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## President's Report

Lisa R. Grossman, J.D., Ph.D., ABPP

As the 2012 President of the Academy, I am so excited to tell you of the many things your Board has been doing this year for our members, the Academy and ABPP.

### *Mentoring Program*

Our Mentoring Program is one of our most valuable and popular initiatives. Currently, we have approximately 18 mentors and 60 mentees. As we get increasingly more requests for mentors, we are in need of Academy members to volunteer to mentor 1-2 candidates. If you are interested in becoming an Academy mentor please don't hesitate to contact me.

Being aware of how important it is for mentors and mentees to clearly understand our mentoring procedures, the Board revised our Mentoring Policy and Procedures document to more clearly reflect responsibilities of both mentors and mentees. You will soon be able to view this revised document on our website at [www.aacpsy.org](http://www.aacpsy.org)

### *Website Initiative*

Our website is currently undergoing extensive renovation to improve layout, readability and content. Our new website will include, among other things, more videos, free CE access, more focus on our members and more photos. Stayed tuned and check it out when it's finished!

### *Membership*

As of mid-September, the total number of Academy members was 489. This is 38% of the total number of Board Certified Clinical Psychologists (1,276). While this percentage mirrors that of many State, Provincial and Territorial Psychological Association membership numbers, we would like this number to be closer to 100%. The Board has been in intense discussion as to how to increase Academy membership and we have discussed

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# An Archetypal Perspective for Combat Trauma

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In psychology's academic and professional worlds, the name of Carl Jung seems largely to have fallen into history, yet Jungian journals and books continue to flourish. His archetypal perspective has been especially helpful recently for many combat veterans trying to make sense of their experience. One does not have to be a "Jungian" (whatever that is), or to accept some awkward and dated accounts of his archetypal theory, to appreciate this contribution and to take it up in one's professional work. While this perspective can enrich one's work it obviously cannot substitute for specific clinical skills. For some colleagues, perhaps, it can become part of the ground on which specific techniques and interventions might be figured. Hopefully, this account might be helpful for those readers trained in very different traditions.

There are a growing number of women who are combat veterans and they need to be honored and related to accordingly. It is awkward and clumsy to negotiate "he or she" consistently through this essay. I ask the reader's forgiveness or indulgence.

Consistent with recent thinking in the DoD, I shall use the term post traumatic stress "injury" (PTSI) rather than "disorder" (PTSD).

## *Jung's perspective*

Before discussing the phenomenology of combat experience and some recent literature in which Jungian sensibilities and ideas are found, it can be helpful to realize that Jung's work is not primarily about psychosexual drives and object relations (Freud), feelings (Rogers and the humanists), or thinking (cognitive psychology), but about the organizing patterns and processes of the human imagination, which he understands as the autonomous ground of being human. Imagination and the images that comprise psychological life are autonomous in the sense that they are not derived from something else, such as hypothetical instincts. Therefore, Jung's interest in the workings of the human imagination is not merely a heuristic for approaching their supposed origins in in-

stinctual activity, family relations, feelings, or thoughts. He writes about the phenomenology of images and imagination's processes as such, on their own terms (Brooke, 1991; 2009).

From a Jungian perspective our understandable professional focus on relieving suffering can mean that we fail to ask whether there might be meaning in combat PTSI symptoms. What purpose, or psychic function, might they serve? In addition, we can look to the wider cultural and mythic imagination in which we might understand the challenges of combat experience and trauma, and then facilitate the return home.

Jung addresses such questions through the lens of what he calls individuation, which is a process of psychological deepening and spiritual maturation. It implies psychic spaciousness, self-acceptance, greater responsibility for one's conduct, and a meaningful place in the wider community. This lens helps us situate our understanding of combat experience and PTSI in life span developmental terms.

With this approach, the guiding insight is that the psychological wounds of war are a universal human experience, and that, as we discover in traditional warrior cultures, there is a common structure to the requirements and processes of healing. These wounds have been named in all cultures, and described in our own western culture more than two-and-a-half thousand years ago. What we now call post traumatic stress injury is described by an Egyptian physician in 1900 BCE and in the ancient Sanskrit book, *Mahabharata* (Jayatunga, 2012); and Homer's *Illiad* and *Odyssey* can be usefully read as depictions of the sequelae of combat trauma (Shay, 1995, 2002). It is our own culture that has socially constructed this universal as a psychiatric condition, burdening the individual veteran with all the negative consequences that implies.

### *Phenomenology of combat experience*

Combat experience has been described as numinous--an experience of coming face-to-face with Ares, the god of war. That is why, as Decker (2007) says, "Combat is such a mix of horror and bravery that it can be called mysterious.... Such an experience can not only horrify and repel but also attract and sanctify" (p. 47). This strange mixture of focused intensity, terror, adrenaline high and psychic fragmentation is never forgotten, even if it never leads to clinical PTSD. It remains in the background, like the sound of summer lawn mowers, present again with the merest shift in attention. The experience marks a difference in the structure of one's being-in-the-world that can never be completely undone. Here is a brief summary of some identifying themes.

1. In the war zone and combat the omnipotent and idealized fantasies that belong to youth shatter; one becomes mortal ("old") overnight.
2. Dissociation: Grossman (2004) has documented in careful detail how experience and memory become splintered and discontinuous, with some images remaining with intense clarity but with many events, including one's own behavior, disintegrating from consciousness and memory. Images that seemed "seared into one's brain" sometimes turn out to have been hallucinatory and simply never happened. Experience and memory are more like a collage than a single narrative.
3. Combat experience is numinous, sublime, awful and awesome, horrific and oddly sanctifying.
4. Combat shatters the communal order, which is our network of human relations, social expectations, and institutions. The sense that the world is mostly trustworthy and predictable is blown to pieces. What combat veterans have is knowledge--not a mere "belief"--that the fabric of the human order is thinner than civilians at home ever imagine.
5. Combat experience is an encounter with human evil and reaches into one's moral core. It changes one forever. It is this moral pain, described so movingly by Marin (1981/95) which marks com-

bat PTSD as qualitatively different from other forms of PTSD. As Tick says, "If we do not address the moral issues, we cannot alleviate it, no matter how much therapy or how many medications we apply" (Tick, 2005, p. 117).

6. One experiences a personal empowerment that comes with combat competence. Boys become men, and women, too, enter the community of combat veteran warriors.
7. Survivors experience a depth of brotherhood and sisterhood with both the living and dead comrades which lasts a lifetime.
8. Resisting the temptation to dehumanize the enemy and honoring the enemy dead are challenges that are crucial for long term psychological recovery and health.
9. Combat experience requires complex processes of integration and healing afterwards if the return from the war zone is to be satisfactorily accomplished. (see below)

### *Recent books with an archetypal perspective*

Jonathan Shay's (1996, 2002) two books, *Achilles in Vietnam* and *Odysseus in America*, have rightly become modern classics. Shay's method of psychological analysis exemplifies the method of amplification developed by Jung. He finds meaning and structure in the experience of combat post traumatic stress injury by looking to ancient, even mythic, parallels to contemporary experience. *Achilles* is about the erosion and degradation of character in the face of prolonged combat and the experience of betrayal by senior officers and politicians. The gods who turn on him and his friends are in turn interpreted as metaphors for institutions and people in power. "Like the Homeric gods, power holders in armies can create situations that destroy good character and drive mortals mad" (Shay, 1996, p. 153). *Odysseus* is about a veteran hero who took ten years to

return home, by which time he had betrayed his friends, done drugs, suffered from boredom and rage, and behaved like a criminal. To situate a struggling veteran's experience in these iconic terms is to lift the burden of psychopathology and shame from the veteran, to begin to dignify his (or her) suffering, and to help him (or her) find a common brotherhood (or sisterhood?) with all veteran warriors everywhere. This frees the veteran to ask how to take up his experience into the rest of his life and into his social world. More than this, Shay's two books are packed with insightful discussions of the archetypal needs of combat veterans, including facing the moral and spiritual core of trauma, the needs for storytelling, the communalization of grief, honoring the enemy as fellow warriors, making peace with the dead, and establishing a new identity in which this experience can be integrated.

