantel. And when I vacated CAPP for my new position, Elaine LeVine filled my position. So, CAPP, the governing body for the APA Practice Directorate and Practice Organization, has had and continues to have excellent representation and leadership from the prescribing community.

“I will see you all on the ground in Nashville in February, 2009!”

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Nordal & APA’s commitment to RxP continued
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The Practice Organization continues its unwavering support of the RxP movement with consultative support to state associations from Deborah Baker, J.D., Director of RxP, in our Legal/Regulatory department and from Dr. Dan Abrahamson, Assistant Executive Director for State Advocacy, both of whom also collaborate with the Div. 55 National Strategy Task Force (TF). The Practice Organization, through the authorization of CAPP, has also provided nearly $2.5 million in grants for prescriptive authority initiatives at the local level. We do not know how many states will apply for grants for the 2009 legislative session, but we expect to continue to receive a record number of requests for more dollars than we have to give.

On the policy side of our APA house, the 1996 curricula for prescriptive authority and model state legislation for RxP are currently under revision by a joint CAPP/Board of Education Affairs TF chaired by Drs. Ron Fox and Linda Campbell. That group is also developing a process for the designation of RxP training programs and will determine the appropriate oversight body within APA for program designation. It is planned that these documents will be presented to the APA Council in 2009 for adoption as APA policy.

As part of our continuing support in the Practice Organization I will be convening a “Prescriptive Authority Team” drawing from staff across various departments, such as State Advocacy, Governance Relations, Legal/Regulatory, and Public Relations, to further advance the RxP agenda and ensure that this project continues to receive the attention and support it needs. Deborah Baker, J.D., will be the team leader for RxP. Feel free to contact her at dbaker@apa.org with your suggestions, concerns, or questions. For questions about CAPP grants, contact Dr. Abrahamson at dabrahamson@apa.org. Grant requests for RxP legislative initiatives are usually processed in the fall. Please also feel free to contact me at knordal@apa.org regarding our RxP agenda.

I want also to personally thank each of you for your very valuable contributions to psychology’s RxP agenda. As said earlier, I wish I could bottle the energy, enthusiasm, and unrelenting dedication each of you brings to RxP agenda for our colleagues. They only have to view you in action to know what advocacy is really about and how to do it right! I am deeply appreciative to each of you for what you have so selflessly given to our profession and the patients we serve. If we had that kind of commitment from all of our colleagues about all of our practice issues, we would have moved mountains by now. Hope to see many of you at convention in Boston.

If not Boston, until I see you in Nashville, I remain very thankfully yours...Katherine

Dr. Nordal is APA’s Executive Director for Professional Practice. Dr. Nordal received her Ph.D. in psychology from the University of Mississippi in 1976. She has maintained a full time private practice in Mississippi since 1980. Dr. Nordal’s clinical interests include: learning, behavioral, and emotional disorders in children and adolescents; neuropsychological assessment; brain injury in children and adults; and, civil forensic psychology.

Dr. Nordal is a fellow of the American Psychological Association and the Mississippi Psychological Association. She was the Chair of the Committee for the Advancement of Professional Practice (CAPP) from 2005-07 and a Trustee of the American Psychological Association Insurance Trust from 2005-07. Dr. Nordal served on the APA’s Board of Directors from 2001-03 and was the Board’s liaison to the APA’s Ethics Office, Committee on Legal Issues, the APA/ABA Task Force, and the Public Interest Directorate. Dr. Nordal is a fellow of APA Divisions 42 (Independent Practice), 31 (State Associations), and 35 (Women) and a member of Div. 41 (American Psychology Law Society). Dr. Nordal has also served as chairperson of the APA’s Committee on Rural Health, as treasurer of the Division of State Psychological Associations, and as Finance Chair for the Division of Independent Practice. She is a past president of the Brain Injury Association of Mississippi and currently serves on its board of directors.

Dr. Nordal is a recipient of the APA’s Karl F. Heiser Presidential Award for advocacy on behalf of Psychology. She was an APA/AAAS Congressional Science Fellow (1990-91) and served as a legislative assistant in the U.S. House of Representatives and with the House Select Committee on Hunger.

Dr. Nordal is a past president of the Mississippi Psychological Association and has served on the Mississippi Board of Psychology. She is a recipient of the Mississippi Psychological Association’s Kinlock Gill Outstanding Professional Psychologist Award and in 1997 was presented with the association’s Distinguished Practitioner Award. In 2003 she was recognized with the MPA’s Distinguished Fellow Award.
Role of the Psychologist in Minimizing Polypharmacy in Older Adults
Interview with Merla Arnold, Ph.D., R.N.

Editor’s note. Dr. Arnold recently published the following article:

Dr. Arnold graciously agreed to an email interview. Please see the original article for more information. In addition, if you happen to read this before the 2008 annual APA convention in Boston, please consider signing up for the all-day CE workshop presented by Dr. Arnold and colleagues, cosponsored by the APA Committee on Aging and the APA Office of Continuing Education in Psychology. The all-day workshop is scheduled for August 13, 2008:

**What Psychologists Should Know About Working With Older Adults.**
Workshop Code: WKPC#5. For further information: [http://apadiv20.phhp.ufl.edu/Precon5_CONA.pdf](http://apadiv20.phhp.ufl.edu/Precon5_CONA.pdf)

You note the projection that by 2010 there will be 40.2 million older adults. While each discipline on an interdisciplinary team brings different strengths to the table, what is the unique contribution that psychologists might make relative to other mental health professionals?

With some additional education and training specific to aging and older adults, I’m not sure there is a discipline that can be more effective at bringing together the varied tracks of emphasis, namely, the biological/medical approach of psychiatrists and the psychosocial approaches of counselors and social workers. Our skills in assessment, differential diagnoses, case planning, delivering services and working with others (and organizations), whether individually or in groups, are the core of a biopsychosocial approach to health care. We have a unique opportunity to cultivate an interdisciplinary approach to health (not always illness) care services and policies.

**In your article you cited data indicating that the price tag for inappropriate prescribing for older people can be as much as $20 billion per year. Has there been any research documenting cost savings by having someone such as a psychologist available to monitor medications and functioning on a weekly basis? How might a doctoral student set out to test this hypothesis?**

So far, what I noticed is that most of the studies looking at cost savings have been done by pharmacists, since they are the ones usually tasked with pharmacology reviews in nursing homes. The psychology doctoral student might ask if the study examines, documents, or demonstrates any unique aspect of the role of the psychologist. The studies of the effects of monitoring (with basic follow-up) have generally shown cost savings so there is a likelihood of a positive outcome. But, that said, the student might also want to include quality of life improvements. We know that when you take away an unnecessary drug you diminish the likelihood of an untoward event.

