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Editor: Nicholas S. Patapis, PsyD, MACJ, MSCP

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Breaking News

U.S. Congressman Beto O'Rourke (D-TX 16th) introduced federal legislation to give psychologists in the Veterans Administration prescriptive authority. Congressman O'Rourke stated, "I'm about to file a bill that will give VA psychologists the power to prescribe medications, which they don't have today. They have that in the Department of Defense. They have that in other branches of our government. They don't have that within the VA, and we desperately need it." He further stated, "Something is deeply wrong with the VA in El Paso. That is not to say that there's anything wrong with the doctors, nurses or the mental health practitioners there. There just aren't enough of them. We need more resources from the VA in D.C."

President's Podium

Current Status and Future Directions of Prescriptive Authority for Psychologists

James H. Bray, PhD
President, Division 55



James H. Bray, PhD

Psychologists trained in psychopharmacology have been prescribing psychotropic medications as *part of the treatment* they offer their patients for over 25 years through both federal and state programs. Psychologists with specialty training in psychopharmacology also regularly consult with physicians and help them properly diagnose their patients and make recommendations for psychotropic medications.

Further, psychologists with training in psychopharmacology routinely teach medical residents, such as family medicine and pediatrics, on how to diagnose mental disorders and how to prescribe medications for their treatment. *These facts make the question of whether we should prescribe medications moot.*

James H. Bray is the President of the American Society for Advancement of Pharmacotherapy (ASAP), Division 55 of the American Psychological Association and the 2009 President of the APA. Address correspondence to: James H. Bray, PhD, Department of Family and Community Medicine, Baylor College of Medicine, 3701 Kirby Drive, 6th Floor, Houston, TX 77098. Email: jbray@bcm.edu.

From Psychosocial Fixation to the Biopsychosocial Model

With advances in neuroscience, genetics, behavior-genetic interactions and expansions of translational research, psychology is more relevant than ever and there are many new opportunities for our profession (Bray, 2010). These new opportunities are also created by federal health care reform through the Affordable Care Act (U.S. Congress, 2010). One of those growth opportunities is for appropriately trained psychologists to prescribe psychotropic medications.

The fixation on behavior and psychosocial issues by some psychologists is dated and does not fit with current scientific evidence about the integral biopsychosocial nature of human beings (Kaslow, Bollini, et al., 2007; McDaniel, Campbell, & Seaburn, 1990). Thus, psychologists need to adapt to these new understandings and implications for practice or we will soon be left out of the rapidly changing health care scene. The progression of evidence-based psychotherapies has improved our overall profession. There is no evidence in states or federal programs where psychologists can prescribe that the profession has fundamentally changed or “turned us into junior psychiatrists.”

Current Status of Prescriptive Authority for Psychologists

There are 43 prescribing psychologists credentialed through the New Mexico Board of Psychologist Examiners and 83 who are licensed through the Louisiana Board of Medicine (Vento, 2014). Of the approximately 15 prescribing psychologists working in various branch-

es of the military, some are credentialed through New Mexico, some through Louisiana, some are among the original 10 DOD demonstration projects graduates, and some may be credentialed in accordance with other specific military requirements. The six prescribing psychologists currently employed by the Indian Health Service are credentialed through New Mexico.

Of the 135 psychologists currently credentialed to practice, safety data regarding the few prescribing psychologists who are not among those credentialed through either New Mexico or Louisiana is not currently known. However, it is known that no complaints have been filed regarding any prescribing psychologist credentialed through either New Mexico or Louisiana (Vento, 2014), nor are there any records in the military healthcare system of prescribing psychologists operating outside established standards of care. Opponents of prescriptive authority for psychologists have not unearthed any licensing complaints or law suites against prescribing psychologists.

It is estimated that prescribing psychologists have written more than a million prescriptions since the inception of this specialized practice, with no evidence of unsafe or unsatisfactory results, if the absence of Board actions and lawsuits or entries into the National Provider Databank are used as indicators (Alley, 2013). The absence of indications of any safety issues as evidenced by Board complaints or lawsuits should be of some comfort to skeptics.

Future Directions for Prescriptive Authority for Psychologists

Currently, there are a number of states working on RxP legislation at various stages of development. In addition, there are international efforts in progress. The Province of Ontario in Canada is working on legislation, as are New Zealand and Australia. Because of the shortage of psychiatrists and other physicians, the New Zealand Ministry of Health is promoting prescriptive authority for appropriately trained psychologists

as discussed in a symposium at the 2013 APA convention. Further, there have been several cohorts of psychologists from the Netherlands trained in the U.S. to prescribe psychotropic medications as well.

Recently, U.S. Congressman Beto O'Rourke introduced federal legislation to give psychologists in the Veterans Administration prescriptive authority. Congressman O'Rourke stated, "I'm about to file a bill that will give VA psychologists the power to prescribe medications,

which they don't have today. They have that in the Department of Defense. They have that in other branches of our government. They don't have that within the VA, and we desperately need it." He further stated, "Something is deeply wrong with the VA in El Paso. That is not to say that there's anything

wrong with the doctors, nurses or the mental health practitioners there. There just aren't enough of them. We need more resources from the VA in D.C."

The Affordable Care Act has created unprecedented expansions of opportunities and service needs for mental health and substance abuse issues. Because of the increased access to care by millions of people in the U.S., there are great concerns about the lack of providers for these services. Both federal and state legislatures have studied these issues. Even in conservative states, these issues are being recognized to meet the unmet needs of the populous. In a recent legislative study report on *Mental Health Workforce Shortage in Texas* (2014) pursuant to House Bill 1023, the study group concluded the following, "Physicians might cede some of the simpler tasks and practice "at the top" of their training, allowing other professions to fill in the gaps through role extension..... Federal programs (Caccavale, Reeves, & Wiggins, 2012) and the states of New Mexico and Louisiana have granted prescriptive authority to psychologists trained in psychopharmacology... Responsible role expansion should continue to be considered" (p. 20).