The pioneering humanistic psychologist, Stanley Krippner (Paulson and Krippner, 2007) writes that an archetypal approach "helps veterans think about their situations without being enmeshed in its personal fallout" (p. 56), such as negative emotions, avoidance, suppression, and substance abuse. He goes on to discuss combat experience as a hero's rite of passage, which includes 1) the call, 2) the initiation, and 3) the return. Veterans, who come back from deployment and leave the military, left to their own devices, are in effect abandoned in the middle of this rite of passage. Krippner's co-author, Daryl Paulson, was a Marine who served in Vietnam. In his own memoir (Paulson, 2005), he describes how he found behavioral and emotional steadiness and spiritual meaning in his experience once he understood and accepted it archetypally, as a rite of passage common to all warriors everywhere.

Karl Marlantes, author of the acclaimed novel, *Matterhorn*, has recently written *What it is like to go to war* (Marlantes, 2011; see also his interview with Bill Moyers, 2012). In this book he draws extensively from his own experience as a Marine officer in Vietnam, while situating his understanding in the above archetypal perspective. He spends considerable time on the moral theme of confronting

what Jung calls the shadow, one's own participation in the human proclivity for destructiveness and evil. What emerges for the mature warrior is the need for a degree of self-knowledge not typically required of civilians. "In war, we have to live with heavy contradictions," he writes. "The degree to which we can be aware of and contain these contradictions is a measure of our individual maturity" (p. 44).

Marlantes also writes that the mature mood of the combat veteran, perhaps accessible only as the decades go by, is sadness. He wishes that our combat veterans could be taught to pray for the dead--both friendly and enemy--immediately after firefights in which people had been killed. He even offers such a prayer (p. 79). There is a moral and spiritual depth to this book that is at once sobering and intellectually satisfying. It is an important counterpoint to what I regard as the facile and probably doomed project of so-called "positive psychology" in military resiliency training. (For reasons that go beyond this paper, I fear/hypothesize that the positive psychology resiliency interventions in the military will *increase* the psychological and behavioral problems of our service members--I am not alone in thinking so: Tick, personal communication; see Edelson *et. al.*, 2011).

The Jungian analyst, James Hillman (2004), argues that we shall never find the peace we supposedly wish for until we honor and own our "terrible love of war." The heroic fantasies of combat, of defeating an enemy that is seen as without rather than within, and of facing the sublime, even spiritually cleansing, gods of war, are a seduction that both calls for self-knowledge but also pulls like an irresistible force against self-knowledge at the same time. He thinks that Plato was probably right to say that only the dead have seen the end of war. Hillman's book is disturbing because it asks of us who work with veterans to find a capacity for a cold empathy for the pull towards these dark forces that have traditionally been called gods.

Ed Tick (Tick, 2005; see [soldiersheart.net](http://soldiersheart.net)) is a psychotherapist, interfaith minister, and authority on warrior cultures around the world, especially the Greek, Norse, Celts, Samurai, and Plains Indians. He

## An Archetypal Perspective for Combat Trauma (continued)

has been initiated in, and practices, Native American healing ways in retreats for veterans. He has written on the use of dreams in ancient Greek healing, and, over the past fifteen years, he and his wife, psychotherapist Kate Dahlstedt, have taken veterans back to Vietnam for healing ceremonies. Tick's work is especially topical right now. He was contracted for 2012 to provide training to all two thousand Chaplains in the US Army.

Tick's approach is explicitly indebted to Jung's archetypal perspective. He has distilled several central themes in the healing rituals of traditional warrior cultures. The extent to which our own military works in a way that is consistent with this archetypal structure is the extent to which it is meaningful to veterans and significantly helpful. The central themes in healing include purification, atonement, remembrance and storytelling, making peace with the dead, restitution in community, and initiation into elder warrior status. In his retreats, which are necessarily compacted into four days, he and his wife, sometimes with additional helpers, lead veterans through these stages. It is understood that these retreats, however transformative--which they are--are also in need of follow-up support and counseling, and structures are set in place to try and ensure this happens. This is still a work in progress, and outcomes data is being collected.

Readers might note how some current therapy trends and healing behaviors participate in the archetypal structure of warrior healing described above: looking to veteran elders for support and guidance; slowing down and telling the story in detail; suffering the pain of the events in the story with civilians so that the bridge back to the world can be crossed; the need for loving forgiveness and understanding by others so that one can reevaluate one's experience and behavior; grief and mourning, revisited for life; honoring the dead through memorial rituals; writing plays, books, and songs, and making movies, all transforming traumatic flashbacks into narratives with

meaning; taking up one's experience into one's future life as a veteran warrior and wise elder, continuing to serve the community and those young warriors who follow. These features of contemporary veteran activities are new versions of archetypal themes.

### *The archetypal structure of the warrior's return and developmental path*

In traditional warrior cultures combat experience sets the returning warrior on a different path of psychological development, which continues through the life span. He (or, now, she) can never return to the time of innocence and will never be "merely" a civilian again. Instead, he or she is called to take up this experience as a spiritual task in which moral character, self-sacrifice, humility, strength, and wisdom are recognizable themes. The transformation of combat trauma into spiritual meaning is the warrior's archetypal calling. As Tick says, "Warriorhood is not an outer role but an inner spiritual achievement" (p. 199).

Those veterans who try to overcome their demons by hurling themselves drunkenly back into civilian life, determined to leave behind them what they have been through, are doomed to prolonged suffering and are on a slippery slope towards disaster. On the other hand, a veteran with post traumatic stress injury can use the warrior ideal as a guide for healing and growth. It offers dignity, behavioral steadiness, self-knowledge, and cultural meaning. To take responsibility for one's experience is to affirm it with the quality of destiny. Hoge's (2010) fine book, *Once a warrior always a warrior*, situates returning veterans in this ancient tradition.

The intrusive memories that haunt our veterans mark the beginnings of remembrance, but private grief has to be held in communal mourning. As Shay (1996) comments, "Long term obstruction of grief and failure to communalize grief can imprison a person in endless swinging between rage and emotional deadness as a permanent way of being in the world" (p. 40). Grief typically extends beyond one's fallen comrades to the enemy dead as well.

Communal mourning is partly mediated through story telling. The recollection of experiential fragments worked with *Soldiersheart on retreats for Veterans*. His

## An Archetypal Perspective for Combat Trauma (continued)

into narrative serves to integrate experience into a meaningful history. The words used--exciting, frightening, evil, courageous, funny, luck, right and wrong, sick, shame, failure, and remorse--are words that mark out the coordinates of our moral and aesthetic bearings, re consolidating the moral ground of character (Shay, 1996). Storytelling and communal mourning begin to stitch together the torn fabric of the world.