Though the economic value is very concrete and easy to measure, I also encourage the measurement of physical, behavioral, social and psychological improvements (or not) to health and well being. Let’s say for example, a person comes to treatment with memory complaints, depression and difficulty sleeping. A review of the medications shows that the medication regimen is suspect as causal. Now, let’s imagine that the prescriber is able to change the meds around and the symptoms clear but now, the medications are more expensive. Cost in dollars went up. But, if health and well-being improve – what savings over time can be projected? In general, there is likely to be savings in the cost of medications as the number, dose and frequency are able to be reduced because of effective psychological and behavioral interventions. Let’s say we can intervene and reduce obesity, smoking, alcohol and drug misuse, amotivation, and so on. Imagine the benefits. I’d wager we’d see a decline in cancers, heart disease, bone disease, organic mental status changes, diabetes, anxiety, depression...

What about boundaries or guidelines for making comments when a psychologist discovers a problem with a non-psychotropic drug?

I would say, “In the course of my work I noticed that Ms. C takes [insert drug]. I’m wondering if it could be effecting [insert issue] or risk [insert concern] and if there might be another option we could try like, [if you have a suggested option that could be helpful].” Sometimes when I’m concerned about the anxiolytics for example, after the okay from the person I’m advocating for, I’ll offer more frequent

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Minimizing Polypharmacy in Older Adults

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“visits” if necessary, should a reduction or discontinuation precipitate an increase in symptoms.

You helpfully offer the definition that: “Inappropriate polypharmacy occurs when older adults receive more drugs than necessary, which multiplies the risk of adverse events” (Arnold, 2008, p. 284). In your opinion, how much consensus might we expect as to whether or not there are more drugs than necessary on board? Any tips for the risk-benefit analysis?

The literature is clear: polypharmacy is a significant risk to older adults. I think the consensus breaks down at the individual case level where prescribers generally believe a particular medication or regimen is necessary and appropriate. Where I generally start is with interactions risks. A psychotropic interacting with another medicine may place the person at higher risk for serotonin syndrome, for example. The balance of risk and benefits is clearly weighted to high risk. Anxiety or insomnia that can be treated with behavioral interventions, permitting the reduction or discontinuation of anxiolytics or sleep meds also seems worth a try. If safety to self or others is not at risk, I would strongly consider psychological/behavioral interventions over medications. Overall, the job is about the older adult. If that person is at risk, there is little choice but to intervene.

How receptive do you find physicians to your input about polypharmacy?

As you report in the article, there is a probability of over 50% of a drug interaction when an older adult takes five medications, and the probability increases to 100% when taking seven drugs. You then note the possible consequences of overmedication with anticholinergic drugs including increased sedation, mental status changes, falls, broken hips, etc. In addition to psychologists helping to monitor, what other system changes will help to reduce inappropriate polypharmacy?

There has been much talk of late about the requirement of psychologists consulting or collaborating with physicians being written into psychology prescribing laws. I would like to see a reciprocal agreement whereby physicians consult with psychologists when a mental or behavioral health issue is suspected or diagnosed. This can be written into state laws, policy regulations and organizational rules and policies.

Could you summarize why older adults are physiologically more susceptible to drug reactions?

Medications are chemicals that are broken down and delivered to the target site by the body's processes (digestion, blood flow, chemical interactions with the body's chemistry). When the body is healthy and generally at full functioning, the medication is metabolized, distributed and excreted as designed. But, an older adult undergoes changes in body mass (less muscle, more fat) and has organs that may not be functioning effectively (e.g., liver, kidney, brain) and so medicine may act differently than designed, or, it may build up in the body and become toxic. Plus, many older adults take more than one medication and generally suffer with more than one medical illness or chronic disease, each affecting the others; the more of each, the higher the risks.

What might explain the gender and racial differences in polypharmacy, e.g., that older adult women are more likely than older adult men to receive inappropriate medications.

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Minimizing Polypharmacy in Older Adults

I think this is worthy of more attention. I would list as key elements: inequitable access to health care services (with all of its complexities, including institutional racism); how our system responds (or doesn’t) to the “complaints” of women; and ageism as it relates to older women in particular.

Please comment on the risk of encountering drugs with anticholinergic side effects and what these side effects may cause in older adults.

The risks are high and side effects include blurry vision (not good for older adults that already have vision problems), and symptoms that can mimic dementia or other mental health problems such as confusion or behavioral disturbances. And, of course, there is delirium - a medical emergency. Add to this: decreased gut motility (adding to problems with constipation), dry mouth, orthostatic hypotension, sedation, voiding problems, lightheadedness, and postural instability (e.g., risking falls, fractured bones and even death).

For the psychologist not trained in psychopharmacology, what drugs might they keep an eye out for?

Drugs that are sedating, addicting or have anticholinergic side effects should be used with extreme caution, if at all. Even the newer generation of drugs can be problematic for older adults. Like Ambien, a sleep med that should be used on a short term basis. It increases the risk for seizures, depression and suicidality.

What sources of drug information do you recommend for other psychologists who occasionally or regularly see older adults?

I use a database like Epocrates for quick, basic information. I might also ask those that are close to the older adult (family, health care persons) to assess for side effects or effectiveness of a particular intervention (including meds).

Given this issue, it would seem that a psychologist trained in psychopharmacology might play a useful administrative/utilization review role in a state or federal agency such as a Medicaid system – e.g., helping to prevent, track and correct inappropriate polypharmacy. Any comment?

I agree.

You note (p. 287) that “antihistamines have potent anticholinergic properties, putting the older adult at high risk for confusion, delirium, and behavior disturbances.” What is the pharmacologic connection between antihistaminic and anticholinergic effects?

The antihistamines block the histamine receptors so your nose stops running, your eyes stop tearing, etc. They can also have the effect of blocking muscarinic receptors which can cause an anticholinergic reaction. This muscarinic action influences nerve impulses affecting the heart, secretions (gut and otherwise), and the bronchioles (affecting breathing).

You note the need to avoid tri-cyclics as much as possible due to anticholinergic properties. Trazodone is not a tricyclic but is commonly prescribed as a sleep med. Do you see problems caused by trazodone?

Trazodone should be used with caution with older adults in general and for those with cardiovascular or cerebrovascular disease, suicide risk, or impaired renal or liver functions; problems not uncommon in older adults. Though sometimes a medicine is necessary, I would try psychological/behavioral/environmental interventions before adding a medication, wherever possible. If a med is needed, I’d work to discontinue or reduce the dosage as these other approaches take hold.