Integrated Health Care. Health care reform has also brought forth an increase in primary care and inte-

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grated health care systems (U.S. Congress, 2010). The growth areas for psychologist are not in traditional mental health settings, but in primary care and integrated health systems (Bray, 2010; Bray, Frank, McDaniel, & Heldring, 2004). Because of the increase in emphasis on primary care and the greater access to these services by newly insured people, it is estimated that there will be large workforce shortages (McGrath & Sammons, 2011; Texas Department of State Health Services, 2014). Psychologists are in a prime position to fill many of the service gaps by providing both psychological interventions and also providing pharmacotherapy interventions.

The patient centered medical home (PCMH) model also implicitly acknowledges the importance of integrating psychological and behavioral services into the primary care setting (Bray, 2010; McGrath & Sammons, 2011). Having primary care psychologists also have advanced training for prescribing meets many of the needs within the PCMH.

Division 55 Advances During 2014

The Division board of directors is working hard to support the state, provincial and federal efforts to expand prescriptive authority for appropriately trained psychologists. My goal when I joined the board was to see at least 3 more states pass legislation to give psychologists prescriptive authority. With Congressman O'Rourke's bill, I also add expanding RxP in the VA as a goal too.

The Division is planning on having a Division 55 Future of Pharmacotherapy conference in the fall of 2014. The conference will have a continuing education component that will be open to all and there will be a leadership and advocacy component that will be limited to a group of invited psychologists and others to help plan the future of the division and create new momentum to expand RxP in other states, provinces and federal agencies. This part of the conference will be modeled after the successful APA Presidential Future of Psychology Practice Summit held in 2009 that helped develop a new vision and blueprint for the future of psychology practice (Bray, Goodheart, Heldring et al., 2009; Bray, 2010).

I plan to make random phone calls to members to find out your thoughts and ideas about how we can make

the division better and more effective. So if you get a call from me, you will know why I am calling. Engage, get involved—this is your division. You can reach me at jbray@bcm.edu or 713-798-7752.

References

- Bray, J.H., Goodheart, C., Heldring, M. et al., 2009 Presidential Task Force on Future of Psychology Practice. (2009). *Future of Psychology Practice: Collaborating for Change*. Report of the APA 2009 Presidential Task Force On the Future of Psychology Practice. Retrieved from <http://www.apa.org/pubs/info/reports/future-practice.aspx>
- Bray, J. H. (2010). The future of psychology practice and science. *American Psychologist*, 65, 355-369.
- Bray, J. H., Frank, R. G., McDaniel, S. H., & Heldring, M. (2004). Education, practice and research opportunities for psychologists in primary care. Chapter in R. G. Frank, S. H. McDaniel, J. H. Bray, & M. Heldring, (Eds.) *Primary care psychology* (pp. 3-22). Washington, DC: American Psychological Association.
- Caccavale, J., Reeves, J. L., & Wiggins, J. (2012). *The Impact of Psychiatric Shortage on Patient Care and Mental Health Policy: The Silent Shortage that Can No Longer Be Ignored*. American Board of Behavioral Healthcare Practice.
- Kaslow, N. J., Bollini, A.M., Druss, B., Glueckauf, R. L., Goldfrand, L. R., Kelleher, K. J., LaGreca, A. M., Varela, R. E., Wang, S. S-H., Weinreb, L., & Zeltzer, L. (2007). Health care for the whole person: Research update. *Professional Psychology, Research and Practice*, 38, 278-289.
- McDaniel, S. H., Campbell, T, & Seaburn, D. (1990). *Family-oriented primary care: A manual for medical providers*. New York: Springer-Verlag.
- McGrath, R. E. (March, 2014). Personal communication on number of trainees who have attended post-graduate training in psychopharmacology.
- Texas Department of State Health Services, (2014). *The mental health workforce shortage in Texas*. Pursuant to House Bill 1023, 83rd Legislative Session, February.
- U. S. Congress (2010). H.R. 3590 Patient Protection and Affordable Care Act. Washington, DC. Retrieved from <http://www.opencongress.org/bill/111-h3590/show>.
- Vento, C. (March, 2014). Personal communication with New Mexico and Louisiana licensing boards.

Candidate Statements

Candidates for President

Sean R. Evers, PhD, MSCP

I am excited to be considered as a candidate for the Presidency of the American Society for the Advancement of Pharmacotherapy (Division 55). The use of pharmacological interventions alone as the model for treatment of mental health problems has failed resulting in poor outcomes over time and an over-reliance on psychopharmacological medications. I feel that ASAP can be a pivotal force in shaping the future of the collaborative practice of psychological and psychopharmacological treatment asserting the primacy of psychological interventions with a knowledge, understanding and ability to use psychopharmacological interventions when needed to augment treatment.

The excitement of past ASAP meetings and conferences still echoes in my memory. Although there have been frustrating setbacks in the growth of prescribing psychology more states are working on passing enabling legislation each year to spread the prescriptive movement. The initial excitement we all experienced remains but has been hardened by experience. We need to grow our membership as we increase the number of states working on gaining prescriptive authority.

I am asking for your vote to allow me to continue the important work of Division 55 and the expansion of the initiatives begun by our former executive boards and presidents. I will work to enhance the ongoing efforts of Division 55 to encourage collaborative practice, ensure high quality pharmacological training for psychologists training, and support states around the country as they work to pass legislation to grant appropriately trained psychologists prescriptive authority.

Lynnea E. Lindsey, PhD, MSCP

Thank you to my colleagues for the nomination and opportunity to run for the office of President of APA's Division 55. Practicing in underserved areas, without access to fully trained prescribers, ignited my conviction that psychologists hold an essential role in the use

of psychotropic medications. As I was repeatedly called upon to consult with providers I recognized that this was more than an important concept, it required me to pursue an education and training in psychopharmacology. While pursuing the post-doc I became acutely aware that healthcare policy was crafted with little consideration for psychologists to take active psychopharmacological prescribing roles in most civilian settings. As I completed my post-doc, I heard psychologist prescribers speak passionately about investing time, energy and money in the work of advocating at the local, state and national level and of the work of American Society for the Advancement of Pharmacotherapy. Their words rallied me to engage in active state level legislative work. I have testified, crafted legislation, researched, served on legislatively mandated workgroups/committees and actively pursued training models. I serve as a functional prescriber/consultant, with my medical colleagues, in collaborative and integrated settings. These efforts have moved the conversation, yet have illuminated the sometimes daunting complexity and often slow trajectory of change. To you, my colleagues, I offer ongoing passion and intimate experience in the effort to educate and advocate for pharmacotherapy provided by psychologists. I am committed to our work and offer my leadership skills to our division.

