The Clinical Practitioner

National Alliance of Professional Psychology Providers

A Professional Association Representing the Interests of Psychology Doctors in the Health Care System

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E-mail:
admin@nappp.org

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New Local Referral Sources To Grow Your Practice

John Caccavale, Ph.D.

I always thought that I was a fairly good marketer after having created and ran a successful practice, both solo and group, for many years. Over that time period, I sought out and created many opportunities to grow my practice. Because marketing was always an important part of my professional engagement, I rarely, if ever, had any down time despite economic cycles. Never even had a managed care contract. Although managed care had penetrated California first and faster than in other parts of the country, I resisted the trend and developed my own plan to grow my practice. Fortunately, it worked. However, most recently, I was made aware of a marketing opportunity that I never even knew existed. Thanks to my psychologist daughter, Dr. Elle Walker, who obviously is much smarter than her dad, I was introduced to a referral networking group where a psychologist could develop local referrals without any competition!

The concept has been around for quite awhile and works like this. There is a national organization called BNI. They have chapters in every state and city. The sole purpose of the group is to promote referrals and marketing of your services. The rules of the group are simple: Only one person from a profession is allowed in the chapter at any one time.
This means if a psychologist joins the chapter no other psychologist can join. One of each profession or business can be represented. Chapters meet weekly and all are encouraged to help other members get referrals for their respective businesses or practices. Members also can receive all types of marketing and networking assistance.

This type of arrangement clearly has many benefits for psychologists. Since all members are local, the opportunities to meet and make important contacts are right before you.

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For example, making a contact with representatives of companies in your area who could arrange referrals. Other allied professionals, such as physicians and chiropractors, can provide psychologists with many referrals. The word of mouth alone can provide the psychologist member with referrals. All this in a group dedicated solely to growing your practice. Dr. Walker tells me that at her very first meeting, several of the members approached her to arrange referrals!

So where do you get this information? Go to www.BNI.com. On their website locate your state and city to find a local chapter. There you can see all the members who are represented with their business or profession. Immediately, you can see if there is a psychologist in the group. If not, that chapter is yours. There is an application process and you must provide references and agree to come to meetings, which is the whole idea of networking. Their website describes the whole process. I would suggest that everyone give this site a look and find a chapter nearby that you can join. On-going marketing is a must to both grow and maintain a practice.

NAPPP!

Your Practitioner Association Needs You and your Colleagues.

We Can Not Do the Work of Defending Practice

If Practitioners Sit on The Sidelines or are Apathetic.

You Must Recruit Your Friends to Help Build

A Strong and Nationwide Practitioner Association. You and Your

Local Colleagues are the Future of Practice!

When paying

your annual

practice association dues-

NAPPP is the first one

to

consider!

Work Continues On Mental Health Federation

The NAPPP sponsored federation of mental health professionals continues to march towards reality. Under the leadership of NAPPP director, **Dr. Jack Wiggins**, the proposed federation has been working on a mission statement and other issues related to starting a new organization. Several new groups have contacted Dr. Wiggins and expressed an interest in joining the new federation. Dr. Wiggins is psychology's consummate consensus builder and is moving the agenda along. It is expected that the new federation will be formed by the summer. This new organization will allow psychologists and other mental health practitioners to end the isolation and the losing strategy associated with isolation. This has kept us from working and speaking as a group with political power and the ability to form alliances that benefit both patients and mental health practitioners. To survive as a profession, we all need to work together.

Why Are We Failing To Achieve Major Practice Initiatives

Jerry Morris, PsyD, MBA, ABPP

Since one of the early RxP Bills was filed in Missouri in 1991 psychology has had RxP as a national agenda. This bold extension of practice initiative grew out of the "can do" and aggressive thinking of Pat DeLeon and pioneers in psychology who dare to take on "near impossible" tasks and stay with them until they happen. Over the years a handful of such bold leaders have moved psychological societies into major accomplishments (The Virginia Blues, CAPP vs. Rank, Medicare, Medicaid EPSDT, ERISA, EMTALA, independent diagnosis and practice, hospital privileges, admission and discharge and T-plan authorizations in CMHCs expert witness status in courts, state parity with physician rules, state licensure laws, etc).

The large practice iniatives have largely come from small groups of doctors outside the Governance and leadership of psychological associations and often they moved the psychological associations to have to collaborate and get on board.

None of these accomplishments were done with substantive financial and national grass roots organization by APA (which generally puts in a modicum of resources and depends on local psychologists to rise to the occasion and carry the day).

Louisiana and New Mexico RxP were largely accomplished by a handful of local psychologists with a tid bit (in the big picture of over a 100 million dollar budget, and $25,000-$35,000 Presidential Parties).

This trend continues with the RxP Movement. While APA spends between 7-15 million on web site renovation, millions on consultants for a 5 year plan, adds terrific expense and drain on dues as every faction clamors for designate Council Seats (with full financial and expense account support), and allows so called practice divisions to throw $30,000 parties/workshops with expensive academics giving presentations that are right out of their published books, practice doesn't move forward on the RxP Agenda. The PO contribution (to a national agenda) is miniscule when compared proportionally to web renovations, Convention Budgets, and the wealth of special project and discretionary funds in the budget. A practice division with a half-million dollar discretionary fund spends nothing on the national initiative, while one of the smallest practice divisions spends a proportional "widow's mite". No leadership comes to these divisions from APA to correct these situations. States are largely disorganized, lack APA leadership that keeps them from squandering grant money on pins, DVDs, and parties and there are no employed community and grass roots political organizers that lead states into more constructive and accountable use of grant resources. States are allowed to fail to collaborate with other psychological associations to the detriment of the local legislative agenda while scientific societies are given

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standing in national and state activities such as the February 2008 APA Council decision to attempt to establish APA Council seats for four national organizations of ethnic minority psychologists (American Association of Asian Psychologists, Association of Black Psychologists, Society of Indian Psychologists, and National Latino/a Psychological Association. This bylaw change, a remarkable break from protocol in which Council actually sought to give outside organizations voting rights on the APA functional board of directors (called Council in APA, and the so-called APA Board is actually functioning as an Executive Committee of the Board). This effort failed when Council had to submit the initiative to the membership due to the bylaw change. This type of thinking, along with APAs affiliation and dues breaks for APS and other scientific societies while practitioners can not even get the so-called APA Practice Divisions to forward a Council proposal to give practitioner associations the same affiliation and dues break (subsidy) is exemplary of the impalance away from support of practice that has grown in APA, APA so-called practice divisions and state associations (with boards that are increasing made up of academics and scientists) and in APA administrative staff. The APA Practice Organization (formerly the Practice Directorate) didn't even whimper against these continued imbalances and snubs of practitioners while subsidizing academic and special interest external associations at every turn.