Merla Arnold received her PhD from Columbia University. As a licensed psychologist, she maintains an independent practice focused on the needs of older adults living in long term care communities in Western Suffolk/Eastern Nassau Counties, New York. In addition, she is a licensed, registered nurse with board certification and over ten years’ experience in quality and utilization review, assessment, and improvement of health care services in major metropolitan hospitals. In addition to aging areas of interest include end of life, attachment/loss, advocacy, education and training and mind–body relationships as they pertain to health and well being. Dr. Arnold is currently Chair-elect of APA’s Committee on Aging (CONA). E-mail: ma159@columbia.edu
The focus of this paper is the utilization of psychotropic medication to reduce the use of narcotics in postoperative patients. I will briefly review the use and sometimes inappropriate use of narcotics in the postoperative period. I will describe the setting, circumstances and the population that my clinical experience is based upon, and will look at the various classes of agents that can be utilized. I will describe the difference in approach used for the acute post-operative patient, compared to the long-term management of the post-operative chronic pain patient. I will present a case example of successful tapering of narcotics in a post-operative chronic pain patient. Finally, I will attempt to make generalizations that may apply to other populations.

The setting in which my clinical observations are made is a 125 bed general hospital with a strong orthopedic focus. Eighty percent of admissions are for elective orthopedic surgery, the majority of which are for hip or knee joint replacement, or for spine surgery. Because the surgery is elective, there is an opportunity to “pre-screen” patients two to four weeks before surgery. Factors such as use of narcotic analgesia prior to surgery, as well as use of alcohol, and history of post-operative delirium can be determined, and strategies to deal with these potential complications can be planned for at that time. The population tends to be older. Joint replacement patients are seventy years of age, on average, and spine patients, on average, are closer to sixty years of age.

When screening patients prior to surgery, it is often necessary to correct inappropriate use of narcotic and non-narcotic analgesia agents, so as to maximize the effectiveness of the post-operative pain regimen. An example of an inappropriate pain regimen is the use of time-release oxycodone (OxyContin) or morphine (MS Contin) on a three or four times a day schedule, as they are designed to work over a twelve hour period of time. Another example of inappropriate use of narcotic analgesia would be use of the above medications on a “prn” basis. Agents such as tramadol (Ultram) also work poorly as PRNs.

The non-narcotic agents that we will be discussing are as follows:

- **Antidepressants**
- **Anxiolytics**
- **Mood Stabilizers**
- **Atypical Antipsychotics**
- **Other Agents**

**Antidepressants**, such as the SNRIs (Serotonin Norepinephrine Reuptake Inhibitors) venlafaxine (Effexor) and duloxetine (Cymbalta), work not only in a manner similar to SSRI antidepressants, but have a noradrenergic action, usually at higher doses, similar to tricyclic antidepressants that slow or block pain pathways. At low doses amitriptyline (Elavil) and in some circumstances nortriptyline (Pamelor) can provide this noradrenergic action.

While SSRIs (Selective Serotonin Reuptake Inhibitors) are generally not considered first line treatment in the management of chronic pain, they do have some useful applications. For patients that cannot tolerate a SNRI, SSRIs may be helpful. The comorbidity of depression and chronic pain is reported to be anywhere from 30% to 87%. In my clinical experience I find the assessment of depression in chronic pain patients to be challenging, but I usually recommend at least a trial of an antidepressant, with very close monitoring for response. Choosing an SSRI for a pain patient should follow similar selection criteria as choosing an SSRI for treatment of depression. There is some data to suggest that paroxetine (Paxil) may be helpful for patients with headache, and that citalopram (Celexa) may be efficacious for patients with neuropathic pain. If there are no contraindications, TCAs such as amitriptyline can be used with SSRIs at doses from 10mg to 50mg per day, generally given in the evening. This may provide an action similar to the SNRIs.

**Anxiolytics** must be used with caution. They are probably most effective for short-term, post-operative use. Valium has the added benefit of muscle relaxant properties, but its long half-life and active metabolites can be problematic in the elderly. Much caution should be exercised in using benzodiazepines in patients with a history of addiction.
Mood stabilizers, most commonly gabapentin (Neurontin) and pregabalin (Lyrica), while generally most effective for neuropathic pain, can be helpful in combination with other analgesic agents in acute and chronic post-operative pain management. The mechanism of action is thought to be the interruption of dysfunctional nerve firings. Recently, gabapentin and pregabalin have been used together with some success, in both acute and chronic pain. Topiramate (Topamax) has also demonstrated efficacy in relieving neuropathic pain. The other anticonvulsants have been used for neuropathic pain with varying success.

Atypical antipsychotics, such as olanzapine (Zyprexa), have been studied and used to augment pain regimens, particularly in the acute, post-operative period. While olanzapine may have some impact on pain pathways, its relaxant properties also are of value. However, side effects, including weight gain and metabolic syndrome, make long-term use problematic. Low doses for a few days in post-operative patients have been found to be an effective augmentation particularly when additional narcotics will repress respiration to a potentially dangerous level. As a bonus, in patients at high risk for post-operative confusion and delirium, the antipsychotic properties seem to diminish the symptoms of delirium such as delusions, confusion and agitation.

Other agents that should be considered to decrease reliance on narcotics include tramadol (Ultram), acetaminophen (Tylenol), NSAIDS (e.g., ibuprofen), COX 2 inhibitors (e.g., Celebrex), and lidocaine (Lidoderm) patches. Tramadol is unique, and while classified as a synthetic opiate, is chemically similar to venlafaxine. It can be very effective dosed three to four times per day, but because of its serotonergic properties, when combined with other serotonin agents can cause serotonin syndrome. Also, patients should be cautioned against abrupt discontinuations of tramadol, as this can cause a variety of uncomfortable and potentially dangerous symptoms similar to SSRI discontinuation syndrome. Analgesic transdermal patches can also be useful in some circumstances. Non-narcotic analgesics should be utilized when they can safely decrease reliance on narcotics. For example, acetaminophen on a schedule can be very effective, particularly in the elderly, as a strategy for decreasing or eliminating the need for narcotics. Many individuals resist taking acetaminophen because they feel it is ineffective. In my experience, I have found that it has not been taken properly. Acetaminophen is most effective when taken on a schedule. Maximum strength acetaminophen (1,000 mg) every six hours, has been found to be more effective than 650 mg every four hours. Psychological treatments, such as CBT, and exercise programs can be extremely important and should be incorporated into the treatment plan.