Neal Morris, EdD, MS, ABPP-CL

I am honored to stand for election as President-Elect. My commitment to advancing training and practice of clinical psychopharmacology spans over 20 years. I helped bring training to Maryland in 2003. I completed the MS in 2005, passed the PEP & completed a 2-year preceptorship in 2007. Thus making it possible to provide comprehensive and ethical psychopharmacology consultations in both states where I practice, Maryland & West Virginia. I have been involved in many Division 55 activities such as Liaison to CAPP for 7 years & serving on the organizing committee for the 2011 Mid-Winter Conference held in conjunction with APA's State Leadership Conference. I am the 2014 Convention Program Chair. We need to continue our state-by-state

grassroots lobbying and public education programs to obtain prescriptive authority. This means supporting states with current legislative efforts. And, it means re-invigorating efforts to generate or renew interest in as many states as possible. I believe our goal should be to put the possibility of psychologist prescribing for the public good on the agenda of every state. I believe this is possible now that we have entered the reform era of healthcare service delivery. I pledge to help in every way I can to make this goal a reality. I seek your vote for President-Elect in order to lead Division 55 into this exciting new integrative order of healthcare services. I greatly appreciate your vote and all of your efforts in behalf of obtaining prescriptive authority for psychologists.

Candidates for Secretary

Morgan Sammons, PhD

I seek nomination for the position of Secretary of Division 55. As many of you know, I was instrumental in founding the Division and served as one of our Council reps for two terms. I am a past-president of the Division and have served on the Fellows committee and as Awards Committee chair for many years. Several years ago, I stepped back from a leadership position on the Division 55 board, as it was (and remains) my philosophy that changes in leadership are healthy for the progress of the Division. Over the past several years, however, I have noticed that the Division seems to have become rather stagnant, and that, among other things, our membership numbers have dropped considerably. I rejoined the Board this year at the behest of Dr. Bray to fill a vacant member at large position, and believe it is now time for me to become re-engaged in Division leadership. Accordingly, I respectfully ask your vote as Secretary of the Division.

Christina Vento, PsyD, ABMP

My name is Christina Vento and I am asking for your support for the position of Secretary of Division 55. I am a practicing prescribing psychologist in New Mexico and currently hold the office of Secretary for the Division 55 Board. I've been a Division 55 member for 15 years and have been involved in RxP advocacy in NM and other states since that time. As a current Board member, I started a Division 55 Task Force to try to measure the behavioral health disparity reduction national impact of prescribing/medical psychologists, an

effort I piloted in NM in 2013. This information will be used in future legislative efforts to demonstrate that where we have been granted prescriptive authority, it has been both safe and effective at helping those most in need. I am also interested in revitalizing the Division's Committees that have grown largely dormant in recent years.

In addition to five years of prescribing, I am also the former training director of the Master's in Psychopharmacology program at NMSU and have been a member of the PEP Exam Revision Committee. I have a strong commitment to public service: I worked for the State of NM for 12 years including 6 years at public inpatient treatment facilities. Recently, I have led efforts to improve reimbursement for NM prescribing psychologists by advocating a change in Medicaid rule to allow us to bill 99 codes.

Please consider a vote supporting my ongoing efforts to improve our Division's activity and efficacy.

Candidates for Member-at-Large

Dr. LaSonia A. Barlow, LLP, LPC, RAC

My name is LaSonia Adrene Barlow, PsyD, LPC, RAC, I am running for the office of Member at Large for Division 55. I have a doctorate degree in clinical psychology. I am a certified forensic consultant, licensed professional counselor, registered addiction counselor, crisis care psychological first aid provider, and certified for the Disaster Assistance Team (DART). Currently, I am a student attending Fairleigh Dickinson University, in pursuit of a degree in Clinical Psychopharmacology.

I have worked extensively with the substance abuse and mental health population in in-patient and outpatient settings. Currently, I am the Senior Outpatient Therapist at an inner city outpatient substance abuse clinic located in Detroit, Michigan. Also, I have a private psychological and forensic consultant practice in Farmington Hills, Michigan, where I treat a variety of patients. I offer a very diverse skill base and academic preparation. I would be honored to serve in the position of Member at Large, to promote the mission of Division 55.

Alan Lincoln, PhD, MSCP, BCBA-D

My name is Alan Lincoln, PhD, MSCP, BCBA-D. I am a father of four children and have been a licensed psy-

chologist since 1982. I am a past chair and chair elect for Division V (Psychopharmacology) of the California Psychological Association. For the past 30 years I have been involved in programmatic NIH research on neurodevelopmental disorders as part of my core faculty role as a professor of clinical psychology at the California School of Professional Psychology of Alliant International University. I have been teaching psychopharmacology to graduate students for the past several years. I also have served as the director and CEO of a midsize corporation providing multidisciplinary care to persons with neurodevelopmental disorders. I see training in psychopharmacology and the potential to achieve prescriptive authority as critical to the future of clinical psychology as we move toward integrative healthcare in the United States. I strongly believe that we are the only discipline of healthcare providers that can give balance to our medical colleagues for evaluating the efficacy research involving psychotropic medications, and in particular the alternative methods of evidence-based interventions that also show efficacy for the treatment of mental disorders. As a member of the board of Division 55, I would be committed to supporting the efforts of the division to secure its mission.

Cherie B. Ruben, PhD

I am seeking your consideration for a Member-at-Large position of Division 55. I received my BA (summa cum laude) from Columbia University (1987) and my PhD from Syracuse University (1992). I underwent Prescribing Psychologists' Register's Psychopharmacology training (coursework, preceptorship) and passed both their exam as well as APA's PEP exam (2001). In 2007, the American Board of Medical Psychology granted me their specialty board certification.

I am currently on the NYSPA (New York) Prescriptive Authority Task Force. I specialize in depression and outreach. I am one of the only psychologists in Western New York conducting home visit psychotherapy to the under-served (geriatric, medically disabled, rural).