Further evidence toward the drift of APA away from a practitioner focus is the recent hiring of a University President CEO, replacing of the Chief Financial Officer with Archie Turner (qualified, but clearly having a track record of management in scientific fields-The National Academy of Science. APA picked a very nice and talented doctor, Katherine Nordal for the Executive Director of the PO. She is nice, has some state and mildly significant national contributions, but she is no Nick Cummings, Rogers Wright, or other national practice leader that have changed American Psychology and have a commanding national healthcare leadership mantel.

Why are we failing to achieve major practice initiatives and establishing boots on the ground community, regional, and national action development strategies? There are several reasons. First, APA puts real resources into Books, Sales of Books and Journals, Web Sites that sell journals and books, real estate investments, parties/conventions and meeting, state association and division management (accounting, banking, service contracts and publishing), and assistance for career and grant development for academics and scientists. These are APA's core businesses and focus. This is what they do well, like to do, and they are only drug into other business initiatives and activities kicking and fighting and digging in their heels. Thus, the first problem is that APA has a narrow core business, stays focused on it, and doesn't evolve efficiently when market and mission myopia becomes apparent.

The second problem is that they hire executives, mid-level managers, and consultants that fit their narrowly defined core business and market and mission myopia well and thus set up a perpetuation of their current problems and lack of adaptation to a changing market. The multi-million dollar web site and strategic planning consultants will not help practitioners, or even clearly identify the lack of real funding, management, and coordination of national practice agendas. Does APA think practitioners would rather see a 10-20 million dollar web side upgrade and strategic plan (I've done them and they generally turn out just the way management likes and they define the constricting parameters-remember, I'm also an MBA). Practioners would like a 20 million dollar investment in things that help practice like the almost forgotten hospital admitting and attending psychologist agenda, the RxP agenda, the fight against the biomechanization and over medicalization of mental and behavioral disorders, and the development of specific psychology solution focused initiatives such as assisting psychologists with funding and establishing and accrediting psychologist operated residential care centers as a cost effective alternative to expensive (and over-medicalized) psychiatric hospitals and wards, state hospitals, and psychiatric nursing homes. We would rather have a 10 million dollar initiative to add California to the RxP states (focused, boots on the ground, fighting in the trenches, and grass roots community organizers instead of parties/conventions, DVDs, pins, etc.). Psychologists would rather have external (to APA) dues and other subsidies for practice associations (like the academic and science associations).

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The third problem is that practitioners are confused and apathetic. Most of the top practitioners in America today are not joiners and are often not members of APA, state associations, and other psychological associations. They leave the thinking and doing to salaried and funded people who do not make a living on hour by hour piece work. They sometimes become satisfied with a spouse's income and a part-time boutique practice and lots of quality time off. They do not want more commitment, to share their part-time resources, and their focus is their patients and "the good life". They "leave the decisions and sacrifice to others and act bothered or indifferent when asked to contribute their time and resources". The result, like Congress, we do not get the brightest and best, most ethical and reasonable, and most insightful and experienced in the exigencies of practice and the healthcare industry making the decisions and shaping the future. This is a problem, sometimes nearly insurmountable, for APA and all psychological associations (and there are over 100 of them nationally. You simply can not get bold initiatives done with people who let other people pull their oar!

The fourth problem is that APA and all psychological associations in America are politically and corporately conceptualized rather than leadership and guild focused. People "get elected" and that means running a "popularity contest" rather than competency based and achievement based promotion. It means competition for votes, market share, and brand identity (number one, or the only one representing psychology) and this kills collaboration, pooling of resources, and real strategic planning which identified Situations, Options, Consequences and knits them together in a strategy. It leaves leaders nudging and begging rather than directing and establishing and maintaining a vision and strategy. Note the RxP debacles and chaos with no real APA leadership and coordination, no ability to work to form and maintain coalitions, and no ability to discipline coalition members of the last two years. Note, that as I ask for more substantive legislative grants, the provided a couple of $50,000 grants (up from about $15K), but failed to supervise what the money was spent to do, and it was again squandered.

So what is the good news? The good news is that psychologists are beginning to see these problems (and especially since they have been predicted before they evolved and then came true-good credibility regards the conceptualization). While APA has not moved aggressively to change any of its' ways and policies and vision, the pressure is mounting for them to do so. They are the big kid on the block and practitioners must discipline them by voting with their dollars and other means of balancing accountability and power. They must form and grow practitioner associations that are collaborating with each other, modeling practitioner focus and clarity of analysis, and must demonstrate competition and leverage among practitioner associations and use this dynamic to become a more influential force in policy and decision making. They must quit electing academics and scientists (brothers and sisters in psychology, but not in organizational politics and leverage) masquerading as practitioners to boards, committees, and management of associations. They must step up and fully fund PACs, attend grass roots legislative gatherings, and stand up aggressive for the use of any and all techniques which psychologists can master to treat our patients. We need bold people, a bold agenda, bold dues and resource investment strategies, and to know shiest from shinola!

You Need to Be one of the Bold and Beautiful

Go to NAPPP (http://www.nappp.org/) and Pick Up Your Oar!

If you are not a part of the solution, you are part of the problem!

What's In a Name?

John McCoy, PhD

In treating our patients, we operate under the assumption that certain issues require examination to improve their quality of life or prevent future complications. Unfortunately, there are insidious developments that have affected our profession and require our urgent attention, as well.

Some psychologists, astute in professional politics and knowledgeable of our competitors are already well aware of an enormously damaging media threat to our profession. There is a pervasive journalistic policy in which only physicians and dentists can be called 'Dr.' Psychologists are mentioned by name only, without 'Dr.' or their degree—PhD, PsyD or EdD. This unfortunate trend is not a random occurrence, but rather the result of many years of successful efforts by our competitors in the marketplace of mental health care.

It has spread coast to coast and is now so pervasive that there are only a few media outlets that still recognize our professional title. These include the New York Times, many small television stations and some small newspapers. Some psychologists have taken an apathetic view of this. Many are not interested in it because they believe that nothing can be done about it and don't want to be bothered. Others haven't yet noticed. There are a very few psychologists who say they don't care if they are called 'Dr.' or not. These include academics, who prefer 'professor' to 'doctor."

The style used in media outlets is greatly influenced by stylebooks published by the Associated Press and Reuters News Service. Others doctors, such as optometrists, veterinarians, scientists, academics, etc., are also to be referred to with their name only, with one bizarre exception. The Reuters Handbook for Journalists explains how 'doctor' can be used: "When used as a title for a physician, abbreviate to Dr. without a full stop. Do not use Dr. for doctors of philosophy, etc, but it can be used for archbishops and the like in preference to honorifics like Very Rev. or the Most Rev."

Reuters takes the position that some members of the clergy, particularly high-ranking Catholic clergy, who don't have a doctor's degree, can be called doctor, while psychologists and others who have earned a doctor's degree can't. If we run into trouble fighting this very peculiar policy, we could inform the Baptists or the leaders of other very large, non-Catholic religious leaders about it, and they probably would feel the need for action, as well.