Case Example
A forty-year-old male, one year S/P revision of lumbar fusion (L4, L5). Original lumbar fusion was two years earlier, and the patient has used OxyContin and Percocet for almost four years. There was no other significant past medical history. There was also no past history of substance abuse or tobacco use. At the time of the consultation, he was prescribed OxyContin 60mg, tid, and Percocet 5-325, two tablets tid prn. The patient was referred for consultation by his orthopedic spine surgeon because he had been requesting Percocet refills after two to three weeks rather than four weeks as scheduled. His use of Percocet had escalated over the past six months. He continued to complain of lower back pain, sciatic pain, and insomnia.

The patient reported that nighttime and early morning were the most difficult times of day for him. He reported feeling depressed, and his appetite had been poor for the past six months. Although his activity level was reduced, he had lost twelve pounds over the past six months.

The plan of care recommended began with changing OxyContin to 100 mg bid and discontinuing Percocet. He was given oxycodone 10 mg bid, PRN, for two weeks, then one time daily as needed. The plan outlined called for reducing the OxyContin dose by 20 mg per day every two weeks. The patient was started on Effexor (XR), titrating to a target dose of 225 mg/day. Other recommendations are listed below.

1. Acetaminophen, 1,000 mg, four times daily.
2. Ibuprofen, 200 mg, three times daily.
3. Neurontin, titrated to a target dose of 300 mg, four times daily.
4. Amitriptyline, 10 mg, at bedtime.
5. Valium, 2.5 mg, at bedtime.
6. Lidoderm patch applied to right lower back (sciatic) for 12 hours, overnight.
7. Walking three times per week and maintaining a log of time and distance.
Emergence of the Prescribing Psychologist Within the U.S. Public Health Service

Meeting the Need:
The grass roots emergence of the Prescribing Psychologist within the U.S. Public Health Service.

Lieutenant Commander Michael R. Tilus, Psy.D., MSCP
U.S. Public Health Service

See APA Div 55 web site for Full Article:
http://division55.org/RxPinUSPHS.htm

DISCLAIMER: The opinions expressed in this article do not necessarily reflect the official position of the U.S. Public Health Service or the Indian Health Service.

U.S. Public Health Service Prescribing Psychologist: Responding to the Grassroots Need for Access to Quality Mental Health Care

Prescribing psychologists (PP) have an opportunity to answer the call to support America’s health responders through the U.S. Public Health Service (USPHS) Commissioned Corps. Driven by the grass roots emergence of the social shift in primary care, a growing number of psychologists within both the USPHS Corps Officers and federal civilians are gaining prescriptive authority while serving their various state and federal service regions.

The USPHS Commissioned Corps is an elite, specially qualified team of more than 6,000 highly trained, discipline-driven, public health professionals dedicated to the mission of protecting, promoting, and advancing the health and safety of our Nation. Many of these officer clinicians and their families have chosen to devote their personal and professional life to service with isolated, remote, and medically underserved populations. Such a mission demands steadfastness, heart, courage, and tenacity. A psychologist with prescriptive authority can especially be a critical Mission Resource Multiplier.

The Aberdeen Area IHS and Dr. Vickie Claymore-Lahammer, Ph.D., the Director of the Division of Behavioral Health for the Aberdeen Area IHS, saw this potential mission impact of having prescribing psychologists in the small Service Units providing both psychotherapy and prescriptive clinical services. She thus spearheaded and supported the prescriptive training for seven psychologists as a part of her division’s Strategic Behavioral Health Initiatives. As a “lead by example” director, Dr. Claymore-Lahammer joined this cohort and also began formal prescriptive training. (This is another example of the successful precedent of prescriptive authority for psychology in the IHS established by Dr. Floyd Jennings in Santa Fe).

To date, the Aberdeen Area Behavioral Health Division has seven openings for psychologists, with hopes of placing prescribing psychologists in each. The current openings are in Belcourt, ND, Rapid City, SD, Rosebud, SD, Pine Ridge, SD, Ft. Thompson, SD, Sisseton, SD, and Standing Rock, SD. (The Billings Indian Health Service Area also has a prescribing psychologist position open at Ft. Peck, MT). Six of these seven currently open psychologist positions rank high on the list of the IHS Loan Repayment Program which assists in repaying a practitioner’s school loans for their service in these communities. Please see LCDR Michael Tilus for more information.

Department of Defense Memorandum of Understanding (MOU) with the USPHS, to include Prescribing Psychologists

A second opportunity for prescribing psychologists within the USPHS involves the new Memorandum of Understanding recently signed with the Department of Defense (DoD). This joint agency agreement will place USPHS mental health professionals (prescribing psychologists, clinical psychologists, psychiatrists, psychiatric nurse practitioners, and clinical social workers) at DoD facilities to provide assistance, coordination, and direct care for of our returning and deploying personnel, and their families. It is expected that prescribing psychologists who are stationed at DoD sites will be granted privileges across their full scope of practice (as reported by officials in the Navy and Air Force).

If you wish to discuss the application process to become a U.S. Public Health Service prescribing psychologist and are interested in the Department of Defense positions please contact CAPT O’Neal Walker. Please follow this web address for further information: www.usphs.gov/profession/behavioral/default.aspx

Please see the Div 55 Website for the full article and all Points-of-Contact. http://division55.org/

(Continued on page 14)
Prescribing Psychologists Within the U.S. Public Health Service

Lieutenant Commander Michael R. Tilus is serving as the Director of Social Services and Mental Health Programs at Spirit Lake Health Center in Fort Totten, North Dakota. He and his wife have chosen to serve in isolate, remote, medically under served populations as the focus of their Public Health Service career. They have seven adult children and one grand-daughter in their blended marriage. Mike's wife, Zhaleh, is a retired chef who actively works with him on the reservation by volunteering with the adolescent treatment programs, cooking for major tribal activities, participating in drumming, talking circles, and crafts.

Mike served in the U.S. Army for 12 years as a Chaplain and is a combat veteran of the first Gulf War of 1991. In addition to being a licensed psychologist and marriage and family therapist, he is an ordained minister with the International Church of the Foursquare Gospel for 30 years and is credentialed as a "Pastoral Psychologists and Chaplain". Mike works hard to integrate cultural beliefs, positive spirituality, psychopharmacology, and family psychology into his psychology practice on the reservation.