As various states move forward in their efforts to gain prescriptive authority for psychologists, I stand firmly for the strategy emphasizing the need to reach these under-served populations. At times there seems to be even a crisis accessing available prescribers. Until we

have the ability to prescribe, our training enables us to be competent collaborators with PCPs when psychiatrists cannot be involved. Please consider electing me to further our psycho-pharmacological mission.

Candidates for APAGS Representative

Anthony Biduck

No statement received.

Andrea Krunnfusz

Withdrawn from the election.

Joseph C. Walloch, MA

My name is Joseph C. Walloch and I'm currently a 4th year student in clinical psychology at CSPP at Alliant International University, San Francisco and I'm writing to gain your vote for the APAGS representative position for APA Division 55. I've been a member of APAGS since 2010 and have remained abreast of the new developments in the field, especially the great strides made for the advancement of psychopharmacotherapy among psychologists.

As a training psychologist, I'm enthused about the opportunity to be a part of the board in hopes of serving as an outreach member to other graduate programs in clinical psychology. One of my proposed potential roles would be to serve as a liaison, helping promote the benefits of education in pharmacotherapy and the post-doctoral training programs in psychopharmacology to novice psychologist trainees who may not yet be familiar with this type of training and what it entails.

As we move into the future where integrative health care will become more of the norm rather than the exception, it is imperative that psychologists take a more proactive role in educating themselves about the advantages of learning more about the important role psychopharmacotherapy can play in patients' treatment, and also about the benefits of becoming a prescribing medical psychologist, not only for the psychologist, but also for the patient. As an enthusiastic trainee, I would like to have the opportunity to be a part of Division 55's board to help promote the advancement of prescriptive authority for psychologists. Thank you.

An Overview of Commonly Used Over-The-Counter and Herbal Psychopharmacology

Julie L. Kangas and Aldo Rossi

Department of Psychology
Southern Methodist University
Dallas, TX

It is estimated that over-the-counter (OTC) and herbal medications are used by the majority of adults worldwide (LaFrance et al., 2000). Though this form of medication is not typically as potent as prescription medication, misuse and overuse may lead to serious health consequences. Misuse and overuse are even more likely due to frequent self-diagnosing, self-prescribing, and lack of monitoring by health professionals (Charlton, 2005). It is further estimated that 70% of patients do not inform their doctors when using OTC and herbal medications (LaFrance et al., 2000), which may lead to serious drug interactions and may either enhance or decrease the effectiveness of other prescriptions. The purpose of this article is to review commonly used herbal and OTC psychopharmacology, discuss the potential interactions and side effects of these medications, and references studies supporting their medicinal benefits. This article is intended to aid psychologists in educating patients about the ramifications of not reporting medication use, identifying patient's side effects and use of OTC and herbal medication, and understanding how to proceed with patients interested in non-prescription psychopharmacology.

Correspondence concerning this article should be addressed to Julie L. Kangas, Department of Psychology, Southern Methodist University, P.O. Box 750442, Dallas, TX 75275-0442. Email: jkangas@smu.edu

OTC and Herbal Psychopharmacology for Depression

St. John's Wort

St. John's Wort extracts have many components, and the exact composition varies according to the extraction method. The antidepressant mechanisms are not entirely understood but among ten active ingredients, Hypericin activates dopamine receptors and blocks reuptake of serotonin and norepinephrine and Adhyperforin acts as a GABA reuptake inhibitor. In a meta-analysis of 23 trials, St. John's Wort was seen to be more effective than placebo and similarly effective as other antidepressants (Linde et al., 1996) in reducing depressive symptoms. It has also been seen to be more effective than fluoxetine in treating mild to moderate depression (Fava, Alpert & Nierenberg, 2005). Taking St. John's Wort along with other selective serotonin reuptake inhibitors (SSRIs) can cause serotonin syndrome, resulting from too high of serotonin levels in the body (NCCAM, 2013), causing diarrhea, tremors, confusion, a drop in body temperature, photosensitivity, and, in rare cases, death. St. John's Wort alters liver metabolism and weakens the effectiveness of prescription medications including antidepressants, birth control, digoxin, HIV medications, cancer medications, and warfarin (NCCAM, 2013).

S-adenosylmethionine (SAM-e)

S-adenosylmethionine (SAM-e) is a natural chemical found in the body. Studies have shown SAM-e to act as a mild tricyclic antidepressant (Papacostas et al, 2010). Studies have also demonstrated SAM-e's ability to de-

crease pain from osteoarthritis (Bradley et al., 1994) and lower bilirubin levels (Hardy, Coulter & Favreau, 2003). There are many precautions that should be considered before taking SAM-e supplements. There have been reports of SAM-e causing those with bipolar disorder to convert depression to mania (Friedel, Goa & Benfield, 1989). SAM-e is shown to increase serotonin levels in the body and thus should not be taken with prescription SSRIs to avoid the risk of serotonin syndrome (Memorial Sloan Kettering Cancer Center, 2011). It has also been reported to alter the common Parkinson's medication, levodopa, decreasing its effectiveness (Ehrlich, 2013). Some side effects of SAM-e supplements include headache, mildly upset gastro-intestinal tract, gas, nausea, and vomiting.

Omega-3

Omega-3 is a polyunsaturated fatty acid (PUFA) that is necessary for human health but is not naturally produced by the body. It plays an essential part of the central nervous system, as 20% of brain mass is made up of PUFAs. Levels of omega-3 have decreased in diets of western countries, creating a need for more purposeful consumption of omega-3 (Logan, 2004). The mechanism of Omega-3 in reducing depression is unclear, but it is speculated that increasing the fatty acids of the brain increase the permeability of the brain. Omega-3 has been shown to improve depressive symptoms and protect against bipolar disorder and seasonal affective disorder (Logan, 2004). Omega-3 supplements have been shown to have drug interactions with prescription medications including an increased effect of blood thinning medications, increased blood pressure levels, increased blood sugar fasting levels when taking blood sugar lowering medications, and kidney failure in patients taking transplant medications such as cyclosporine (Hawkins, 2007). It has also been found to have positive interactions with prescription medications including improvement of psoriasis symptoms when using topical steroids, increasing effectiveness of cholesterol lowering medications, and reducing risk of ulcers when taking anti-steroidal anti-inflammatory drugs (Logan, 2004). Side effects of omega-3 supple-

ments include upset stomach, nausea, and loose stools (Hawkins, 2007).