Veteran warriors continue to be of service to the next generation and the community. This role is recognized by the society, so that, in time, the veteran becomes a spiritual elder and cultural guardian. This does not apply only to cultural icons, such as Mandela, Carter, Powell, McCain, but also to all those veterans who take care of their young, coach Little League, and serve in their churches and community organizations. One of the functions of the elders is to inhibit violence and the rush to war. They have the moral authority and credibility to encourage peaceful conflict resolution, and they serve as role models of self-knowledge and restraint to the next generation. Their caution cannot be dismissed as cowardice or ignorance. (In the buildup to the Iraq war, it was striking how the two combat veterans in President Bush's inner circle, Gens. Shinseki and Powell, were brushed aside by those who had never been in combat and seemed to have little idea of the forces they were about to unleash.)

### *Lessons from the Xhosa*

The traditional Xhosa of South Africa (Nelson Mandela is Xhosa) have much to teach us. *Kanene* is the returning warrior's insight into the depth and burden he carries, following him like a shadow reminding him of what he has done (Mbuqe, personal communication). He needs to be forgiven by both the living and the dead, including the enemy dead, so that his own soul may be returned from the battlefield. Forgiveness is mediated through *ukubula*, which is the confessional telling of all that happened. The community's obligation is to tolerate the pain of listening, no matter how difficult it may be, so that the community accepts responsibility for the violence that has been done in its name. (Readers

might recall South Africa's Truth and Reconciliation Commission, headed by Archbishop Desmond Tutu; it was rooted in this tradition of *ukubula*.) The warrior is forgiven, peace is made with the ancestors, and the souls of the dead *and the living*, which have been left on the battlefield, are returned. The warrior's soul does not return to him from the scenes of battle until he has made peace with the souls of the enemy dead.

### *Archetypal process in a dream*

The archetypal perspective is intimately relevant to the lives of the combat veterans with whom we work. What is archetypal in the following vignette is the definitively human need to recover one's own humanity through honoring the dead, to atone for one's guilt, to tell one's story to a listener who will listen without judgment, and to restore that sustaining ground of wellbeing people have traditionally called the soul.

This is a composite of many such dreams. An Iraq veteran with TBI and PTSI tells me that he has been having nightmares. He was a good soldier, he says, doing what he had been trained to do, going through doors and "taking out targets." Then, in great psychic pain, he says, "But in the dreams the targets have faces." After we spoke a little more, I suggested to him that, if he could bear to stay with the dream, he might find that it is a healing dream. The next morning he said to the group that he felt he was becoming human again.

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## An Archetypal Perspective for Combat Trauma (continued)

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*formative professional years were in South Africa in the 1980s. He and his oldest son are paratroopers.*

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## Cholesterol, Neurodevelopment, and Aggression

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### Abstract

*With members of the medical community emphasizing the cardiovascular ramifications of high cholesterol and related cholesterol-reducing procedures, clinical psychologists may not be aware that low or insufficient cholesterol levels are associated with aggression, both in children and adults. This is important given recommendations for use of cholesterol-lowering agents for children and adolescents classified as obese or hyperlipidemic. Data related to the role of cholesterol in brain development are reviewed relative to myelination and the*

*integrity of the neuronal cell membrane. A prevailing explanatory hypothesis for the low cholesterol-aggression relationship is presented that focuses on inadequate cholesterol levels in a serotonergic brain circuit that includes the frontal lobe and the amygdala. Lowered cholesterol may disturb serotonin transport and impede inhibitory regulation of the amygdala.*

### Cholesterol, Neurodevelopment, and Aggression

The societal obsession with preventing heart disease by aggressive pharmacologic management of cholesterol levels has led to widely publicized (if controversial) recommendations such as those of a recent study arguing for the adoption of cholesterol-reducing drugs, “statins,” even among adult patients without elevated low density lipoprotein LDL (so-called “bad cholesterol”) levels (Ridker, Danielson, Fonseca, Genest, Gotto, Kastelein, Koenig, Libby, Lorenzatti, MacFadyen, Nordestgaard, Willerson, & Glynn, 2008). Also, despite the fact that cholesterol-lowering drugs or “statins” cross the blood-brain barrier, there are proposals for administering them to pediatric patients. Thus, individuals as young as ten, classified as obese or “hyperlipidemic” (having abnormal levels of fat in the bloodstream), are being viewed as suitable subjects, at least under some circumstances, for administration of statins. (Daniels & Green, 2008; but see Parker-Pope, 2008).

Such recommendations for children need to be carefully reviewed in relation to a comprehensive understanding of the role that cholesterol plays in neurodevelopment. Moreover, low or insufficient cholesterol levels may in and of themselves be a significant risk factor for behavioral disorders including those marked by aggression and violence among children and adolescents, as has been demonstrated in a number of studies with adults (Mufti, Balon, & Arfken, 1998; Wallner & Machatschke, 2009).

Cholesterol is a hydrophobic substance, meaning it cannot dissolve in water and is not directly soluble in the blood. This means that cholesterol in the blood—produced in the liver or coming from dietary intake—does not reach the brain. Instead the cholesterol needed by the brain—which is the most

cholesterol-rich organ in the human body—is produced in the brain itself (Bjorkhem, Starck, Andersson, Lutjohann, von Bahr, Pikuleva, Babiker, & Diezfalusy, 2001). Since, as mentioned, statins do cross the blood-brain barrier, they should be used with extreme caution, if at all, in developing persons because of their potential to inadvertently disrupt important neurodevelopmental processes. Moreover, it is to be expected—given the multiplicity of critical roles played by cholesterol in neurodevelopment—that the most pervasive adverse effects for children and adolescents may result from insufficient, rather than excess, central nervous system cholesterol availability.

One of the problems with using statins to reduce peripheral (i.e., blood) cholesterol levels is that the end target is a single lab value that is being used as a proxy for a whole array of potential clinical risk factors. Though reduction of cholesterol by means of statins correlates with reduced heart disease in middle-aged men, the same correlation has not been established by randomized trial data for any other population. There are just no data for this in children and adolescents. Moreover, we cannot even assume that blood cholesterol serves as a marker for brain cholesterol or predict how modification of peripheral cholesterol with statins may affect central cholesterol levels. (B. A. Golomb, personal communication, November 18, 2011). Given the complicated and interacting nature of these pathways, it is currently impossible to weigh the multiple possible effects of cholesterol lowering by means of statins in children and adolescents. Certainly there are other, less problematic, approaches to deal with children and adolescents with metabolic issues, including regular exercise and dietary interventions. At least until better studies are available, we believe it is safest to avoid the use of statins with children and adolescents altogether.

A brief review of cholesterol’s role in brain structure and function

A brief primer on the roles of cholesterol in neurodevelopment may be helpful, as this literature is not likely to be familiar to clinical psychologists, or for that matter, psychiatrists and general medical

practitioners. In part, this is attested by the fact that cholesterol levels are not routinely assessed by pediatricians and family practice physicians, nor are they evaluated among patients referred for issues of aggression and violence to behavioral inpatient units—an omission that seems particularly inexcusable given the fact that many of these patients arrive on one or more psychotropic medications, including some that are notorious for causing elevations in lipids.

Unesterified cholesterol (i.e., cholesterol not converted into phospholipid soluble form or “bad cholesterol”) is an essential structural component of the plasma membrane of every cell, including neurons and glia in the brain. During evolutionary development, the plasma membrane came to play an additional, highly specialized role in the central nervous system as myelin; cholesterol is the major architectural component of compact myelin, and consequently, the mean concentration of unesterified cholesterol in the central nervous system is higher than in any other tissue (Dietschy and Turley, 2004).