Mike and Zhaleh love to raise a large vegetable garden and have flowers all around their home. Zhaleh continues to bring joy to others through her crafts, canning, and hospitality. Since returning to the Upper Prairies, Mike has renewed his passion of white tail deer hunting and walleye fishing. Mike also enjoys classical music and is a trained classical pianist.

Reducing Narcotic Use continued

8. Pool exercise three times per week.

At six weeks, the patient was taking OxyContin 40 mg, bid, and reporting adequate pain control. He was using Oxy IR 10 mg (oxycodone immediate release) less than five times per week, usually following walking or water aerobics. He agreed to reduce the Oxy IR to 5 mg tablets with a maximum of six tablets per week. Over the next six months the patient was able to reduce OxyContin to 10 mg bid, and Oxy IR 5 mg, to three times per week. He was also able to substantially increase his exercise regimen. He is now able to walk two miles three times per week, and can do water aerobics three times per week. He was then able to discontinue OxyContin. He now uses fewer than three Oxy IR tablets per week, and his use of acetaminophen and ibuprofen has been reduced to 650 mg three of four times per day, and 200 mg prn respectively. He reports sleeping well most nights and his mood has improved. He has gained approximately eight pounds over the past twelve months. He has agreed to continue the current regimen for another twelve months.

Summary

In summary, the principles that have proven to be effective in my practice to reduce narcotic use are somewhat different in the acute post-operative patient than in the post-operative chronic pain patient. In all patients we attempt to minimize the use of short-acting "prn" narcotics, and find that maximizing non-narcotic analgesics is helpful. Short-term use of atypical antipsychotics, typically olanzapine at low doses, can be helpful for several days in the acute post-operative period. Because of their longer onset of action, antidepressants are more appropriately used managing the chronic pain of a post-operative patient.

Dennis P. Girard, Ed.D., ABPP, ABMP, is Board Certified in Clinical Psychology and Medical Psychology. He is on the faculty of the post-graduate M.S. program in Clinical Psychopharmacology at the Massachusetts School of Professional Psychology. He is Clinical Instructor of Psychology in the Department of Psychiatry at Harvard Medical School, and a member of the Active Medical Staff at the New England Baptist Hospital.
workshops from national experts with a history of successful advocacy for prescriptive authority and other practice issues for the profession. An announcement for the final CE program will be forthcoming. Monday evening TN and D55 will host a reception for Tennessee legislators. Over 100 legislators are expected to attend for drinks, food, and networking. Tuesday will be an exciting day of direct advocacy. We hope that you will arrange to be present for this opportunity. In addition to the CE and advocacy offerings, representatives from many training programs in clinical psychopharmacology for psychologists will be present, providing opportunities for interested clinicians and graduate students to learn more about this aspect of professional education. We are inviting the participation of members of Division 55, members and leadership of state psychological associations interested in pursuing similar legislative initiatives, members of other Divisions of APA with an interest in prescriptive authority, and other psychologists to attend. Further information will be posted on the Division 55 website as the dates draw near. How about it 55’ers, let’s get ready to support our Tennessee colleagues!

Division 55 elections were recently completed and ASAP continues to be very fortunate in the quality of leaders the membership is selecting. No surprise that Dr. Owen Nichols will be our President in 2010. Owen has already proven himself to be an RxP leader, and I am looking forward to Owen taking the division to new heights. Dr. Mark Skrade will continue in his role as Treasurer for the Division. As you may recall, Mark’s appointment to Treasurer was unanimously approved by the board earlier this year, following Dr. James Bray’s election to APA President. We are privileged to have Mark serving as our Treasurer. Dr. Vickie Brewer was elected Member at Large to the board, and Chris Campbell, M.A., will begin serving as the APAGS Representative. On behalf of the membership, I wish to extend our congratulations and sincerest appreciation not only to our newly elected officials, but also, to those who ran for office. Thank you, Dr. Jeanne Bennett, Dr. Norman West, Dr. Marci Manna, and Ms. Jacqueline Wright.

I would also like to acknowledge the Division 55 2008 Award Winners, who were honored at the recent APA Convention in Boston in August. Dr. Elaine LeVine received the D55 2008 Outstanding Contribution to Prescriptive Authority on the National Level Award. Dr. LeVine’s un-surpassed contributions as a trainee, trainer, advocate, drafter of legislation, lobbyist for the first state law recognizing prescriptive authority for trained psychologists, implementer of that law through writing of regulations, enforcer of the law and regulations as a member of the licensing board in New Mexico, and leadership in ASAP and APA clearly distinguishes her and indicates that she has “done it all”. Dr. Marci Manna and Dr. Mark Skrade were awarded the D55 2008 Outstanding Contribution to Prescriptive authority on the State Level Award for their passionate, persistent, and unyielding work in pursuing prescriptive authority for appropriately trained psychologists in Missouri. Dr. Roy Holand and the Honorable Representative Danie Moore received the D55 2008 Special Legislative Award for championing prescriptive authority legislation at the Missouri State Legislature. Our heartfelt appreciation goes out to these two inspirational individuals. Dr. Robert Pietrzak received the D55 2008 Patrick H. DeLeon Prize for his research entitled, “Effect of Treatment with Stimulant Medication on Visuospatial Executive Function and Visuomotor Processing Speed in Children with Attention-Deficit Hyperactivity Disorder”. Dr. Pietrzak received a $500 honorarium as the winner of this award. A special award was given out this year to a special person. Dr. Gordon Herz received the D55 2008 Award for Outstanding Service on behalf of the Division. Dr. Herz’s roles as Listserv Monitor and Web Page Director have been outstanding and unparalleled on behalf of the members of ASAP.

At the suggestion of Dr. Stephen Seaman, the board has launched an effort in an attempt to establish liaison and coordination with the Association of State and Provincial Psychology Boards (ASPPB). Dr. Stephen Seaman and D55 Board Secretary, Dr. Glenn Ally have been selected to contact ASPPB and begin coordination efforts regarding licensure issues and psychologists with prescriptive authority. We are hoping for a fruitful and long lasting relationship with ASPPB in order to synchronize our mutual efforts in support RxP.

As you all know, the Tablet is an essential and critical component of our Division. Dr. Laura Holcomb is preparing to take over as Editor from Dr. Jeff Matranga, who has performed brilliantly during his tenure. Laura E. Holcomb, Ph.D., is a licensed psychologist in Waterville, Maine, specializing in health psychology/behavioral medi-

(Continued on page 16)
Presidential Column continued

(Continued from page 15)

cine.