5-hydroxytryptophan

5-Hydroxytryptophan is an intermediate metabolite in the conversion of essential amino acid L-tryptophan to serotonin. It is naturally produced by the body, but

when taken orally is absorbed into the bloodstream where it can cross the blood brain barrier and increase CNS synthesis of serotonin (Birdsall, 1998). 5-Hydroxytryptophan has been seen to

have a more rapid anti-depressive response over other antidepressants, and in a double-blind study, 91 out of 161 saw improvement in their depressive symptoms (Birdsall, 1998). Due to the direct effect on serotonin levels, serotonin syndrome is a risk when taking 5-hydroxytryptophan supplements with SSRIs (Turner & Blackwell, 2005). Another risk factor has been eosinophilia myalgia syndrome, a condition linked to contaminated L-tryptophan, resulting from production methods using bacterial fermentation with inadequate filtration. Improved methodologies have eliminated this risk in recent years (Das et al., 2004).

Nutritional supplements

There is recent evidence that nutritional supplements may improve both symptoms and quality of life in adults with depression. A double-blind study by Lewis and colleagues (2013) administered vitamin B supplements or placebo to 60 participants diagnosed with major depression and other depressive disorders. After two months, participants who received the vitamin B supplements demonstrated moderate short-term improvements in depression, anxiety, and overall mental health with no adverse side effects (Lewis & Tiozzo, 2013). Another group studied the relationship between magnesium intake and depressive symptoms. This cross-sectional study assessed magnesium intake of 402 participants over a 12-month period. Controlling for other demographic and lifestyle factors, an inverse relationship between magnesium intake and depressive symptoms was observed. This could have promising implications in depressive patients who may benefit from magnesium dietary supplements if levels

There is recent evidence that nutritional supplements may improve both symptoms and quality of life in adults with depression.

are low in their current diets (Yary, Aazami, & Solei-mannejad, 2013).

Light therapy boxes

Light therapy boxes are most commonly used for patients with depression resulting from seasonal affective disorder, in which patients develop depression in seasons with less sunlight. Most research on light therapy boxes with mood disorders lack important aspects of a clinical trial design because of the challenges in creating an acceptable placebo (Golden & Gaynes, 2005). One review found that light box therapy that utilized at least 2,500-lux white light for two hours daily or 10,000-lux for 30-mins daily were similarly effective (Tam, Lam & Levitt, 1995). Common side effects include headache, eyestrain, nausea, and agitation. The light may also irritate some skin conditions and may be linked to transitions to hypomania or mania in patients with bipolar (Golden & Gaynes, 2005).

OTC and Herbals for Anxiety and Sleep Disturbance

Kava Kava

Kava Kava, also known as piper methysticum, is a tall shrub on the islands of the Pacific Ocean. It is traditionally used by grounding the plant to a pulp and mixing it in cold water, though it also comes in the forms of dried extracts, tablets, capsules, and liquid drops. The active ingredient is kavalactone, with effects described as being similar to alcohol. The exact mechanism in which kavalactone works is not known, but speculations include the modulation of GABA activity, inhibiting MAO-B, inhibiting norepinephrine reuptake, and acting as a CB1 agonist (Sarris, LaPorte & Schweitzer, 2011). Kava Kava is commonly used to treat insomnia, anxiety, and nervous disorders, but it is not advised to take Kava Kava if one has depression, liver disease (e.g., hepatitis), or Parkinson's disease. Damage to the liver is a risk when taking Kava Kava, and consuming alcohol will increase this risk. It is also seen to increase the effects of anticonvulsants, diuretics (leading to dehydration), and CNS depressants such as benzodiazepines and Xanax (Ehrlich, 2011a).

Valerian Root

Valerian Root is most commonly used for insomnia, though it was used during World War II to treat anxiety and "shellshock." Its interaction with the GABA system is not fully understood but is suspected to interact with glutamic acid decarboxylase (Awad et al., 2007). It is usually combined with other herbs that cause

drowsiness, such as hops or lemon balm. It is recommended to take two hours before bedtime, though it may not take effect until after two weeks of use (Ehrlich, 2011b). Valerian Root is commonly favored as an

insomnia remedy because it does not cause drowsiness upon awakening, unlike many other alternatives (Bent & Padula, 2006). Common side effects are headaches, drowsiness, dizziness, allergic skin reactions, and excitability and/or uneasiness (i.e., paradoxical stimulation). It is also reported to cause minor depression and apathy. Additive effects may be experienced with other depressants; therefore it is not advised to take Valerian Root under the influence of alcohol or while using prescribed depressants such as benzodiazepines (Ehrlich, 2011b).

Melatonin

Melatonin is a hormone in the body synthesized from serotonin. It is the primary regulating hormone of circadian rhythms and plays a large role in initiating and maintaining sleep. Human melatonin plasma levels are highest during the dark part of the night and lowest during the day. It is synthetically made as a daily supplement. Melatonin is commonly used as a remedy for insomnia due to high blood pressure medications or ADHD. It has also been reported to help children with sleep disorders; however, it is not recommended for healthy children due to the risk of melatonin affecting other hormones throughout development (Weiss, Wasdell, & Bomben, 2006). Melatonin also serves as a sleep aid for patients who have recently stopped taking benzodiazepines and has been shown to help adjust to jet lag (Buscemi & Vandermeer, 2005). Patients experiencing delayed sleep phase syndrome have also reported benefits from melatonin (USNLM, 2013). Side

Most research on light therapy boxes with mood disorders lack important aspects of a clinical trial design because of the challenges in creating an acceptable placebo.

effects of melatonin include headache, short-term feelings of depression, daytime drowsiness, dizziness, stomach cramps, and irritability. It may also increase blood sugar levels, which should be monitored carefully in diabetes patients taking melatonin. It may also increase depressive symptoms and may increase the risk of having a seizure for patients with seizure disorders (USNLM, 2013).