Myelination, the development of the protective cover or insulation of neurons in the central nervous system, is currently a subject of active research. Post-mortem studies have shown that myelination occurs as a wave or progression of cellular maturation events that begin near the end of the second trimester of fetal development and extends well into the third decade of life and beyond. In general, myelin progresses from inferior to superior and from posterior to anterior brain regions. Thus, brain stem and cerebellar regions myelinate before cerebral hemispheres, while frontal lobes develop last. Magnetic resonance imaging studies have broadly affirmed these findings, albeit instead of following the posterior-anterior progression, cortical changes between the childhood and adolescent developmental periods have been found to occur mainly in dorsal brain regions and are most prominent in the parietal lobes (Sowell, Thompson, Holmes, Jernigan, & Toga, 1999).

### Hypocholesterolemia in Children

There has been relatively little research relating hypocholesterolemia in children and adolescents

specific to clinical issues. The studies that have been done support associations between hypocholesterolemia and aggression in children and adolescents similar to those among adults. An early study looking at hypocholesterolemia and suicide ideation in children hospitalized for psychiatric dysfunctions showed that children with adjustment disorders and concomitant depression had the highest group suicide tendencies and the lowest covariance-adjusted total cholesterol, while those with disruptive behavior and attention deficit hyperactivity or oppositional defiance disorders had lower suicidal tendencies and higher covariance-adjusted total cholesterol values (Glueck, 1994). A small study by the present authors comparing adolescents in the general population with those in an outpatient mental health clinic and a correctional residential facility for youngsters with primarily aggressive issues found low cholesterol levels were significantly associated with mixed disorders of mood and conduct, aggression and violence (Sheehan & Thurber, 2006). Moreover, as part of the Third National Health and Nutrition Examination Survey (1988-1994), serum total cholesterol was measured in 4,852 children aged 6-16 years. After adjustment for variables such as family socioeconomic status, maternal marital status and education, nutrition, and academic performance, Caucasian children with a serum total cholesterol concentration below the 25<sup>th</sup> percentile (<145 mg/dl) were found to be almost threefold more likely to have been suspended or expelled from schools than their peers with total cholesterol at or above the 25<sup>th</sup> percentile (>160 mg/dl). The authors concluded that, at least among non-African American children, low total cholesterol may be a risk factor for aggression or a risk marker for other biologic variables predisposing to aggression (Zhang, Muldoon, McKeown, & Cuffe, 2005). Clearly, in many pediatric and adolescent patients, low cholesterol is a much greater risk factor than high cholesterol, since injuries and deaths from violence, including homicidal violence and suicide, are much higher than from heart disease! Yet low cholesterol is rarely taken into an account as a factor for morbidity and mortality in this population, even by those specifically charged with caring for them (pediatricians, general medical practitioners, and

psychologists).

### Theory Development

Theoretical explanations regarding cholesterol levels and aggression have been formulated and will require future refutability investigations. The role of cholesterol in serotonin metabolism is a central notion of this theorizing (Multi, et al., 1998; Wallner & Machataschke, 2009). The gist of the explanatory hypothesis is that inadequate neurotransmission involving serotonin is the key to the biochemistry and neurocircuitry of aggressive and violent behavior (see Golomb, Stattin, & Mednick 2000). Low serum cholesterol may affect the integrity of neuronal cell membranes, and this in turn may result in reduced effectiveness of serotonin transport to the synaptic cleft. Among its many roles, serotonin is a neurotransmitter that is involved in prefrontal inhibitory regulation of the amygdala. Reduced serotonergic transmission may attenuate adequate inhibitory functioning in relation to firing of the amygdala, a brain structure implicated in the mediation of fear and aggression (see Witte, Floel, Stein, Savli, Mien, Wadsak, Spindelegger, Moser, Fink, Hahn, Mitterhauser, Kletter, Kasper, & Lanzenberger, 2008).

### Conclusions

This aim of this essay was to present information to members of the Academy regarding the relationship between low serum cholesterol and aggression and violence, a domain that is likely unfamiliar to the clinical psychology community. Earlier studies with adults and more recent investigations with developing persons attest to such a relationship. Medical personnel, knowledgeable concerning cardiovascular implications of high serum cholesterol, may not be as aware of the above nor of the potentially disruptive effects on neurodevelopmental systems related to conformance to current pharmacologic recommendations for lowering cholesterol in children and adolescents.

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## Cholesterol, Neurodevelopment, and Aggression (Continued)

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## Integrating Clinical Psychopharmacology within the Practice of Medical Psychology \*

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Mark Muse, Ed.D.  
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The defining characteristic of medical psychology is *integration*. It purports to integrate psychobiosocial aspects of human functioning into the diagnosis and treatment of mental health disorders, syndromes and conditions. One aspect of the practice of medical psychology is clinical psychopharmacology, or the management of pharmacokinetics and pharmacodynamics in the treatment of psychological disorders. *Clinical psychopharmacology* is not engaged in as a sole approach or treatment within medical psychology, but is integrated into *multidimensional analyses of behavior* and *multimodal treatment strategies*. Aspects of human psychology (e.g. behavior, cognition, affect), biology (e.g. genetics, age, sex, race, health/disease), and social context (e.g. family-gender-cultural/ethnic associations; political-economic environment) are not only assessed and weighed for their respective influence on a given individual, but they are integrated into the medical psychologist's orientation and thinking in such a way as to allow a holistic approach to understanding and responding to the person who presents as patient/client.

When engaged in clinical psychopharmacology, the medical psychologist is aware of multiple factors, beyond any particular drug's chemical makeup, which may contribute to response outcome in a given patient. Family history may at times point the way to inheritance tendencies in such conditions as schizophrenia and bipolar disorder (Berrettini, 2000), whereas a previously positive response by a family member to a particular medication for the same condition suffered by the patient has predictive value for determining the confidence with which the same drug can be prescribed to the patient (O'Reilly, 1994). Other factors that should be weighed when considering the proper role of pharmacotherapy are the patient's beliefs (Makela & Griffith, 2003), as well as social support, economics and environmental situation (Roy, et al., 2005). For example, the benefits of prescribing the latest, most expensive medication while a patient is treated inpatient must be assessed in terms of the patient's ability to continue with the prescribed treatment once discharged.

The possibility of the discipline of medical psychology integrating treatment options by discerning whether medication or psychotherapy are best applied as *stand-alones* or in combination with one another in the treatment of an array of emotional disorders was made explicit in Morgan Sammons' volumes on the subject (Sammons & Levant, 1999; Sammons & Schmidt, 2001). Conclusions of those works include the following: 1) In the treatment of OCD, research indicates that *single treatment modality* (behavioral therapy) is more effective than *combination treatment* modality when symptoms are primarily compulsive, but a combined treatment modality (medication-behavioral therapy) is more effective than single treatment modality when symptoms are primarily obsessive; 2) For most other conditions, single-modality treatments should be attempted before combined treatments are implemented; and 3) Not all single therapy approaches are equal: For example, pharmacotherapy is less effective as a single modality approach than psychotherapy when treating chronic depression with an Axis II disorder.

Contemporary with Sammons' work, has been Robert Julien's effort at ferreting out differential indications for drug vs. talk therapy in his seminal book (Julien, 2005; Julien et al, 2010), *A Primer of Drug Action*, now entering its twelfth edition. Among Julian's conclusions on the integration of psychotherapy with pharmacotherapy are the following: 1) In the treatment of phobias such as agoraphobia, simple phobia and social phobia, cognitive-behavioral therapy is more consistent and provides longer-lasting effects than medications; 2) In the treatment of obsessive-compulsive disorder, posttraumatic disorder and generalized anxiety, medications and behavioral approaches are equally effective; 3) Psychotherapy (cognitive-behavioral) and medication (SSRIs, TCAs, benzodiazepines and MAO-Is) are equally effective in acute treatment of panic disorder, but combining behavioral therapy and medication in the treatment of panic disorder is superior to either monotherapy; 4) In the treatment of major depression, cognitive-behavioral therapy and antidepressant medication are equally effective and display additional efficacy when combined; and 5) In the treatment of eating disorders,

cognitive-behavioral therapy is superior to SSRIs.