She earned her doctorate in clinical psychology from the University of Tennessee, Knoxville. She completed an internship in health psychology at the Cleveland VA, and a postdoctoral internship in behavioral medicine at Dartmouth Medical School. She completed the Masters in Clinical Psychopharmacology in 2005 from Massachusetts School of Professional Psychology. Laura provides psychopharmacology consultation to primary care practitioners, a nursing facility, and medical/surgical wards at Maine General Medical Center, where she is on the consulting staff. In her private practice at Health Psych Maine, she specializes in cognitive behavioral treatment of anxiety disorders, biopsychosocial factors related to coping with chronic and life-threatening illness, pre-surgical evaluations for bariatric surgery and organ transplant, and chronic pain management. Please, let’s all welcome and offer our support to Laura in her new role as D55 Editor of the Tablet, beginning in 2009.

E. Mario Marquez, PhD, ABMP

Differential Effects of Tea Versus Coffee?

Interview with Janet Bryan, Ph.D.
Interviewer: Jeff Matranga, Ph.D.

Editor’s note. Australian psychologist Janet Bryan, Ph.D. published an interesting review of the literature, on the effects of caffeine and of L-theanine, an ingredient in tea, on cognitive and psychological parameters.

Financial disclosure: Dr. Bryan’s review of the literature on the effects of tea on psychological variables was funded in part by Unilever Australia, makers of Lipton products.


Dosage. Your review noted that over the course of a day lower dosages of caffeine seem to have a more positive impact on alertness and reducing fatigue than higher doses. Could you please elaborate?

Lower doses of caffeine refer to those around 75 mg. A cup of tea contains around 40 mg of caffeine, about half that found in a cup of coffee (75mg). Many studies use higher doses of caffeine (200-300mg) but those that use lower doses find more positive effects.

In her review, Dr. Bryan noted (2008):

<table>
<thead>
<tr>
<th>Product</th>
<th>Ounces</th>
<th>mg of Caffeine</th>
<th>mg/oz</th>
</tr>
</thead>
<tbody>
<tr>
<td>espresso, single shot</td>
<td>1.5</td>
<td>77</td>
<td>51</td>
</tr>
<tr>
<td>Dunkin’ Donuts Coffee</td>
<td>16</td>
<td>143</td>
<td>9</td>
</tr>
<tr>
<td>Starbucks Grande Caffe Americano</td>
<td>16</td>
<td>225</td>
<td>14</td>
</tr>
<tr>
<td>Starbucks Short Coffee</td>
<td>8</td>
<td>180</td>
<td>22</td>
</tr>
<tr>
<td>Starbucks Tall Caffe Americano</td>
<td>12</td>
<td>260</td>
<td>22</td>
</tr>
<tr>
<td>Starbucks Grande Coffee</td>
<td>16</td>
<td>330</td>
<td>21</td>
</tr>
</tbody>
</table>

Source: http://www.energyfiend.com/the-caffeine-database

The similarity of L-theanine to glutamate has led to the suggestion that it may have neuroprotective effects through the antagonism of this excitatory neurotransmitter. Indeed, in animals, L-theanine has been found to reduce post-ischemic neural death in the hippocampus, reduce the size of cerebral infarcts, and inhibit neural death caused by brief exposure to glutamate. These findings from animal studies suggest that L-theanine may have neuroprotective effects against brain injury, such as that resulting from stroke. (p. 85)

Okay, so, what is L-theanine? Where is it found? How does it impact neurotransmitters?

L-theanine is an amino acid found almost exclusively in tea with similar amounts found in black, green and white teas (25-60mg). From animal studies it appears to impact on
neurotransmitters as follows:

1. Inhibition of glutamate reuptake and antagonism of glutamate receptors which may suggest a neuroprotective effect (Kakuda., 2002).
2. Increases GABA concentrations with regulatory and anxiolytic effects (Lu et al., 2004).
3. Increases dopamine release - a performance enhancing effect (Lu et al., 2004).
4. Increases serotonin – a mood enhancing effect (Nathan et al., 2006).
5. Appears to moderate or oppose effects of caffeine on blood pressure (Eschenauer & Sweet, 2006) and serotonin.
6. It increases alpha activity, which is suggestive of a relaxed awake state.

Based on the available literature, what differences might be expected when consuming the same amount of caffeine in coffee versus different types of teas?

Given that tea contains caffeine, theanine and some catechins (mainly epigallocatechin gallate or EGCG) and given that there is some evidence for positive combined effects of caffeine and theanine (see the literature review) we might expect different effects of tea and coffee containing the same amount of caffeine. However, as yet there is no evidence for this. There are a small number of studies that have equated caffeine in tea and coffee and found no differential effects on cognition and mood.

When psychologists work with individuals who have anxiety disorders, it is standard to ask about coffee and other caffeine consumption as a parsimonious first place to start. What suggestions do you have based on the research on tea as to the need to taper consumption if there is an anxiety disorder?

Coffee consumption increases performance and mood but there is evidence to suggest it also increases anxiety. Tea has similar effects on cognition and mood but does not increase anxiety. I’d suggest that moderate tea consumption (up to 3 cups per day) would not negatively affect anxiety.

Your review article cited some interesting results of L-theanine on the ability to focus on one stimulus while ignoring distractions. Please explain.

The study showed that when performing a selective attention task, alpha activity in relation to the stimuli of the task that should be attended to was increased while background alpha activity was decreased suggesting focused attention on the task-relevant stimuli.

Does this mean that L-theanine might be conceptualized as a mild ADD drug?

I don’t think so; this would be going beyond the data and there’s been no work on the effects of tea on ADD.

Is there any research available on the differential impact of coffee versus tea on irritability or anger?

No research that I know of. Caffeine tends to increase anxiety and jitteriness. As far as I know irritability and anger have not been looked at.

“One of the most interesting and potentially important findings is that very low doses of caffeine (37.5 mg), such as would be found in a single cup of tea, taken at regular intervals throughout the day, have been found to benefit speed of perception, as measured by the CFF [critical flicker fusion test]. Furthermore, when the level of caffeine in tea is increased such that it is equivalent to coffee (i.e. 75 mg and 100 mg per serving), caffeinated tea appears to provide an advantage over coffee in the rapid increase and maintenance of the CFF threshold. This suggests that regular tea intake across the course of a day may result in more consistent levels of simple task performance” (Bryan, 2008, p. 83). Please comment.

The CFF measures the ability to focus perception and the efficiency of perception. While higher doses of caffeine increase performance on this task, lower doses maintained performance over the course of the day. This suggests that lower doses of caffeine might be beneficial for maintaining concentration on simple tasks longer than higher doses.