The AP Stylebook states: "Use Dr. in first reference as a formal title before the name of an individual who holds a doctor of dental surgery, doctor of medicine doctor of osteopathy or doctor of podiatric medication degree: Dr. Jonas Salk." The only connection that I see between these four professions is that they deal
in blood. Apparently, you have to work with blood to be considered worthy of the title. AP notes some minor exceptions to this, however. The AP states that if the person is clearly identified as a psychologist, etc., then doctor can be used. In practice this is almost never done, however. I have never seen an example of it.

This policy is based on the illogical AP conclusion that the public frequently identifies "Doctor" only with physicians and therefore the public must be protected from non-physicians. Their conclusion is that the public must be protected from its own ignorance. This conclusion has been carefully and persistently influenced by the medical lobby, in my opinion. Transparently, they also refuse to identify us as PhD, which would be acceptable to most psychologist and differentiate us from physicians, if this were the real issue.

The media, however, brought this whole problem on itself by using doctor as exclusively synonymous with physician. I recently saw a caption on CNN that referred to a dermatologist as a "Skin Doctor." I have never seen a media outlet go to this extent to make doctor replace 'physician' or 'dermatologist.' Some younger people don't remember when the family physician had a sign on his or her door reading 'Physician and Surgeon.' In many big city yellow pages, some psychiatrists have their name listed under 'psychologists.' These are not cases where a psychologist practices with the psychiatrist, but rather a psychiatrist posing as a psychologist. The intent here is to dupe members of the public who don't know that psychiatrists are not psychologists.

I recently testified in a trial that was covered by a newspaper from a small city with a population of 14,000. Initially in the article, I was mentioned by my name only, followed by "a clinical psychologist." From that point on, I was listed as "McCoy," such as McCoy said this, etc. A psychiatrist there, who had almost no role in the trial, was addressed as Dr. throughout the article.

I was amazed that a newspaper this small had this policy so I called them. They stated without apology that they were "just following the AP style."

Many documentaries on national channels have interviewed or quoted psychologists or other scientists without identifying them as Dr., psychologist, PhD/PsyD/EdD, etc., leaving the public to wonder if the person has a graduate education or is a layperson interested in the topic.

I have learned that a number of psychologists have called the American Psychological Association over the past several years, asking them to face this problem and correct it. This remains a low priority at APA, however. In previous years, APA lacked any useful strategies and had no significant successes. Typically, APA staff told these psychologists that they were working on the problem by talking about it with reporters and others in the news field whenever they ran into them. A dismissive and sarcastic attitude from some APA staffers served to ward off such calls.

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Recently, faced with increasing criticism about the media problem, APA staff corresponded with the overseer of the AP Stylebook, Darrell Christian, in March and April of this year, presenting the case for showing psychologists as doctor, or with their degree, and simply asking AP to change their stylebook. AP response was that the stylebook would remain the same.

A number of psychologists told media outlets that asked to interview them or quote them, that they wouldn't participate unless they were addressed as Dr. Typically, they were quickly replaced with someone without such concern.

There are several more effective ways that the media problem might be addressed. The AP and Reuters policies can be perceived as mean spirited and unfair. The public would view the Reuters policy as carelessly written, a trait that editors aren't supposed to have. More troubling is the likelihood that they are they have been manipulated and influenced by the medical lobby. As supposed independent and fair operations, they certainly wouldn't like publicity to this effect.

Neither AP nor Reuters wants the public to see them as mean or easily manipulated. After all, their credibility and independence is their most important asset. I suspect that this would happen if it came down to a lawsuit against AP or Reuters. For this reason alone, they might make favorable changes. And, of course, it might be illegal or a valid case for civil action. That would correct the problem quickly.

When physicians, dentists, osteopaths, and podiatrists want to make a claim for the word doctor, and when media outlets oblige, they discriminate against not only us but optometrists, veterinarians, scientists, etc. Coalitions with these and other similar groups would help to change the onerous media style. Help from religious leaders affected by the policy might also help. The practice of refusing to identify us as PhD's underscores that the motive is not to protect the public from thinking we are physicians, dentists, or podiatrists.

I talked with APA staff about these possible solutions, however I couldn't convince them they should try anything aside from visiting with media staff and writing letters of request. When I asked about a coalition with others similarly affected, one APA staff member told me, "We have plenty of coalitions." Unfortunately, the ones they have are not intended to deal with this problem.

The legislative history behind this issue is very revealing. An attempt to make it illegal for us to be called doctor without always explaining that we are not physicians, recently failed in the U.S. House of Representatives. Basically, to do otherwise was to be treated as an unfair or deceptive act or practice against physicians, etc. The law was to be enforced by the Federal Trade Commission. Some would consider such behavior by physician-advocates to be unfair or deceptive actions against us, and it may very well be. The APA legal staff has so far declined to look at this, citing more pressing projects.

In this law we were referred to as "NPC's," or, "Nonphysician Clinicians, along with social workers, nurses, etc. It was filed by U.S. Rep. John Sullivan of Tulsa. Another member of the House explained that it failed, "because the House is not in the business of taking things away from people."

The PhD is the most prestigious degree in the world. It preceded the M.D. degree. In the 1600's, roughly, physicians were largely apparatus of the church. Surgeons took on a role that barbers could no longer fill.

There is a trade school quality to the training of physicians, dentists, etc., in that most of their time is spent in learning by observation and learning by doing. This type of education is not designed to produce scholars. It is the same type of format widely used by electricians, plumbers, etc.

The big question is when this started and why. This style has been spreading around the country for more than 25 years. The first reference to it that I found was in the 1980 AP Stylebook, which was then called, ironically, "The Associated Press Stylebook and Libel Manual." One psychologist thought it came from one of the early Emily Post books, but so far there is no evidence of this. Another thought that physicians planned it and saw to it that it was placed in effect by the wire services. Even some behavioral health insurance companies and EAP's have go to considerable length to avoid calling us doctor or PhD/PsyD/EdD. One of the largest refers to us by our name only, followed by LP. Apparently, this means licensed psychologist. Prior to this, this same company tried calling clinical psychologists 'professor,' again to avoid any reference to us as doctor. Why is this happening? Some think it would take a powerful group such as the AMA to bring it about. So far, however, there is no proof this occurred. So far no one knows. Certainly not the APA.

In June 2008, the AMA proposed a plan that would allow only physicians to be called 'doctor,' 'resident' or 'intern' in healthcare settings. They apparently anticipated better luck in hospitals and clinics than physicians have had with laws that sought to make it illegal for anyone to be called doctor aside from them and dentists, anywhere. The APA wrote the AMA about this, supporting use of doctor, resident and intern for psychological practitioners in medical settings, and asking AMA to alter their proposal in our favor. Letters of requests in these situations, as seen in the AP example, are not usually very effective.