Chamomile

Chamomile has had documented uses for thousands of years, but very little research has been invested in this herb. The white flower is used to make teas and extracts which may be consumed or washed in the mouth but may also be used as a topical cream or taken in pill form (NCCAM, 2012). The active component of chamomile, apigenin, binds to the same receptors as benzodiazepines (Avallone et al., 2000). The most common use for chamomile is to remedy anxiety and gastrointestinal issues and to aid sleep. There are allergic reactions to chamomile, which has relations to plants in the daisy family such as ragweed, marigolds, chrysanthemums, and daisies. These allergic reactions have caused symptoms such as skin rashes, swelling in the throat, shortness of breath, and anaphylaxis. Chamomile contains small amounts of coumarin, which may cause mild blood thinning if chamomile is consumed in high doses and will increase the effect of warfarin and any other blood thinning medications. It is also speculated that chamomile might have similar effects as estrogen, which may decrease the effect of birth control and estrogen pills (NCCAM, 2012).

Other OTC and Herbals

Ginkgo supplements

Ginkgo supplements are derived from the leaves of a Ginkgo tree. Ginkgo can be taken in pill form or the leaves may be used to make tea (USNLM, 2013). The exact mechanism of ginkgo is not known, but it is speculated that the flavonoids, terpenoids, and organic acids in the leaves act as free radical scavengers. The most common use of Ginkgo is to increase blood flow, specifically to the brain to help memory loss, headache, difficulty concentrating, hearing disorders, and mood

disorders (Ihl, 2012). Other uses include improving circulation and treating leg pain. There have also been reports of Ginkgo relieving tenderness in the breasts in premenstrual syndrome, improving vision for those with glaucoma, and improving color vision in diabetes patients, but there are mixed reviews on the efficacy of the herb (National Institute of Health [NIH], 2013;

USNLM, 2013). Some common side effects reported include upset stomach, headache, dizziness, constipation, forceful heart contractions, and allergic reactions. While consuming the leaves is safe, eating cooked seeds can have

severe side effects like difficulty breathing, weak pulse, seizures, loss of consciousness, or shock (NIH, 2013). Fresh seeds are considered poisonous and could lead to seizures or even death. Ginkgo has also been shown to have blood thinning properties, so patients are advised to stop taking ginkgo at least two weeks before surgery (NIH, 2013).

Potential use of herbal remedies for children

There is some evidence of effective use of the above herbal remedies in children (see Kemper & Shannon, 2007 for a review). There are also novel herbal remedies under current testing for use in children. For example, a mix of extracts from St. John's Wort, Valerian root, and Passionflower in a 120mg tablet was administered to 115 children with behavior problems 2-3 times daily. After being assessed by physicians, 81.6-93.9% of children with problems with attention, social withdrawal, anxiety, and depression had symptom elimination or reduction in 9 out of 13 observed symptoms (Trompetter & Weiss, 2012). This herbal mix could be desirable for parents who prefer alternative therapies to avoid side effects from chemical medication.

Another herb, originating in Japan, has been found to be beneficial treatment for children as well. A group of medical doctors out of Japan explored the effects of the herb called Yoku-kan-san-ka-chimpi-hange (YKCH) on psychogenic dizziness in children. Prior to this study, no conventional pharmacotherapy was available to treat psychogenic dizziness in children due to the potential adverse reactions from medications used

Chamomile has had documented uses for thousands of years, but very little research has been invested in this herb.

by adults. YKCH was administered to four pediatric patients with cases of pediatric psychogenic dizziness. Of the four patients, three showed significant improvements after four weeks while the fourth was unable to continue the medication. This study shows the impact YKCH can have on pediatric psychogenic dizziness patients who previously were unable to be treated sufficiently (Goto & Morimoto, 2013).

Discussion

Use of herbal and OTC medications is common and is often without medical advisement or supervision. It is important for doctors and patients to be educated about potential drug interactions and side effects, but it is also important for our field to continue research on the impact of herbal and OTC psychopharmacology on other prescribed medications and on patient well-being. One important risk posed from herbal medications is that this industry is not regulated by the FDA. This means the ingredients, effectiveness, and safety of the products are not well monitored, and the way each ingredient interacts with prescription medications is not completely understood. Though there is a strong base in the literature supporting the benefits of herbal remedies, there is not a large incentive for drug companies to invest in research or efficacy trials because natural supplements cannot be patented. Without a patent, corporations are unable to make a sizable and secure profit. However, it is important to remember that many active ingredients in drugs commonly provided in hospitals, prescribed by doctors, and purchased over-the-counter were derived from botanical sources (e.g., morphine from poppy, aspirin from willow bark, atropine from Belladonna tops, digitalis from foxglove). This demonstrates the potential that herbal ingredients can have, if given adequate research.

While risks are posed in the lack of FDA regulation and lack of doctor supervision over the use of herbals and OTC psychopharmacology, there is potential benefit for patients suffering from a variety of psychiatric issues. Patients suffering from common symptoms of depression, anxiety, and insomnia may find beneficial effects with potentially less side effects than prescription medication. These medications may also help patients easily transition out of prescription treatments. Children could also potentially find benefit, especially those whose parents are hesitant to administer prescription medications. The potential and implications

for herbals and OTC psychopharmacology the psychiatric field should not be overlooked.