Prior to Sammons and Julien, other investigators' attempts to answer the question of when to medicate, when not, and when to combine medication with psychosocial interventions drew equivocal results with conflicting conclusions (Weissman, 1981). Fisher and Greenburg (1989) noted what they considered to be an over reliance on drug therapy, and concluded that in many of the studies that they reviewed the practice of adding medication to psychotherapy yielded no improvement in outcomes. These authors' later book (1997) argued still further that pharmacological agents in the treatment of mental disorders are in general no more effective than placebo. More recent arguments have been proposed to explain pharmacotherapy's clinical results (Moncrieff & Cohen, 2009) by considering psychotropics as nonspecific agents, reminiscent of the *common factors theory* explanation of psychotherapeutic effectiveness, which induce a complex, global response--analogous to empathy's pervasive healing effect as a nonspecific agent across psychotherapies (Riess, 2010)--and yields a sense of subjective improvement. The fact that most psychotherapies are of equal efficacy when compared in meta-analysis, or the so-called *Dodo-bird effect* (Wampold, et al, 1997), has led to the search for underlying mechanisms to explain this, one being the *Wampold hypothesis* (Sammons, 2010). This view is in opposition to the reigning biological paradigm which assumes that there is a specific underlying neurological mechanism for each psychiatric condition and that drugs are effective because their respective mechanism of actions differentially address specific imbalances inherent to the disorder under treatment. In contrast to the strict biological model, the alternative view suggests that whether norepinephrine or serotonin are targeted in the treatment of depression, or whether cognitive-behavioral or psychodynamic therapy are implemented, or whether pure placebo is applied, the interpersonal relationship with a provider and the ensuing patient's expectation for positive change is what is largely driving condition improvement, aided somewhat by a nonspecific *psychobiosocial*

change inherent in all treatment approaches used. This new line of reasoning complements Stanley Schachter's earlier experimentally-derived *Two Factor Theory of Emotion* (Schachter & Singer, 1962; Schachter, 1964), where specific meaning is derived by the observer from general subjective emotional arousal according to the context in which it occurs. An extended analogy would contend that SSRI's are attributed with specific antidepressant effect because they are present when a patient recovers from depression, although a more parsimonious interpretation might be that most therapeutic agents effect positive subjective changes, regardless of the specific intervention employed or condition under treatment.

Other investigators, on the other hand, have drawn differential recommendations for specific disorders. In one of the earliest studies on combining treatment modalities, Hogarty, et al. (1974) concluded that a combination of medication and psychosocial interventions prevented relapse in schizophrenic patients. Rush and Holland (1991), suggested that pharmacotherapy or cognitive therapy, or a combination of both, were equally effective in treating non-bipolar and non-psychotic depression, while pharmacotherapy appeared indispensable in treating bipolar and major depression with psychotic features. With agoraphobia, Mavissakalian (1991) found after reviewing six contemporary studies that imipramine tended to be as effective as exposure therapy in treating panic, whereas exposure approaches are somewhat more effective in treating phobic behavior, while a combination of both appeared to give some advantage in the treatment of panic with phobic avoidance. Nevertheless, approximately one quarter of patients experiencing agoraphobia responded equally well to placebo while about one quarter did not respond to the combination of both pharmacotherapy and exposure psychotherapy. Mavissakalian also indicated that sequencing pharmacotherapy, initially for eight weeks, followed with 16 weeks of imipramine plus exposure therapy, tended to enhance the initial effect of drug treatment alone.

Large-scale studies such as NIMH's *Star\*D--Sequenced Treatment Alternatives to Relieve Depression--*(Gaynes, et al., 2005; Fava, et al., 2004) and the *STEP-BD--Systematic Treatment Enhancement Program for Bipolar Disorder* (Sachs, et al., 2003; Kogan, et al, 2004) the *CATIE--Clinical Antipsychotic Trials on Intervention Effectiveness* (Lieberman, et al, 2005) the *CuTLASS-- Cost Utility of the Latest Antipsychotic Drugs in Schizophrenia Study* (Jones, et al, 2006) and the *MTA--Multimodal Treatment Study of ADHD--*(MTA Cooperative Group, 1999b), as well as expert consensus projects such as the *Texas Medication Algorithm Project--TMAP--*(Kashner, et. Al, 2003) have attempted to shine light on the specific impact of various treatment interventions with particular disorders. While subtle differences have been detected among treatments, more impressive is the lack of substantial clinically significant differences.

Although many clinicians have come to assume through the years that combined therapies is the gold standard in psychiatric treatment (Conte, et al., 1986; Riba, et al., 2005; Kraly, 2006), Beitman and Binder (2003) more recently revised thinking in the first part of this decade by proposing that combined therapies are not necessarily more effective than their constituent *monotherapies*, and should be avoided unless specific evidence to their comparative effectiveness outweighs the additional cost and the potential for increased negative side effects (Healy, 2004) of combining treatments. Notwithstanding the undisputed benefit from pharmacotherapy of a subset of diagnoses which include bipolar, schizophrenia and major depression with psychotic features, psychotherapy, in addition to being indicated in an array of other conditions as a stand-alone approach, generally aids in supporting the use of medication as it tends to assist with overall compliance (Guo, et al. 2010). More to the point, according to Beitman and Binder, mono-psychotherapy has been shown to be effective with major (non-bipolar) depressive disorder, dysthymia, panic disorder, obsessive-compulsive disorder, social phobia, generalized anxiety disorder, bulimia and primary insomnia; and we might suggest that the addition of medication to the treatment of these conditions is best reserved for those cases in which the potential for side effects is justified by the lack of

adequate response to psychotherapy. In mild to moderate depression, combined therapy adds little, while in severe depression a combination of medication and psychotherapy appears to increase positive outcomes.

Past research has begged many questions that are only recently beginning to yield potential clinical direction. The most recent research indicates (Founier et al., 2009) that subject variables may influence outcome within diagnostic categories, such that being married, unemployed and undergoing significant life events predicts a better response to cognitive therapy over antidepressant medication in the treatment of moderate to severe depression. Also, the severity of a given condition, such as depression, may determine whether there is any advantage at all to medication over placebo (Founier, et al., 2010). Similarly, recent findings point out the subtle interference of medication on the long-term effect of psychotherapy such that in the case of sleep disorders the intermittent use of zolpidem in cognitive-behavioral therapy (CBT) for chronic insomnia (Morin, et al., 2009) tends to reduce the effectiveness of treatment; CBT is more effective singly in the treatment of insomnia than when “aided” by PRN medication use. Contradictory findings, however, continue to be the theme in determining the usefulness of combining therapies for the treatment of depression. March and Vitiello (2009), for example, indicate that combination CBT-fluoxetine is superior to either of these agents singly in the treatment of severe to moderate depressive disorders in adolescents, while Kocsis and colleagues (2009) find no advantage to adding adjunctive psychotherapy to pharmacotherapy for the treatment of chronic depression, and Blier, et al. (2009) find combining fluoxetine with a second antidepressant medication is more effective than fluoxetine alone. Indeed, combining multiple medications has become increasingly common, but there is scant evidence that such *polypharmacy* practices provide superior results. Mojtabai and Olfson (2010) conclude that these trends “put patients at increased risk of drug-drug interactions with uncer-

tain gains for quality of care and clinical outcomes” (p.26). Dobson, et al. (2008) has pointed out the importance of psychotherapy’s effectiveness beyond the treatment stage in a study in which patients treated to remission with CBT are only about half as likely to relapse following treatment termination than patients treated to remission with medications.