The National Association for Professional Psychology Providers (NAPPP) then wrote a more direct letter to the AMA, stating in part, "Please be advised that should the AMA adopt the proposed Resolution 303, our organization will file a complaint before the Federal Trade Commission against the AMA for restraint of trade and for attempting to steal the property rights of licensed psychologists."

Reportedly, the AMA now is considering a plan where psychologists can be called doctor, resident or intern if their training and profession are made clear at each encounter with others in the health care setting.

Many years ago, the Nassau County New York Psychiatric Society sued Adelphi University's PhD program in clinical psychology because psychologists were using the title "doctor." The judge threw the case out.

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The title of 'doctor' is hard earned. Psychologists are troubled to see physicians, etc., attempting to attain it for their exclusive use. They are also distressed about the large number of people who have obtained bogus doctor's degrees over the internet, which are thought to be appropriately trained by the by the general public. In Tennessee, a man got a 'doctor's' degree in psychology in Peru and was refused a license by the TN Licensing Board twice. He finally received a license to practice psychology when a state legislator passed a special bill tailored for him personally. His graduate study lasted one year and nine months. One year out of this was in an internship.

Apparently, all of the state and federal attempts to make it illegal for us to be called doctor have failed. As a profession, we have done far better with the legal attacks that the media abuse. Sometimes politicians are called irrational, but they have been uniformly rational with these bills. Also, we must be vigilant to protect the professional gains we have already made.

Dr. McCoy is in private practice in Memphis, TN. psychmccoy@mindspring.com

APS-The Science and Teaching Powerhouse

An Academic Splinter Group further extends their separatism from APA by starting their own master's and doctorate psychology training program accrediting group. The APS (Association for Psychological Science formerly American Psychological Society) broke from APA when they decided that their psychology subindustry was not being adequately represented by the more diverse and amorphous national association. Now, they've taken the separatism to the next level-accredited training and establishing training standards.

A similar group of practitioners NAPPP has formed and established a practice focus and begun to write about what a skilled training faculty and curriculum dedicated to turning out healthcare psychologists would look like. The program gets affiliate status and dues abatement (subsidies) from APA and coordinates with over 45 inside and outside APA science and academic psychology groups (see their web site subsection at http://www.psychologicalscience.org/about/links.cfm). The University of Missouri counseling psychology proudly discusses it's master's programs for psychologists at the APS web site. They advertise how poorly most clinical training programs are and tout the programs that have actively moved to scientifically validated training and research as parts of their clinical programs. They have active involvement in APA Conventions, coordination of access to grant monies, and close association with many leaders in APA and other psychology organizations. Their 20 years of existence have been spent on solidifying collab oration among power groups representing science and teaching inside and outside of APA. Once viewed as a rouge and hated separatist group from APA, they are now a powerful and feared coalition of psychologists in the industries of science and teaching. They have powerful student organizations and an action group called RiseUp. They advertise the APA accredited clinical psychology training programs, have a jobs service for teachers, and run a competing journal and research data base with APA called questia.com. During March of 2008 the APS moved its' national offices to Washington, DC where it lobbies as the "voice of scientific psychology" directly in the face of APA. In May of 2008 APS formed a partnership with the magazine The Scientific American Mind (http://www.sciam.com/MindAPS). APS claims to represent 18,000 members. The organization gets right in APA's face with the statement that they represent the nations top scientists, academics, clinicians, researchers, teachers, and administrators (http://www.psychologicalscience.org/about/). Clearly, this is not true-but, it shows the "brand identity" that APS seeks ("we are more important than APA and represent the top psychologists in the country").

Even NAPPP is not that bold, arrogant, and anti-APA! Yet! NAPPP catches significantly more opposition than APS, and even from the "so-called APA practice divisions"! Perhaps, they don't understand the tradition at APA of embracing (academic and science) splinter groups!

Still, APS stands as a shining example of the necessity of building a separate power base that is more homogenous than APA and which can rally a cohesive focus to defend and extend sectors within the psychology industry. Their advocacy for teachers of psychology, psychological science, and control of the practice of psychology by teachers and scientist is firm. Their web site represents a smorgas board of the most interesting science in both psychology and neurology and genetics. Their capacity to infiltrate and become a massive political block in APA is admirable. They are so powerful and infiltrated that APA has dropped all early efforts to brand them as rouges, anti-APA, and outsiders. APA not only cooperates and collaborates with them, but subsidizes their membership in APA with dues discounts, and discounts for their affiliate scientist and teacher psychological associations and organizations.

It is possible that as psychology evolves and reaches the stage of a diverse set of mature industries that both a national general association and specific subindustry associations are becoming necessary. Certainly, the scientists and academics first realized this and are well on the way to making the transitions. Certainly, the nearly 50 science and teaching psychology associations and organizations in the US, supplemented by many similar international associations.

Practitioner are now in the unenviable position of defending against powerful, organized, focused, and homogenous groups both inside and outside APA. These groups lay claim to more than science and teaching training and skills but seek to claim dominion over practice theory, technique, and standards. They want to control how practitioners are trained, what level of practitioner may diagnose and treat patients, and which interventions they must use. They pretend to have the best psychologists who know the most about how to treat patients and run a practice. Their elitism extends to what they advertise, what they say to the Government, and is independent of APA and true practice organizations.

NAPPP has been around for just over two years!

Wouldn't it be great to be in the position of APS for our twentieth anniversary?

How APA must have lobbied against psychologists joining APS during the first 5 years and attempted to discourage membership!

Congratulations APS on your 20th Birthday! Your members courageously took on Goliath and walked off the field heroes. Are there enough heroes left in the practice community?

NAPPP Complains In AMA Restriction of Title Case & AMA Backs Off

National Alliance Of Professional Psychology Providers
P.O. Box 6263
Garden Grove, CA 92846
An Alliance Of Psychologists For Psychologists

NAPPP

June 12, 2008

David Lichtman, MD, Chair
AMA Reference Committee C, Medical Education
Director, Office of the House of Delegates Affairs
American Medical Association
515 N. State Street
Chicago, Il 60610

Dear Chairman Lichtman:

Please be advised that should the AMA adopt the proposed Resolution 303, our organization will file a complaint before the Federal Trade Commission against the AMA for restraint of trade and for attempting to steal the property rights of licensed psychologists. NAPPP is an organization that represents licensed clinical psychologists only, and we will fight any attempt to restrain our trade and diminish our rights. As healthcare professionals, we are amazed that our physician colleagues are so insecure that you feel the need to literally hijack a title that historically was never yours. While we realize that the AMA resolution has no impact in law, we believe that any attempt to take what is not yours must be fought vigorously and without hesitation.

NAPPP is a strong believer in collaborative practice. We try to instill in our members the value of working with physicians. This resolution will have the effect of creating an adversarial relationship that psychologists have tried to avoid. We remain surprised and clinically interested as to why some physicians need such a resolution. Does the AMA not think that there are no other more pressing issues to deal with?