References

- Avallone, R., Zanolli, P., Puia, G., Kleinschnitz, M., Schreier, P., & Baraldi, M. (2000). Pharmacological profile of apigenin, a flavonoid isolated from *Matricaria chamomilla*. *Biochemical pharmacology*, *59*(11), 1387-1394.
- Awad, R., Levac, D., Cybulska, P., Merali, Z., Trudeau, V. L., & Arnason, J. T. (2007). Effects of traditionally used anxiolytic botanicals on enzymes of the γ -aminobutyric acid (GABA) system. *Canadian journal of physiology and pharmacology*, *85*(9), 933-942.
- Bent, S., & Padula, A. (2006). Valerian for sleep: A systematic review and meta-analysis. *The American Journal of Medicine*, *119*, 1005-1012.
- Birdsall, N. D. (1998). 5-hydroxytryptophan: A clinically-effective serotonin precursor. *Alternative Medicine Review*, *3*(4), 271-280.
- Bradley J. D., et al. (1994). A randomized, double blind, placebo controlled trial of intravenous loading with S-adenosylmethionine (SAM) followed by oral SAM therapy in patients with knee osteoarthritis. *Journal of Rheumatology*, *21*, 905-11
- Buscemi, N., & Vandermeer, B. (2005). The efficacy and safety of exogenous melatonin for primary sleep disorders. a meta-analysis. *Journal of General Internal Medicine*, *20*(12), 1151-1158.
- Charlton, B. G. (2005). Self-management of psychiatric symptoms using over-the-counter (OTC) psychopharmacology: The S-DTM therapeutic model—Self-diagnosis, self-treatment, self-monitoring. *Medical hypotheses*, *65*(5), 823-828.
- Das Y. T., Bagchi M., Bagchi D. & Preuss H. G. (2004). Safety of 5-hydroxy-l-tryptophan. *Toxicol Lett*, *150*, 111–22.
- Ehrlich, S. D. (2011a). *Kava kava*. Retrieved from <http://umm.edu/health/medical/altmed/herb/kava-kava>
- Ehrlich, S. D. (2011b). *Valerian*. Retrieved from <https://umm.edu/health/medical/altmed/herb/valerian>
- Ehrlich, S. D. (2013). *S-adenosylmethionine*. Retrieved from <http://umm.edu/health/medical/altmed/supplement/sadenosylmethionine>
- Fava, M., Alpert, J., Nierenberg, A. A., Mischoulon, D., Otto, M. W., Zajecka, J., & Rosenbaum, J. F. (2005). A double-blind, randomized trial of St John's wort, fluoxetine, and placebo in major depressive disorder.

- der. *Journal of Clinical Psychopharmacology*, 25(5), 441-447.
- Friedel H. A., Goa K. L., Benfield P. (1989). S-adenosyl-L-methionine: A review of its pharmacological properties and therapeutic potential in liver dysfunction and affective disorders in relation to its physiological role in cell metabolism. *Drugs*, 38, 389-416.
- Golden, R. N., & Gaynes, B. N. (2005). The efficacy of light therapy in the treatment of mood disorders: A review and meta-analysis of the evidence. *The American Journal of Psychiatry*, 162(4), 656-662.
- Goto, F., & Morimoto, N. (2013). Treating pediatric psychogenic dizziness with a Japanese herbal medicine. *The Journal of Science and Healing*, 9(1), 41-43.
- Hardy, M., Coulter, S., & Favreau, J. (2003). S-adenosyl-L-methionine for treatment of depression, osteoarthritis, and liver disease: Summary. *AHRQ Evidence Report Summaries*.
- Hawkins, E. B. (2007). Possible interactions with: omega-3 fatty acids. Retrieved from <http://umm.edu/health/medical/altmed/supplement-interaction/possible-interactions-with-omega3-fatty-acids>
- Ihl, R. (2012). Ginkgo biloba extract egb 761: clinical data in dementia. *International Psychogeriatrics*, 24(1), 535-540.
- Kemper, K.J. & Shannon, S. (2007). Complementary and alternative medicine therapies to promote healthy moods. *Pediatric Clinics of North America*, 54, 901-926.
- LaFrance, W. C., Lauterbach, E. C., Coffey, C. E., Salloway, S. P., Kaufer, D. I., Reeve, A., ... & Lovell, M. R. (2000). The Use of Herbal Alternative Medicines in Neuropsychiatry: A Report of the ANPA Committee on Research. *The Journal of Neuropsychiatry and Clinical Neurosciences*, 12(2), 177-192.
- Lewis, J. E., Tiozzo, E., Melillo, A. B., Leonard, S., Chen, L., Mendez, A., ... & Konefal, J. (2013). The effect of methylated vitamin B complex on depressive and anxiety symptoms and quality of life in adults with depression. *ISRN psychiatry*, 2013.
- Linde, K., Ramirez, G., Mulrow, C. D., Pauls, A., Weidenhammer, W., & Melchart, D. (1996). St John's wort for depression—an overview and meta-analysis of randomised clinical trials. *BMJ*, 313(7052), 253-258.
- Logan, A. C. (2004) Omega-3 fatty acids and major depression: a primer for the mental health professional. *Lipids Health*, 3(25).
- Melatonin. (2013). *Medline Plus: A service of the U.S. National Library of Medicine, National Institutes of Health (NIH)*. Retrieved from <http://www.nlm.nih.gov/medlineplus/druginfo/natural/940.html>
- Memorial Sloan Kettering Cancer Center. (2011). *Sam-e*. Retrieved from <http://www.mskcc.org/cancer-care/herb/sam-e>
- National Center for Complementary & Alternative Medicine (2012) *Chamomile*. Retrieved from <http://nccam.nih.gov/health/chamomile/ata glance.htm>
- National Institutes of Health. (2013). *Ginkgo*. Retrieved from <http://www.nlm.nih.gov/medlineplus/druginfo/natural/333.html>
- National Toxicology Program. (2013). Toxicology and Carcinogenesis Studies of Ginkgo biloba Extract (CAS No. 90045-36-6) in F344/N Rats and B6C3F1/N Mice (Gavage studies). National Toxicology Program technical report series, (578), 1.
- Sarris, J., LaPorte, E., & Schweitzer, I. (2011). Kava: a comprehensive review of efficacy, safety, and psychopharmacology. *Australian and New Zealand Journal of Psychiatry*, 45(1), 27-35.
- St. John's Wort and Depression. (2013). *National Center for Complementary & Alternative Medicine*. Retrieved from <http://nccam.nih.gov/health/stjohnswort/sjw-and-depression.htm>
- Tam E. M., Lam R. W. & Levitt A. J. (1995). Treatment of seasonal affective disorder: a review. *Canadian Journal of Psychiatry*, 40, 457-466
- Trompeter, I., Krick, B., & Weiss, G. (2013). Herbal triplet in treatment of nervous agitation in children. *Wiener Medizinische Wochenschrift*, 163(3-4), 52-57.
- Turner, E. H., & Blackwell, A. D. (2005). 5-Hydroxytryptophan plus SSRIs for interferon-induced depression: synergistic mechanisms for normalizing synaptic serotonin. *Medical hypotheses*, 65(1), 138-144.
- U.S. National Library of Medicine (2013). *Ginkgo*. Retrieved from <http://www.nlm.nih.gov/medlineplus/druginfo/natural/333.html>
- Weiss, M., Wasdell, M., & Bomben, M. , (2006). Sleep hygiene and melatonin treatment for children and adolescents with ADHD and initial insomnia. *Journal of the American Academy of Child and Adolescent Psychiatry*, 45(5), 512-519.
- Yary, T., Aazami, S., & Soleimannejad, K. (2013). Dietary intake of magnesium may modulate depression. *Biological Trace Element Research*, 151(3), 324-329.