ADHD studies have tended to confirm the effectiveness of analeptic medication in ameliorating behaviors such as distractedness and hyperactivity, but consistently find that combination therapy is superior to mono-pharmacotherapy (Jensen, et al., 2005); yet uniformity across studies is lacking on how medication effectiveness is assessed (Faraone, et al., 2006), and bias can only be ruled out when future studies more adequately control variability in study design. On the other hand, recent research has indicated that behavioral approaches are unequivocally effective in treating Tourette Disorder, and appear to be as effective as medication (Piacentini, et al., 2010).

Apart from clinical research into differential use of various biopsychosocial interventions in the treatment of emotional distress, psychosocial orientations promulgate theoretical considerations which question the appropriateness of across-the-board medication as first-line treatment in the majority of mental health cases (Crystal, et al., 2009). Such theoretical stances propose that there are genuine life issues involved in most emotional disturbance and that it is best to treat the disturbance through resolving the issues rather than suppressing symptoms. It is the patient’s adjustment to life issues, intrapersonal as well as interpersonal, which is the definition of positive change, and the improvement of symptoms is a reflection of this growth process, and more likely to occur when the precocious suppression of symptoms by psychotropic drugs has not preempted personal adaptation. A symptom of anxiety is not necessarily an anxiety disorder, just as there is a functional side to nearly all emotions (May, 1950), and many symptoms of distress have an adaptive value which can be lost if symptom elimination is the only clinical goal in the rush to eradicate “disorders”. The trend over the last 10 to 15 years has been to increase the role of psychotropics to suppress symptom manifest

manifestation while reducing the comparative role of psychotherapy (Olfson & Marcus, 2010). Medication management alone, however, is far more likely to promote the treatment of symptoms without delving into the cause behind them, not only because medications are aimed at symptoms but because they are, by and large, prescribed by non-mental health professionals (Mark & Buck, 2009) who have little or no expertise in evaluating beyond the presenting problem (Muse & McGrath, 2010).

Notwithstanding non-mental health prescribers, and unlike psychiatrists who have specialized in pharmacotherapy to the relative abandonment of psychotherapy “motivated by financial incentives and growth in psychopharmacological treatments in recent years” (Mojtabai & Olfson, 2008), the medical psychologist who attempts to integrate multimodal evaluation and treatment of emotional response is more likely to concede that a certain amount of “distress” is motivating for the patient to make the effort needed for growth, and that the premature suppression of emotional symptoms runs the risk of delaying or aborting personal adaptation through new learning. Discomfort, seen in this light, is a requirement for therapeutic change (Rogers, 1961).

While we have only looked at psychotherapy here, the larger question concerns *psychosocial interventions* (with psychotherapy being a subset of such interventions) vs. *pharmacotherapy*, and how these are best integrated. And yet another question along this same line is whether medication can, by its nature, ever be a stand-alone treatment or, to the contrary, whether it is an integral part of psychosocial interventions. Unless it is dispensed from a vending machine with no form of human contact intervening between patient and pharmacologic agent, there is bound to be a form of engagement between patient and dispensing professional. Such a relationship is the basis of most psychotherapy (Wampold, 2001). How, then, is the true, stand-alone effectiveness of a drug ever to be measured when it is inevitably encased in expectation, placebo and transference issues inherent in the rapport

through which it is obtained (Norcross & Goldfried, 2003; Busch & Sandberg, 2007)?

A related issue is that of the temporal nature of any research findings, findings which give the impression that even substantiated trends discovered today may be ephemeral, and vanish with time. Case in point is the fact that *placebo effect* is growing within the present mental health treatment zeitgeist (Silberman, 2009), with pharmacological agents acquiring increasing potency as people have come to expect more from them through massive advertisement campaigns that “sell” the product. If the present “biological explanation” of emotional disorders, with its implied need to medicate, were to fall into disrepute or relative disuse (that is, if psychotherapy were to become more popular for whatever reason), some of the research discoveries about the relative effectiveness of one treatment over another may flip, as the placebo effect associated with drugs decreases as a result of generalized skepticism and, perhaps, a parallel re-engendered belief in psychotherapy invests the psychosocial modality with greater placebo.

One approach which circumvents culturally determined fluctuation in placebo effect is found in the relative immutability of established principles of learning and the application of conditioning for therapeutic effect. Medical psychologists are in a unique position to integrate the effect of conditioned learning that parallels the dispensing of medication in a way that reinforces desired therapeutic directions by integrating medication into behavioral principles of learning. Not only does this create a synergic therapeutic intervention that enhances the effectiveness of pharmacologic agents, it reduces the acquisition of learned, undesirable secondary effects. Examples of integrating behavioral therapy (Wolpe, 1969) and behavioral modification (Skinner, 1974) into pharmacotherapy include using medication as reinforcers within the operant paradigm for motivating patient compliance and rehabilitation effort in the treatment of chronic pain syndromes (Fordyce, 1976); managing medication schedules to avoid positive and negative reinforcement contingencies that promote reliance and addiction to analgesics; using medication effect as an unconditioned response for pairing with the conditioned stimulus within the respondent paradigm for counterconditioning of phobias; using

aversive substances as unconditioned stimuli in pairings with the conditioned response of sexual arousal, to achieve a *Garcia Effect*-like extinction in the treatment of pedophilia; using a drug-induced, state-dependent learning paradigm to accelerate relearning in PTSD; using medication as an initial mitigator of Subjective Units of Distress (SUDs) attached to hierarchical items in the systematic desensitization of severe vaginism (Muse, 2010a); and optimizing the approximately 70% placebo effect of antidepressant medications (Rief, et al., 2009) as a booster in stalled stages of psychotherapy to reinforce previous effort and facilitate renewed positive expectancy in the professional relationship. These are but a few of the possible applications of behavioral principles in the administration and management of pharmacotherapy.

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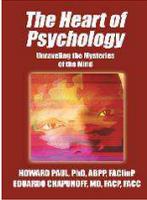
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## Book Review

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John R. Thibodeau, Ph.D., ABPP  
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**The Heart of Psychology: Unraveling the Mysteries of the Mind, Howard Paul, Ph.D., and Eduardo Chapurroff, M.D., AuthorHouse, Bloomington, IN (2012) 304 pp., \$28.99 (Hardbound), \$19.95 (Paperback).**

The authors' avowed intent for the book was to introduce a wide variety of topics in psychology to the lay audience with the hope of both educating and increasing interest in the field of clinical psychology as a field of study or even perhaps as a profession. It was also felt that the book might prove to be a good supplemental text in high school and introductory psychology classes.

The reader might be tempted to ask why a board-certified clinical psychologist would seek to write a book about the mysteries of psychology with a board-certified cardiologist and not with another psychologist. One might suggest that it was perhaps to capitalize on the lay concept that both the heart (cardiology) and the mind (psychology) make up the complete human, as the title seems to imply. Whatever the reason was or reasons were for their coming together, the collaboration was a successful one. It produced a very, very good book.