Other psychology organizations may feel the need to try to appeal to your sense of reason but NAPPP has no such intent to do this. It is clear that the AMA seeks hegemony over all of healthcare at a time when consumers not only need choice but competent practitioners. So,
go ahead and pass your resolution. We accept that in a democracy, people and organizations have a right to engage in any activity or activities even if outright ridiculous and destructive.

However, these activities must not butt up against the nose of the next person. I would think that physicians would want to devote more attention to gaining more competencies and helping patients as opposed to spending time and resources trying to convince the public who are the "real" doctors. Psychologists need no such resolutions or laws because we have a degree and independent license that says we are doctors. Perhaps, you should take another look at your degree. If you do, I'm sure this will be all the validity that you will need to establish your appropriate title.

Very truly yours,

Dr. John Caccavale
Executive Director, NAPPP

US Public Health Service Hiring RxP Psychologists and Psychologists

The two US invasions and multiple deployments of national Guard soldiers has resulted in record levels of physically disabled veterans with emotional problems, veterans with marital and family problems, PTSD, depression and suicidal episodes in veterans. These problems are likely to represent a wide geographic distribution of veterans with mental health and psychological rehabilitation needs for the next decade or more. Consequently, the VA and US Public Health Services Corps is hiring psychologists.

Recently, interested psychologists were directed to make all DoD RxP psychology inquiries directly to the two following officers: CAPTAIN O'Neal Walker (RxP Psychologist), Director of Recruiting: Oneal.walker@hhs.gov (email best)

Or

LIEUTENANT COMANDER Christopher Dunbar at 240.453.6045
Christopher.dunbar@hhs.gov

Basic Directions:

1. Contact either officer for direct information on your particular duty station interest.
2. Visit web site, download an application, and submit it to the US Public Health Service Corps (NOT the two officers above): **usphs.gov**

You can also visit USPHS Commissioned Corps Management Information System web site for other specific information: **dcp.psc.gov**

Army Assignment Possibilities Summer 2008

Installations

This installations are listed in their order of overall priority. However different installations may have different needs for specialties.

Ft. Benning
Ft. Bragg
Ft. Stewart
Ft. Hood
Ft. Carson
Ft. Bliss
Ft. Knox
Ft. Campbell
Ft. Polk
Ft. Leavenworth
Ft. Drum
Ft. Riley
TAMC
WRAMC
EAMC
BAMC
MAMC
Ft. Leonard Wood
Ft. Sill
Ft. Wainwright

Air Force:

33 Bases with 35 openings

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Ward Lawson, PhD, ABPP

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In Missouri and MoNAPPP for 2008!

Dr. Lawson is the Director or a Rural Health Center and is

on the Board of Directors of MoNAPPP.

He is a former board member and Treasurer or the state psychological as-

Practitioner Focus

John McCoy, M.S., PhD, has been a clinical psychologist for 28 years and is in private practice in Memphis, TN. His interests include writing stories for several national publications on psychological issues, treatment of addicts and alcoholics, advocating for increased funding for A & D treatment in Tennessee (which is 48th in A & D funding nationally), and forensic psychology.

An Oklahoma native, he received an M.S. in psychology and a PhD in clinical psychology from Oklahoma State University. He did an internship in Memphis in the late 1970's and has remained there since. He is a activist in opposition to the widespread national media 'style' of calling only physicians, dentists and podiatrists 'doctor.' Media outlets typically omit 'PhD' in addiction to the title of doctor.

He was recently quoted in a small Mississippi newspaper for a city of 14,000 population regarding his testimony in a double murder trail. He notes that while he played the major defense role in the trail while a psychiatrist was there only briefly, the newspaper referred to him as "John McCoy, a psychologist," and thereafter as "McCoy," while consistently referring to the psychiatrist as 'Dr.' The newspaper staff said they were only following the Associate Press Stylebook, which doesn't recognize psychologists or other scientists as 'doctor.' He has been encouraging the APA to make this a high priority, so far without success.

Dr. McCoy is a practitioner member of NAPPP.

Neuroscience and Overcoming Biomechanistic Oversimplification

Many physicians, psychologists, and researchers have warned about the dangers of biological reductionism and of creating a false mind-body dichotomy. American healthcare has suffered many setbacks, much in the way of long-term side effects, and great and renowned silliness as a result of biological reductionism.

In a recent article, *Contributions of Neuroscience to Our Understanding of Cognitive Development, Diamond and Amso, in Current Directions in Neuroscience, Volume 17, number 2,* 2008 provides a more balanced approach and delineates the importance of environment on the expression and evolution of our biological sub strata. A major contribution of neuroscience to understanding cognitive development has been in demonstrating that *biology is not destiny.* The field has been repeatedly demonstrating the remarkable role of experience in shaping the mind, brain, and body. Even gene expression and actions at the brain's cell nucleus have been shown to be triggered, changed, and modified by experience and external factors.

Only rarely has neuroscience provided wholly new insights into cognitive development, but often it has provided evidence of mechanisms by which observations of developmental psychologists could be explained and delineated. If they can be explained and delineated, they may be controlled and guided. This is what psychologists have been saying for generations. It is good to see that neuroscience is catching up with the claims of psychologists since the late 1940s and 1950s.

Behavioral findings have often remained controversial until an underlying biological mechanism for them was offered due to a bioreductionistic prejudice that has been continually offered and reinforced by certain components of the medical and research establishments. Neuroscience has demonstrated promise for detecting cognitive problems before they are behaviorally observable—and, hence, promise for early intervention. However, the bioreductionistic prejudice threatens to oversimplify these interventions and confine them to biomechanistic entry points and techniques.

The article noted above gives examples drawn from imitation and mirror neurons, phenylketonuria (PKU) and prefrontal dopamine, maternal touch and stress reactivity, and nongenetic (behavioral) intergenerational transmission of biological characteristics to balance the approach.

Clearly, the Diamond and Amso paper chronicles definitive proof from rat licking and maternal touch studies, infant mimicking studies, and cognitive development that indicate that the environment is a major determinant of development and even gene expression. It is no longer scientific to maintain that mental illnesses and addiction are genetic disorder. Even the great Stephen Stahl, MD, PhD has acknowledged this in his recent 2008 book.

We are beginning to have both the information and the integrative capacity to move beyond mind-body dualistic boxes and bioreductionism and to think and intervene in much more sophisticated fashion. This increased depth and integrative capacity in science should usher in a new era of integration of primary care and the behavioral sciences. If used properly, it will change the staffing patterns and capacity to train the whole person in the nation's primary care centers and medical/surgical hospitals.

Northcentral University (NCU) and NAPPP Announce Post-Doctoral Master's Degree in Psychology with Specialization in Clinical Psychopharmacology

Northcentral University, working with **NAPPP**, has developed a specialization for its Master's of Arts (M.A.) degree in Psychology designed to educate psychologists and increase proficiency in understanding patients' needs for medication and collaborating with other healthcare providers to meet those needs. Students applying to NCU for the M.A. with a specialization in psychopharmacology will be required to hold a doctorate in clinical psychology.