Making a Real Difference

Patrick H. DeLeon, PhD
Former APA President



Patrick H. DeLeon, PhD

Having served for nearly four decades on Capitol Hill, I remain impressed by the astute observation of former APA Congressional Science Fellow Neil Kirschner, more than a decade ago, at our annual convention in Toronto: “More often than not, research findings in the legislative arena are only valued if consistent with conclusions based upon the more salient political decision

factors. Thus, within the legislative setting, research data are not used to drive decision-making decisions, but more frequently are used to support decisions made based upon other factors. As psychologists, we need to be aware of this basic difference between the role of research in science settings and the legislative world. It makes the role of the researcher who wants to put ‘into play’ available research results into a public policy deliberation more complex. Data needs to be introduced, explained, or framed in a manner cognizant of the political exigencies. Furthermore, it emphasizes the importance of efforts to educate our legislators on the importance and long-term effectiveness of basing decisions on quality research data.... If I’ve learned anything on the Hill, it is the importance of political advocacy if you desire a change in public policy.”

Katherine Nordal, Executive Director of the APA Practice Directorate, issued a similar challenge at last year’s State Leadership Conference, reflecting upon President Obama’s landmark legislative accomplishment: “The Affordable Care Act [ACA] has survived,

and implementation of the largest expansion of the health care safety net will proceed. But January 1st is really just a mile marker in this marathon we call health care reform. We’re facing uncharted territory with health care reform, and there’s no universal roadmap to guide us. One of the first steps in positioning for reform is for practitioners to recognize that they bring numerous professional skills and strengths to integrated care setting. Our practitioners increasingly will need to promote the value and quality they can contribute to emerging models of care. No one else is fighting the battles for psychology... and don’t expect them to. Health care is a marathon—we’re in it for the long haul. We can’t hope to finish the marathon called health care reform if we’re not at the starting line.”

Those of you who are working in Long-Term Care are to be truly commended. Many years ago, the late Powell Lawton of the Philadelphia Geriatric Center, who was a visionary in the field of healthy aging, shared his excitement about the potential contributions of the behavioral sciences to the future of our elderly. Even then, it was clear that our nation was rapidly aging and further, with the advances beginning to occur within the communications and technology fields, that it would be increasingly possible to bring unprecedented social-environmental changes (e.g., stimulation modules) to the lives of our most senior citizens, regardless of where they were residing. Today, there is considerable discussion at the national level regarding the ever-escalating costs of health care. The United States spends more on health care than any other industrialized nation, if not twice as much; and yet, our health outcomes are not comparably favorable. Further, the Institute of Medicine (IOM) reports: “Regions that deliver more services

do not appear to achieve better health outcomes than those that deliver less.” “In fact, underuse, misuse, and overuse of various services often put patients in danger.” It is estimated that 50+% of all resource expenditures in hospitals is quality-associated waste (i.e., recovering from preventable foul-ups, building unusable products, providing unnecessary treatments, and simple inefficiency). Health care systems need to be focused and accountable.

A number of the underlying provisions of the ACA are envisioned as building coordinated, patient-centered systems of care where psychology can contribute significantly to integrated care teams—regardless of the age or disability of the patient. Historical

procedure-oriented reimbursement mechanisms are to be steadily replaced with outcome-oriented metrics. Cross-provider and cross-diagnostic comparisons are increasingly being called for. We are optimistic that the critical psychosocial-economic-cultural gradient of “quality” health care will finally be appreciated by other disciplines and most importantly, by those who ultimately make financial decisions. As Katherine continues to emphasize, the ACA is merely a stage in the evolution of our nation’s health care environment.

Unfortunately for psychology, however, our profession is not expressly included in the underlying statute or implementing regulations of either the critical Accountable Care Organization or Patient-Center Medical Home provisions of the law. Further, although historically Medicaid has been the major source of financial support for long term care services, the profession of psychology has been significantly remiss in not being

actively involved. Accordingly psychology is not recognized in many state Medicaid programs. If one appreciates that law and business have long been the major professional backgrounds of those elected to Congress and reflect upon Neil’s observations, substituting “health care” for “research,” one can appreciate that we have a long way to go. And yet, there can be no question that our clinical expertise can make a real difference in the quality of life of our nation’s senior citizens.

Visiting Professor Ann Burgess at the Daniel K. Inouye Graduate School of Nursing, USUHS: “Sexual assault has no barriers to the victim’s age or gender. For example, in the Albert Lea case in Minnesota five teenage nursing

assistants were found guilty of sexual harassment and sexual assault of over a dozen male and female Alzheimer residents over a six month period. Court papers revealed that the nursing assistants were laughing as they talked of poking the breasts and genitalia of elders and taking pictures for online posting. Family members, after learning of the assaults, said they had noticed changes in behaviors but attributed it to advancing dementia or medication. This case emphasizes that therapy has no barriers as to age, gender, or mental capacity. There is the need for caregivers as well as family members to take seriously any patient complaint or behavior that has an oblique or direct sexual content. In addition, studies show that elder demented patients respond positively to expressive therapies, especially music therapy.” Will those who are working with Long-Term Care families take the next step to ensure that psychology’s expertise is appropriately recognized? Aloha.

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The next issue of *The Tablet* is due out in July and will include highlights of our activities planned for the APA Convention, August 7-10, 2014, in Washington, DC. Submit your articles for the issue to the Editor, Nicholas Patapis, PsyD, at npatapis@gmail.com, by **June 15, 2014**.

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