The format of the book is the dialogue, with the physician posing questions or presenting case vignettes and the psychologist commenting on them. Though the book has been described as one that can be read in any order, the first two chapters are very important, as together they form the pillars that support the majority of the book's explanations. The first chapter is a description of the importance of secure interpersonal attachments and summarizes the important points of the classic works of Bowlby and Ainsworth. When we have problems in this area, we are left with painful insecurity. The second chapter introduces the notions of the sympathetic and parasympathetic nervous systems and the fight or flight response. Problems here lead to problems with anger. From this point on, the psychologist is able to rather skillfully explain such seemingly disparate things as jealousy, obsessive compulsive disorders, cruelty, marital conflict, abusive relationships, personality disorders and greed. They can all be traced back to problems with insecurity and inappropriate anger.

The book also deals with the treatment of such difficulties. The psychologist espouses cognitive behavioral therapy and states that change comes about by introducing more positive and constructive internal thought processes (scripts) and inducing practice with them. The book opines that most therapies that have poor outcomes are ones in which the therapist is too focused on knowledge and insight, and not enough on behavior change and practice. The chapter that introduces the cognitive behavioral approach is surprisingly not the strongest in the book, as it reads a bit like a philosophy class thought experiment. But the authors more

than make up for this minor failing by repeating the major points numerous times in the rich examples that follow in the rest of the book. Though pointedly differentiating this approach from that of the classic psychoanalytic one, it is interesting to note that when the author waxes most eloquently about cognitive behavioral theory, his words are hauntingly psychoanalytic, right down to acknowledging the existence of the unconscious. This book appears to demonstrate that when keen minds of different theoretical backgrounds apply themselves to the human condition, they stumble onto some of the same truths. They just don't know, and therefore cannot acknowledge that they have done so. The book would have been improved had the authors been able to acknowledge this overlap, especially as it is construed as a first text for readers to enter the field.

The psychologist is quite ingenious in showing how the key concepts of anger and insecurity can explain so much about life. In the dialogue however, there are times that the questions and dilemmas posed by the cardiologist seem to require deeper explanations than the introductory nature of this book would allow. Nonetheless, the psychologist is still quite deft in shedding significant light on very difficult areas while remaining true to the book's avowed mission. The psychologist is perhaps at his best when utilizing his clinical psychologist, neuropsychologist, and school psychologist knowledge base for explaining ADHD in children and adults. He is also quite compelling in giving advice on how to conduct one's life and how to raise children to be relatively free from the twin evils of anger and insecurity. It is in the messages about how we should ideally treat ourselves and others that this book is at its most useful and most humane.

In sum, this book appears to meet its goals, and appears to meet them well. It would indeed be an ideal book for the lay public as well as those in the early stages of thinking about clinical psychology as a career. Given the messages about family life, marriage and the raising of children, it might also be an ideal text specifically for couples contemplating marriage, young marrieds, and most definitely parents raising children. It is an exemplary book. Readers will likely consider themselves most fortunate that it has been written for them.

*Reviewed by: **JOHN R. THIBODEAU, PH.D, ABPP.** Dr. Thibodeau has received many distinguished teaching awards while on the faculty of the Department of Psychiatry at Albany Medical College and served as Director of the APA-Approved Internship. Currently, Dr. Thibodeau is in independent practice of clinical psychology in Altamonte Springs, Florida.*

## President's Report (continued)

several membership benefit ideas, including, but not limited to:

1. Development of membership brochures
2. Revision of brochures for clients/patients explaining what an ABPP is.
3. Possible revision of membership classes that may include candidates and distinguish between members and fellows
4. Increased number of relevant online CE programs
5. Practice Enhancement Resources
6. Employment Connections
7. Product Discounts

It is obvious that greater membership benefits are vital to increasing our numbers. If you have any other membership benefit ideas, please do not hesitate to contact me.

As a reminder, membership renewal forms were mailed several weeks ago. Please don't forget to renew your membership. If you didn't receive your renewal form, please contact me as soon as possible.

### *ABPP Promotion*

Part of the Academy's mission is to promote the Clinical ABPP. In addition to patient brochures describing ABPP psychologists, we have strategically placed ads in various SPTA and division newsletters, including:

- Ohio Psychological Association
- Pennsylvania Psychological Association
- APA Division 12 (Society of Clinical Psychology)
- APA Division 29 (Psychotherapy)
- APA Division 42 (Division of Independent Practice)
- National Psychologist

We are continuously discussing other ways to promote the ABPP through word of mouth, conferences, workshops, etc. Any and all ideas are welcome!

### *List Serv*

Currently we have two separate list servs. One is for discussions of interest to those members who have opted into this list. Various topics were discussed this year, including:

- Decline in depth therapy
- Virtue ethics
- Licensure upon graduation
- Psychologists working in interrogating organizations

Our second list is for ANNOUNCEMENTS ONLY so that we can communicate with the membership about Academy business issues, such as election nominations and results, dues renewals, etc. This list serv is NOT MEANT for member responses.

### *ABCP and AACP Integration Issue*

Over the last several years, Specialty Boards and Academies have been asked whether they would like to remain separate entities or integrate into one body. The Academy board has been struggling with this issue for several years. As it stands currently, the Academy board believes that it is in the Academy's best interests to remain separate and autonomous for now.

### *Maintenance of Certification*

According to the ABPP Special Task Force on Maintenance of Certification, the ABPP Board of Trustees has taken the position that maintenance of Certification (MOC) is consistent with the organization's strategic objective to maintain the value of board certification. The task force has developed a prototype for maintenance of certification which includes the completion of documentation of specialty-specific continued professional development.

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## President's Report (continued)

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It is anticipated that once the process is vetted and approved, it will be implemented with all board certification. The task force has developed a prototype for maintenance of certification which includes the completion of documentation of specialty-specific continued professional development. It is anticipated that once the process is vetted and approved, it will be implemented with all newly board certified specialists after 2014. The ABPP Board of Trustees will be discussing and perhaps voting on the MOC at their December meeting. Specialty Boards and Academies have been asked for their feedback. While the Academy understands the need for MOC, many of us are concerned about some proposed features, such as face-to-face review, complicated procedures, etc. Of course we will keep our members posted as we gather more information.

Recognized competence in psychology is crucial to the viability of our profession. That is one reason why the ABPP is more important than ever for every single clinical psychologist in the country. The Academy Board is working hard to increase these numbers but we need you, our members, to stand up and not only wear your ABPP proudly, but to recruit as many of your students and colleagues as you can. When we unite in our efforts, the possibilities are boundless.

It has been an honor to serve as your president this year. May we all have holidays filled with love and laughter and a wonderful 2013.

Best,

Lisa Grossman, JD, PhD, ABPP  
*2012 AACP President*

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## American Academy of Clinical Psychology

### Mentoring Policies and Procedures

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#### **Introduction:**

The Academy provides mentors upon request to ABPP Board Certification candidates as well as those interested in applying for Certification. The fact that mentoring is available does not suggest that all applicants “need” or should engage in a mentoring relationship in order to obtain the Clinical ABPP. Nevertheless, mentoring is available to anyone interested in obtaining Clinical certification, and may be particularly useful for those with special concerns, questions, or undue anxieties.

## Mentoring Policies and Procedures (continued)

### Goals:

Mentorship has several goals:

1. To provide information to potential Candidates that will help them begin the certification process.
2. To provide information that will guide Candidates through the ABPP certification process.
3. To help alleviate unnecessary anxiety and concern about the certification process, especially the oral examination.
4. To help the candidate ensure that educational background, professional statement and practice are consistent with each other, or unusual variations are accounted for.