Courses and curricula for the **10-course, 30 credit master's degree** have been developed by NCU faculty and staff in collaboration with NAPPP. All courses are offered online where the student has a one-on-one relationship with faculty and completes assignments using NCU's Learner web site. As part of the course work, students will complete a 1500 hour, 1 year internship with healthcare professionals. The internship in monitored by NAPPP. The purpose of the internship is to offer the students a supervised environment for gaining practical experience in working with patients and their physicians while learning about appropriate use of pharmaceuticals as part of treatment plans.

Northcentral University is an accredited online institution offering bachelor's, master's, and doctoral degrees in business, education, and psychology. NCU currently serves more than 5,000 Learners worldwide. For more information on the Master's degree in Psychology with a specialization in psychopharmacology, visit www.ncu.edu or call NCU at 866-776-0331.

Note: NAPPP members will receive a significant tuition discount amounting to several thousand dollars.

Science Tidbits

Schizophrenia

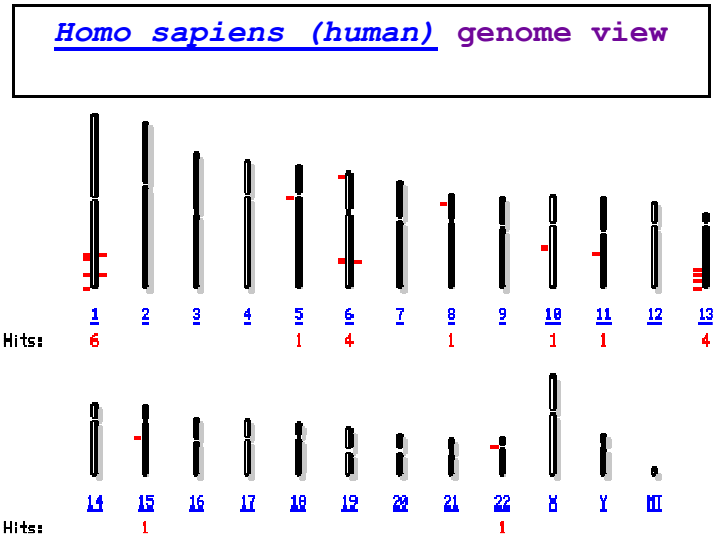
Just how many genes are suspected to be involved in developing schizophrenia? Check out MapViewer to see where some of the candidate genes lie in the human genome (http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=gnd.section.395&ref=toc).

Suspect genes include DTNBP1 and NRG1, and to a lesser extent, DISC1, DAO, DAOA and RGS4.

However, carriers of the at-risk genes only appear to be a slightly increased risk of schizophrenia, and some studies show no change in risk.

About 1 of 100 people develop schizophrenia in their lifetime - a psychiatric disorder characterized by delusions and hallucinations. Such symptoms often appear in the late teens and multiple relapses throughout adulthood can make it difficult to stay in employment and maintain personal relationships.
The cause of schizophrenia is unknown, but it seems likely that a person's DNA plays a role. Studies of genetically identical twins show that if one of the twins has schizophrenia, the other twin is 50% more likely to develop the illness, suggesting the importance of both environmental variables e.g., family relationships and exposure to stress, and the importance of genetic factors e.g., having a relative with the illness.

Many genes have been implicated in increasing a person's risk of developing schizophrenia, including Dysbindin (DTNBP1) and Neuregulin 1 (NRG1). Interestingly though, while scanning the genome to find areas that are linked to schizophrenia, similar areas were also found to linked to bipolar disorder (also known as manic depression). If these two diseases do share some genetic risk, perhaps they also share an underlying cause. Following such leads may eventually help us find a better treatment, if not a cure, for schizophrenia and other psychiatric diseases.



Trends in Prescription Medication Use

The Food and Drug Administration warned doctors recently that prescribing a certain group of psychiatric drugs to seniors suffering from dementia can increase their risk of death.

Antipsychotic drugs are approved to treat schizophrenia and bipolar disease, but doctors frequently prescribe them to treat elderly patients with dementia.

FDA's announcement was an update to a 2005 action, when regulators added warnings about increased heart attacks and pneumonia to drugs called atypical antipsychotic. The medicines include blockbusters like Eli Lilly & Co.'s Zyprexa and Johnson & Johnson's Risperdal.

FDA said Monday those same risks apply to 11 older drugs known as typical antipsychotics, including Pfizer's Navane and Endo Pharmaceutical's Moban. The drugs were developed in the 1950s and have largely been replaced by the newer medications, which are believed to have fewer side effects, such as tremors (atypical antipsychotics). In fact, newer data indicate that these atypical major tranquilizers have been shown to also create EPS as well as diabetes and weight gain with a myriad of physical and psychological complications.

Under FDA's orders, both drug types will now carry boxed warnings — the most serious a drug can carry — describing their risks to dementia patients.

Federal officials have repeatedly urged doctors not to medicate seniors unnecessarily. Despite such warnings, health professionals continue to prescribe psychiatric drugs "off-label," or for uses that have not been approved by FDA. About 20 percent of seniors in nursing homes who receive antipsychotics have not been diagnosed with psychiatric problems, according to data released by Medicare earlier this year.

While FDA regulates the approval and marketing of drugs, doctors are free to use their judgment when prescribing drugs.

The agency based its decision on two studies of a combined 65,000 seniors which showed those taking antipsychotics were more likely to die than those not on the drugs. Agency officials said it's not clear why antipsychotics hasten death. Scientists also could not determine from the data whether one group carries greater dangers than the other.

"We've struggled with this decision but we ultimately decided the data are strong enough to expand this label to drugs in both classes," said Thomas Laughren, director of FDA's psychiatric drug division.

The agency stressed there is "no approved drug for the treatment of dementia-related psychosis," and recommended doctors consider other treatment options.

"A lot of the things can be done to help change one's environment so elderly patients can be more oriented and engaged," said Dr. Eric Hollander, a professor at the Mt. Sinai School of Medicine. It has been long known any of the behavioral problems seen in seniors can be improved with simple, daily routines that patients can follow. Federal guidelines for facilities dictate that these interventions be attempted before resorting to major tranquilizers. However, due to the fact that there are no real and significant staffing guidelines that would make regular mental health doctors available to these facilities such behavioral and psychological plans are often poorly devised and are delivered by mid-level staff with little or no behavioral training.

Bipolar Disorder.
Why a Specialist is Needed to Provide Appropriate Treatment

Bipolar Disorder exists in many sub types, individual and family therapy needs are attached to this disease, and there are a myriad of complications to treating patients with mood disorders and their families. The common practice of diagnosis and treatment by general medical personnel and with medication only are further complicating the treatment of these patients and their families.

Recent evidence indicates that adolescents with bipolar disorder and comorbid substance use disorder have an elevated risk for suicide attempts, trouble with police, and, in the case of female patients, teenage pregnancy and abortion.