Why would higher doses of caffeine (150 mg) result in slower performance (pg. 83)? That seems counterintuitive. Please comment.
(Continued from page 17)

Yes, it does seem counterintuitive. I think it may depend on the level of arousal within the individual. For those who are already highly aroused, additional arousal from caffeine may serve to hinder performance, sort of take them over the edge of their efficiency.

**Interruption of sleep.** At least one study you reviewed indicated that day-long tea consumption is less likely to disrupt sleep than day-long coffee consumption. Please comment. *Is that simply a matter of amount of caffeine or is it more complex? Was that measured through polysomnoigraphy?*

In this study, sleep was measured by a self-report diary. I can’t really comment on the effects of caffeine on sleep apart from the fact that caffeine consumption later in the day would have an arousing effect that would interfere with sleep onset and perhaps sleep quality.

**What advice would you give to a psychologist who has a long day ahead of her or him about coffee versus tea (black, green, white) when they stop at the local coffee place?**

I would suggest they drink tea (black, green or white) at regular intervals (say every 3 hours) rather than coffee.

Janet Bryan, Ph.D., is a Senior Lecturer and the Acting Associate Head of School in the School of Psychology at the University of South Australia. She is a member of the Nutritional Physiology Research Centre and of the Australian Technology Network Centre for Metabolic Fitness. She obtained her PhD in 1998 in the area of neuropsychology and ageing. Her research since then has been in the area of cognitive and neuropsychological assessment across the lifespan and the application of this to areas of health and nutrition.

Her research has resulted in over 40 peer-reviewed journal articles and book chapters and has been supported by over $2m in research funding. She has worked closely with industry partners. Janet is also a member of the Australian Psychological Society and a Fellow of the Australian Association of Gerontology and an International Reader for the Australian Research Council. In October 2008 Janet was appointed the Deputy Chair of the University of South Australia’s Human Research Ethics Committee.

**References & Further Reading**


Update on Antidepressants & Children
Expert Interview with David Antonuccio, Ph.D.
By Lauren Holleb, M.A., Doctoral Candidate

Dr. Antonuccio contributed an article entitled, “Informed Parental Choice About Antidepressants for their Children” for the April 2007 Tablet (http://www.division55.org/Tablet/Vol8No1.pdf). A follow-up interview to last spring’s article was conducted in July 2008.

Based on the Available Scientific Data on Risk and Benefit, Most Antidepressants are Contraindicated in Depressed Children and Adolescents

Is there any new data/change in the data on the effectiveness of antidepressants in treating depressed children and adolescents since last spring?

As I noted in an earlier Tablet article (Antonuccio, 2007a), Whittington et al. (2004) reviewed all of the available data (published and unpublished) from controlled trials of SSRIs in depressed youth. This meta-analysis concluded that the risk benefit profile was favorable for fluoxetine, but was unfavorable for paroxetine, sertraline, citalopram, and venlafaxine. More recent meta-analyses are consistent with this conclusion (Dubicka et al., 2006; Hetrick et al., 2007; Moreno et al., 2007; Wohlfarth et al., 2006). In fact, every single SSRI and SNRI ever studied has had at least one study showing significantly increased suicidality in the active drug condition compared with placebo (Wohlfarth et al., 2006). Fluoxetine is still the only antidepressant meeting the FDA standard for an indicated treatment of at least 2 positive studies demonstrating efficacy (Moreno et al., 2007), but even fluoxetine has also shown increased risk of suicidality compared with placebo.

On May 2, 2007 the FDA broadened its black box warning to include young adults aged 18 to 24 years (US Food and Drug Administration, 2007). What have been the implications of this amendment?

Because the data show an increased risk of suicidality in young adults, hopefully the black box warnings will cause prescribers to be more cautious and judicious in their prescribing habits for these patients, just as such warnings have impacted prescriptions for children and adolescents (Gibbons et al., 2007; Libby et al., 2007; Nemeroff et al., 2007). Of course, along with that caution, it is important that such patients are offered alternative scientifically supported treatments like psychotherapy, something that may not yet be occurring (Libby et al., 2007). Nobody is advocating not offering treatment to children, adolescents, or young adults suffering from major depression.

Changes in the rate of prescription following the warnings: A study examining the decline in pediatric SSRI treatment following the October 2003 advisory (Libby et al., 2007) found that the proportion of patients with depression who did not receive antidepressant treatment increased to three times the rate prior to the warning, yet there was no evidence of a significant increase in the use of alternative treatments, including psychotherapy. Is the literature consistent with a decrease in utilization of antidepressants and no increase in the utilization of CBT, which we know has been shown to be effective in long-term studies of childhood and adolescent depression and appears to fare well in risk/benefit analyses?

This is certainly plausible and suggested by the Libby et al. (2007) data analysis. A reduction in antidepressant prescrip-

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Some scientists have advocated more effectiveness studies, something that could certainly add to our scientific database in important ways. In my mind, the group RCT is still the best way of investigating cause and effect, though causality can also be established with well designed single subject methodology. Taking group RCTs into the real world is challenging but could be illuminating. This would mean having as few exclusion criteria as possible (i.e., including suicidal patients), a challenge for eliciting support of the IRB. However, this type of research would provide us with a clear picture of how our interventions generalize outside the university laboratory with a more representative sample of patients.

It appears very concerning that much research evidence on antidepressants (and even more so with the newer atypical antipsychotics) is extrapolated downward from the adult psychopharmacology literature. Moreover, the majority of available studies are short-term RCT’s leaving us, it seems, knowing next to nothing about long-term outcomes and effects of antidepressants in children. Do we know anything yet about longer term implications of antidepressant treatment on central nervous system, physical, social/emotional, or sexual development?

It is troubling that our medication practices with children are often off label (i.e., are not supported by enough evidence for an FDA recommendation) causing clinicians to extrapolate from short-term studies on adults. I am unaware of any studies that can tell us about the longer term physical, emotional, or sexual consequences from a child taking antidepressants for years and years, though as mentioned in the last Tablet article (Antonuccio, 2007a), there are some data that raise concerns about the possible negative impact of antidepressants on normal sexual development. As a parent of a 10-year-old boy, I share the concern of many parents who would want long-term risk information before proceeding with a medication intervention, especially when there appear to be effective psychosocial treatments without the identified medical risks (see Antonuccio, 2007b).

Do you feel that the scientific evidence on the risk/benefit profile of antidepressants in children/adolescents available to parents/consumers of mental health care has improved?