The risk posed by substance use is devastating in low ego strength and ensueing insight and judgment deficits and often with negative associates and social support systems. This risk far exceeds that associated with other predictors such as conduct disorder and non-intact families, note Benjamin Goldstein (University of Pittsburgh, Pennsylvania) and team who say targeted preventative strategies for averting substance use "are urgently needed." Clearly, the average general physician or pediatrician does not have the training or skills to adequately treat individuals with mood disorders, multigenerational family projection processes, substance abuse and addiction, and poor social and familial support systems. Medications have never been shown to cure mood disorders or handle these corollary individual and family and social system problems. The burden is just too much to expect a general physician armed only with the amount of mental health training of a high school teacher and anti-seizure medications and major tranquilizers or a rare earth salt! Yet America pretends that this disorder is treated with a pill and 12 minute meetings with a physician every 3 months. This represents a "healthcare delusional system" which is unscientific, illogical, and system rather than patient serving.

Despite the known association of substance use disorder with increased disease severity among adults with bipolar disorder, prior studies have not investigated this association among younger patients. Goldstein and colleagues interviewed 249 individuals, aged 12-17 years, who had a DSM-IV diagnosis of bipolar I disorder, bipolar II disorder, or bipolar disorder not otherwise specified.
The lifetime prevalence of substance use disorders was 16% in the total sample. Cannabis use disorders were the most common, with a lifetime prevalence of 12% among all adolescents and 73% among adolescents with a substance use disorder. Eight per cent of all adolescents had a lifetime alcohol use disorder, corresponding to 50% of subjects with any substance use disorder. The prevalence of other types of drug use (eg, cocaine, hallucinogens) did not exceed 3%.
Patients with a substance use disorder were less likely to be living with their parents and more likely to have experienced lifetime sexual and physical abuse than non-users. Notably, they were also more likely to get in trouble with the police (odds ratio[OR]=2.5), attempt suicide (OR=2.8), and fall pregnant in the case of females (OR=7.6).
Goldstein and colleagues note that alcohol use was relatively low among patients in the sample when compared with adults with bipolar disorder. They comment in the journal *Bipolar Disorders*: "Clinical and epidemiologic data suggest that the prevalence of alcoholism among these adolescents will increase approximately seven-fold by middle adulthood. "Clearly this presents an important opportunity for secondary prevention and early intervention that cannot be ignored."

Psychologists must speak out and advocate for improved protocols which include evaluation by a psychologist or psychiatrist (in any primary care center or hospital treating severe and persistent mental illness and standards which make these doctors available), individual and family therapy along with medication management, and careful and accurate diagnosis. Our silence on the state of treatment these patients and the indirect joining of the delusion of adequacy is poor patient advocacy.
http://www.psychiatrymatters.md/headlines/fullpage.asp?C=8728939591914375&svarqvp2=0&xml=/headlines/2008/may/week_20/substance_use_in_bipolar_disorder_associated_with_profound_hazards.xml&em=morris49@ipa.net

http://www.blackwell-synergy.com/doi/abs/10.1111/j.1399-5618.2008.00584.x

Your feelings have impact on economic transactions

People feeling sad and self-focused spend more money to acquire the same commodities than those in a neutral emotional state. To be published in the June 2008 edition of *Psychological Science* a new study follows up on earlier research that established a connection between sadness and buying. Cynthia Cryder, Jennifer Lerner , James J. Gross, and Ronald E. Dahl have now discovered that heightened self-focus drives the connection -- a finding that expands understanding of consumer behavior and, more broadly, the impact of emotions on decision-making. Self-focus helps to explain the spending differences between the two groups. Among participants "primed" to feel sad, those who were highly self-focused paid more than those low in self-focus. Notably, sadness tends to increase self-focus or introspection, making the increased spending prompted by sadness difficult to avoid. First, sadness and self-focus cause one to devalue both one's sense of self and one's current possessions. Second, this devaluation increases a person's willingness to pay more for new material goods, presumably to enhance sense of self. The study is an early step toward uncovering the hidden impact of different, fluctuating, and what would otherwise seem irrelevant emotions on our day-to-day decisions.

The article is available at several websites: Carnegie Mellon: http://www.contrib.andrew.cmu.edu/~ccryder/miseryisnotmiserly.pdf
Lerner Lab: http://content.ksg.harvard.edu/lernerlab/papers.php

Academy of Medical Psychology

Psychology's Prescription for Comprehensive Mental Healthcare

The Academy of Medical Psychology would like to extend an invitation to you to become a Member of an organization that is at the forefront of developments in Medical Psychology and psychologists pursuing Prescriptive Authority.

The Academy is a voluntary, not-for-profit organization with the purpose of registering psychologists who have completed a designated course of training and experience in the area of psychopharmacology and related sciences. The Academy is also involved with developing and promoting standards of practice, enhancing education, and promoting legislative advocacy in the area of medical psychology and prescriptive authority for psychologists. It is the intention of AMP to be helpful to State and Provincial Boards by identifying doctoral level psychologists who have completed an organized program of training in psychopharmacology.

As professional psychology continues to evolve, it is now essential for psychologists to demonstrate a solid understanding of the pharmacology of mental disorders. Psychologists are increasingly called upon to serve as knowledgeable collaborators in the medication management of their patients. Furthermore, as a result of strong national leadership and grass root efforts, psychologists are gathering increasing support and momentum for the expansion of our scope of practice to include prescriptive authority.

Consider the many important benefits of AMP Membership — Professional Development, Networking, Legislative Advocacy and Updates, Clinical Information, Recognition of your Training, and Representation to your State Board to name but a few. In addition, AMP provides an opportunity for students to track their Preceptorships on-line. AMP has also created the opportunity to pursue diplomate status through The American Board of Medical Psychology (ABMP). You want your training to matter and you know that Prescriptive Authority will allow you to be of greater service to your patients. Join AMP and work together with us to accomplish our goals.

Because of AMPs alliance with NAPPP, if you are a member of NAPPP, your first year AMP dues will be waived. So there is no cost to you to join AMP.

AMPs website can be accessed at www.amphome.org or you can contact Dr. Jim Meredith at psych99@sbcglobal.net for more information.

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NAPPP's Bill Of Rights For Practitioners

Preamble

All psychologists, in any stage of professional development, have the right to advocacy and support from a national organization that is dedicated solely to the interests of psychological practitioners and the people who receive our services.

All Practicing Psychologists have the right:

To be respected and valued as professionals reflective of the highest accomplishments and responsibilities for which we have trained.
To practice only under standards that are consistent with those of the profession.
To receive the same level of federal and state investment in training as physicians.
To receive financial compensation consistent with our professional training and activities.
To be protected from discriminatory treatment with respect to financial compensation or career advancement.
To receive continuing education that is relevant and of value to our patients and practice. This includes credit for continuing education in practice development and related business of running a practice.

All Practicing Psychologists have the right:

To be allowed to practice to the full extent of our training and education.
To practice under state laws under which only psychologists are permitted to provide psychological services.
To practice under state laws that clearly identify the scope of practice and responsibilities of psychologists in contrast to non-psychologists and other healthcare disciplines.
To be subject to licensure by a state board dedicated to psychology regulation whose members consist of psychologists in the majority and who practice and provide psychological services.
To be treated fairly in hearings and to be judged by our peers in matters of complaint brought to the state licensing board.
To receive reciprocity as licensees where the salient elements of licensure are similar across state lines.
To practice under state laws that define title protection for psychologists.
To protect the privacy and confidentiality of the relationship with our patients subject to specified ethical and legal exceptions.

Psychologists are asking:

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The following course are now available. CE credit from NAPPP and other alliance partners who are approved providers of continuing education by the American Psychological Association. Non-members of NAPPP are eligible to take our courses. The cost of the classes and credit hours can be found at the end of the course description.

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See http://www.nappp.org/education.php

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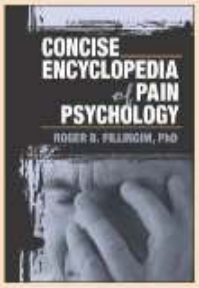

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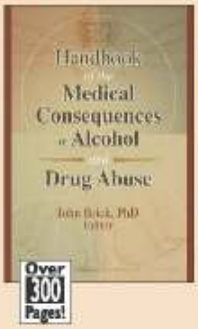

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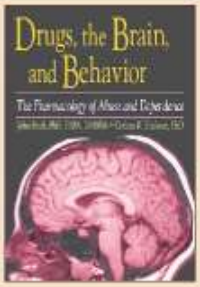

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PAST ISSUES INDEX: THE CLINICAL PRACTITIONER

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Editor's Comment: Jerry Morris, PsyD, MBA, MSPharm, ABPP, NCSP, CCM

I hope you are continuing to enjoy *The Clinical Practitioner* (click here to see back issues). Please consider doing informational, practice, or scientific articles and sending them to me at cmhcjerry@sbcglobal.net or to one of our editors.

In the dust is now cleared from the last year for psychology, which found state and national associations undermining and resisting practitioner and initiatives and the legislature and in forming special interest associations. Even though reasonable doctors, and the public, can have little doubt that psychology is on its own worst enemy, and that many of the associations and entities in the body psychology have made huge mistakes, the even greater shame is that we hear no signs of contrition, recognition of lessons learned, and leadership motivation to change. This bodes poorly for the next legislative and advocacy year. Clearly, the issues raised by your national pride petitioner Association concerning academic psychologist and business men and women's dominance of the national register board, and negative decisions forwarded by the national register which curtail practitioners best interest, the APA's so called practice division'shoarding of half-million dollar war chest without major constructive actions to save practice while spending approximately $30,000 on workshops bringing in academics and get-togethers for divisional leadership have saddened to many. Such actions have even separated many of weighty long time and long-suffering and contributing practice division worker bees from these divisions. Your practitioner Association has kept you abreast of these issues and phenomena, and has pointed out other major areas of concern such as academics dominating the APA CEO position during our lifetime, the failure of the APA Council of Representatives to give the same dues breaks for practitioner associations that it gives for non-APA scientific and academic associations, and the unwillingness for the so called practice divisions in APA to even forword and support a Council Resolution asking for such equality. We have been saddened to see the decline in the APA practice organization and have called for leadership in that organization that has a track record of major leadership and government roles in shaping the health care system in America and the health care fabric (which will be the defining factor for the APA practice organization in the next 10 years). We have been your news beacon for the times when state licensure committees, state psychological associations, and individual psychologists have sabotaged legislative bills, agendas, and how APA's practice organization has stood limply by without firm leadership to work out impasses and form collaborative coalitions among groups. They have organized efforts with labor, government, and in the formation of state chapters, national and state PACs, and help you realize practice enhancement options and alternative sources for practice insurance and consultation.

We have celebrated the successes of practice, and partial practice groups, such as APA's is in joining the large coalitions to turn back the Medicare cuts, the formation and growth of the American Board of medical psychology will as the defining pinnacle of training and specialization in the psychopharmacology movement,and the establishment of practitioner I ended executive psychopharmacology training programs, and other groups that seek to move the practitioner agenda forward. Where they are positive, collaborative, and supportive of the practitioner movement we stand for them and applaud their efforts and appreciate their work, and where they undermine or stand against the practitioner movement for corporate and political reasons, we stand up on your behalf and oppose them. We are not shy, apathetic, unwilling to fight for practice, nor conflict avoidant! We make no policy, except that which focuses upon the good of practice and practitioners, and we make no apology for being staunch and stubborn advocates for such! We are not your grandmother and grandfather's psychologists! We are not genteel and kind at any cost, collaborative with the negative agenda is for political or corporate gain, nor are we pleasant people to be around when you attack practice or practitioners! We can be your best friend, ally, collaborator, advocate if you are focused on the good of practitioners, and we can be your worst enemy, and worse nightmare if you are not! Those who realize this defined as someone different than the traditional psychologist and psychological associations. We are more Guild leaders than statespersons, more lobbyist and advocates than association management professionals, and more action oriented than interested in workshops, white papers, and spending thousands of dollars of our resources on fellowship focused meetings. We are different, fill a different need, and have emerged because needs are not being filled. It is that simple, less sinister and dark than some people would like to imagine, and more real world than psychology culture oriented. Therefore, not all agree with us, want to invest in their resources and dues with us, and we have said repeatedly that we respect that and are not seeking their recruitment. We have focused on that group that sees this need, want's an organization that addresses these needs, and once their resources invested in these functions.

To the extent that we have succeeded, we have developed a cadre of loyal, committed, and eyes open members, a cadre of necessary and meaningful opposition, and the usual cadre of people who stay on the sideline and are neither a part of the solution nor have a meaningful investment in solving the problems. The great weakness in psychology is not APA and its organizational and structural problems which are a natural result of its original design, the problems with our national practitioner Association, or the problems with the direction of the American healthcare system. The problem with psychology is this group of apathetic, uncommitted, uninvolved, psychologist in the bleachers to rarely step up to the plate and invest their resources in their industry and profession, helped carry the yoke of moving the profession forward and defending the profession, find "dd" excuses to fail to pay their dues, volunteer, or get involved, and who are conflict and involvement avoidant. They represent the difference that could make psychology a great profession that has tolerance for the subindustries in sectors and defense itself effectively.

All of the psychological associations, all of the various subsectors and subtypes of psychologists, and all of the leaders in psychology must work the problem of this week link in the body psychology.all sectors of psychology, all industries within psychology, and all psychological associations have more in common in the need to address this problem then they have differences. The real question is, "Will they realize this and jointly address it, or will they continue to find tertiary issue is whether incompatible and disagree"!

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