I have not seen any scientific data that have convinced me that the risk/benefit profile of antidepressants has improved for children. From the TADS studies (TADS, 2004; TADS, 2005; TADS, 2007; TADS, 2008).

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Antidepressants & Children continued

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2007), I have concluded that even for fluoxetine, the only medication approved by the FDA for use in depressed children, a parent whose priority is avoiding risk might reasonably conclude that the psychosocial alternatives have a better risk/benefit profile than antidepressants for depressed children (Antonuccio, 2008a). In other words, choosing a psychosocial treatment for a child with major depression is not an unreasonable choice based on the available scientific data.

John March, M.D., MPH., once stated, “We’re using these medications. We don’t know how they work, if they work or at what cost, and it amounts to a huge experiment with the lives of American kids.” He organized the Child and Adolescent Trials Network in order to provide a “safety registry” on the newer antidepressants. This seems like it might prove useful in helping to predict risk and benefit to the typical patient and in identifying patient factors associated with poor response to medication.

I read this as a candid and courageous quote from a leading child depression researcher. If he is quoted accurately and if he is right, the experiment he refers to violates every ethical principle associated with human subjects research in the most vulnerable among us, children. The safety registry (March et al, 2007) organized by Dr. March represents a creative idea for how to track adverse events and effectiveness in commonly used antidepressants. Such a registry will allow us to understand the relative risk and benefit of different antidepressants. My only concern, if I understand correctly how the registry works, is that there will not be a placebo condition, making it impossible to determine the true balance of risk and benefit of these treatments compared with a supportive psychosocial alternative (i.e., an inert placebo pill). For this information, we must rely on RCT efficacy studies.

Other countries, such as the UK, require that children suspected to have ADHD be evaluated by a child psychiatrist prior to medication treatment, and with less severe forms of ADHD behavior therapy must be tried prior to medication initiation. Do you think the United States would ever move toward a similar model, at least in terms of recommendations/requirements to utilize therapies on the empirically supported treatments list prior to medication initiation?

It seems unlikely that the United States would move to a similar model as the UK for ADHD or depression, though I think such a conservative approach to treating children would make some sense. It is not really a radical concept, though some will make it out to be. The concept really is to try empirically supported psychosocial interventions first before trying interventions with higher medical risks, especially since many patients will benefit and never need riskier interventions. Some will argue that there are risks with psychosocial alternatives as well, which is certainly true, but the TADS (2004; 2007) studies show that the risks are substantially lower than with medication interventions. It is also important to know that the American Heart Association recently recommended that before children diagnosed with ADHD can safely take prescribed stimulant medication, they should have a cardiology screening involving an electrocardiogram to rule out cardiac vulnerabilities that can be exacerbated by these medications (Vetter et al., 2008).

Finally, how do providers ensure that they are not providing “misinformed consent” (Antonuccio, 2007b) to their patients’ when it comes to antidepressants?

Give parents (and their children) all of the information on risk and benefit so they can incorporate their values into their choice of treatments. On page 23 is a simple one-page handout (Antonuccio, 2008b) based on the published TADS data that parents could use to inform their choice. To put this in more human terms, over the course of 3 months of treatment and 9 months of follow-up, in 100 depressed adolescents treated with fluoxetine alone, about 15 will become suicidal compared with only about 6 if those same 100 adolescents are given CBT or 8 if they are given combination CBT/ fluoxetine treatment. In the same 100 patients, 86 will recover if given combination treatment, while 81 will recover with CBT alone or fluoxetine alone. During the 3 months of treatment, 18 of the fluoxetine alone patients will experience a psychiatric adverse event compared with 11 in the combined condition and only 1 in the CBT alone condition. These are the kind of data parents and adolescents need to make their treatment choices.

References

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Treatment for Adolescents with Depression Study (TADS) Team (2007). Treatment for adolescents with depression study: Long term effectiveness and safety outcomes. Archives of General Psychiatry, 64, 1132-1144.


David O. Antonuccio, Ph.D., ABPP is a professor in the Department of Psychiatry and Behavioral Sciences at the University of Nevada School of Medicine. A fellow of the American Psychological Association and an ABPP diplomat in clinical psychology, Dr. Antonuccio is internationally known for his work in depression and smoking cessation. His articles on the comparative effects of psychotherapy and pharmacotherapy have received extensive coverage by the national media and are models of careful scholarship. He was named Outstanding Psychologist by the Nevada Psychological Association (NSPA) in 1993, received an award of achievement in 1999 from NSPA for his work on depression, was awarded the 2000 McReynolds Foundation Psychological Services Award for “outstanding contributions to clinical science”, and received the APAHC (Association for Psychologists in Academic Health Settings) Bud Ogel Award for Distinguished Achievement in Research from the American Psychological Association in 2006. His clinical interests include the treatment of depression, anxiety, PTSD, sexual dysfunction, and smoking.

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### Table 1

**TADS Study Information (TADS, 2004; TADS, 2007)**

<table>
<thead>
<tr>
<th>Who was studied? A total of 439 patients between the ages of 12 and 17 with major depression were treated for 12 weeks with placebo, CBT, fluoxetine, or combination treatment.</th>
<th>Children who took placebo</th>
<th>Children given CBT</th>
<th>Children who took fluoxetine</th>
<th>Children given CBT and fluoxetine</th>
</tr>
</thead>
<tbody>
<tr>
<td>% judged recovered on a global improvement scale</td>
<td>35%</td>
<td>?</td>
<td>43%</td>
<td>81%</td>
</tr>
<tr>
<td>Average degree of improvement on the primary depression measure (CDRS)</td>
<td>32%</td>
<td>?</td>
<td>29%</td>
<td>53%</td>
</tr>
<tr>
<td>% who withdrew consent, terminated prematurely, or dropped out</td>
<td>21%</td>
<td>?</td>
<td>22%</td>
<td>50%</td>
</tr>
<tr>
<td>Side Effects</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% who experienced psychiatric adverse events (e.g., mania, agitation)</td>
<td>8%</td>
<td>?</td>
<td>1%</td>
<td>?</td>
</tr>
<tr>
<td>% who experienced nonpsychiatric adverse events (e.g., headache, sedation, gastrointestinal problems, insomnia)</td>
<td>at least 9%</td>
<td>?</td>
<td>0%</td>
<td>?</td>
</tr>
<tr>
<td>% exhibiting self-harm (e.g., suicidal ideation or behaviors)</td>
<td>5.4%</td>
<td>?</td>
<td>4.5%</td>
<td>6.3%</td>
</tr>
</tbody>
</table>

? = unable to determine from published article.

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