### Mentors:

1. Mentors must be ABPP Board Certified in Clinical Psychology.
2. There is no fee for providing mentoring assistance.
3. Before providing mentoring assistance, the mentor must read the Clinical Examination Manual, describing the Professional Statement, Practice Samples and exam criteria/scoring. Special attention should be given to Sections V (Practice Samples), VI (Oral Examination), and VII (Scoring Criteria).

### Procedures:

#### Mentees

1. Requests for mentors may be received by the current Mentoring Coordinator, the current Academy President, or from the Academy Office Administrator. Contact information can be found on the Academy website at [www.aacpsy.org](http://www.aacpsy.org).
2. Mentees may request a mentor at any stage of the ABPP process, including before an application has been filed or after a failed oral examination.
3. Once provided with a mentor, mentees will be

referred to the **Academy's Mentoring Policies and Procedures** (found at Academy's website [www.aacpsy.org](http://www.aacpsy.org)) as well as the **Clinical Examination Manual** (found at the Academy's website under "Board Certification" or directly from the ABPP website at [www.abpp.org](http://www.abpp.org)).

4. Mentees will be asked to complete Evaluation Forms yearly and at the completion of the ABPP process.

#### Mentors

1. Mentors are assigned without regard to geographic location, theoretical orientation or work setting since mentoring is generic and the **Clinical Examination Manual** applies to all applicants.
2. Once a mentor is assigned a mentee, the mentor should contact the mentee immediately, expressing eagerness to assist, encouraging the mentee to complete the certification process expeditiously and inviting the mentee to contact him/her with questions or concerns.
3. Mentoring contacts may be made by any appropriate means, including e-mail, telephone, or face-to-face if time and location permit.
4. Mentors are cautioned against allowing the relationship to become more personal than professional, since this can lead to confusion about loyalties and commitments.
5. Interactions with mentees will be collegial. There is no set limit to contacts, except for the mentor's time availability and preference.
6. Mentors should be very careful to provide accurate information to mentees as this can make the difference between passing and failing. If there is any uncertainty, it is advisable for the Mentor to check the Manual before providing information. Since the examination Manual, including exam philosophy and procedures, may be updated several times a year, mentors will review the current examination Manual at least twice yearly in order to ensure that the provided information is current and accurate. If uncertainty remains, mentors

## Mentoring Policies and Procedures (continued)

- should check with the ABCP Examination Materials Reviewer or with the appropriate Regional Exam Coordinator.
7. Mentors provide assistance that will enable the candidate to prepare adequately for the Clinical ABPP process and to provide an appropriate Professional Statement and Practice Samples. “Appropriate” in this context means fulfilling the content requirements and providing a clear and useful picture of the candidate and the candidate’s professional work.
  8. Mentors will not review Practice Samples, but may discuss them with the mentee. Mentors may advise that a proposed Practice Sample would clearly not be acceptable to the examiners. (See examples below.)
  9. Guidance to those mentored may include explanations tailored the needs of each applicant concerning the philosophy, structure and rationale for the Board Certification processes, as well as general descriptions of the expectations of examiners for candidate clinical competence. It is the hope that such mentoring will help mentees better prepare their Professional Statements, Practice Samples, know how to describe their practice orientation and be prepared to answer questions about their work as well as ethical issues they may encounter during the oral examination.
  10. Mentors may raise questions about possible deficits in the mentee’s knowledge and skills, and may advise the mentee that a proposed sample would clearly not be acceptable to the examiners. Mentors may, on occasion, recommend independent readings, courses and supervision that might be helpful in the mentee’s development of further skills.
  11. Examples of helpful and appropriate mentoring include, but are not limited to:
    - a. Pointing out that the ethical dilemma in the Professional Statement is not really a dilemma but merely an interpersonal conflict.
    - b. Advising that a proposed Practice Sample would not adequately demonstrate skills commensurate with a specialist in clinical psychology. e.g., educating Masters level therapists in a community mental health setting about the symptoms and treatment of a clinical disorder.
  12. Mentors are not responsible for mentees successfully obtaining the Clinical ABPP. Whether a candidate passes the oral examination is determined completely on the basis of the candidate’s own materials and exam performance. Mentors do not certify mentees’ readiness to take the examination or the applicant’s likelihood of passing the examination. If requested, mentors may offer their own comments regarding an applicant’s professional strengths and weaknesses.
    - c. Indicating that the proposed treatment Practice Sample would be inconsistent with the mentee’s educational and supervisory background. For example, a mentee’s educational background in CBT presenting a case utilizing psychodynamic psychotherapy.
    - d. Advising that the Candidate’s Professional Statement referred to practices that fell significantly outside his education and training, and therefore needed to be accounted for.
    - e. Advising that the Candidate’s “unique” approach to treatment, which fell outside of any generally recognized traditions of intervention within clinical psychology, would not be acceptable.
    - f. Advising a mentee to demonstrate both a broad base in the specialty of clinical psychology as well as particular areas of interest rather than focusing too narrowly only on a specific skill.
    - g. Advising that the proposed demonstration of a neuropsychological screening for possible head injury assessment using only one brief screening instrument would not be acceptable.

## Mentoring Policies and Procedures (continued)

13. The comments and advice of mentors are not communicated to ABCP or to examiners, have no bearing on the examination outcome, and may not be used to appeal an examination outcome. Mentors should never give candidates advice that the candidate could construe as representing the views of the Examining Board or advice about the Professional Statement or Practice Samples that the candidate could construe as approval or as meeting the standards of ABCP for Board Certification, since this can lead to appeals of failed exams citing that the mentor assured the mentee that the material would pass. The mentor should not be involved in the examination itself, or its outcome, with the single exception of helping the failed candidate to understand the written feedback provided by the panel and to discuss with the candidate what steps might be taken in preparing for reexamination.
14. Mentors are advised to keep e-mails or other records of interaction with mentees so that any concerns about the mentoring process can be reviewed if necessary.
15. Questions about the mentoring process, unusual circumstances, or concerns while mentoring should be referred to the Academy's Mentoring Coordinator or the President.

Mentoring Coordinator shall send an Evaluation form each year from the time a mentor was assigned until the mentee has successfully obtained the ABPP or prematurely stopped the process.

4. The Mentoring Coordinator shall use the Evaluation Form not only to assess the strengths and weakness of the Academy's Mentoring Program but also to assess the strengths and weaknesses of assigned Mentors.
5. If a Mentor receives a negative evaluation from a mentee, the Mentoring Coordinator shall contact the Mentor to discuss whatever problems may have occurred in the mentoring process. If a Mentor repeatedly receives negative evaluations from different mentees, the Mentoring Coordinator may choose, along with Board approval, to not further use that individual in the Mentoring Program.

*We wish to acknowledge the Academy Board for developing the Policies and Procedures with special thanks to Drs. Lisa Grossman and Roger Brooke for their invaluable contributions and commitment to the project.*

### **Mentoring Coordinator:**

1. The Mentoring Coordinator shall maintain a record of all mentees, including date of first contact, name, e-mail address, mentor assigned, employment type, city and state, whether regular or Senior Option and the date of Board Certification.
2. The Mentoring Coordinator shall maintain a list of all mentors, how many mentees they have mentored (past and present) and outcome of mentee evaluations.
3. The Mentoring Coordinator shall collect written Evaluation Forms from all mentees after their Oral Examination, whether or not the mentee passed. The

## Recent Board Certified Psychologists and Fellows of the Academy

*The Board of Directors of the Academy and Membership welcome the following recently Board Certified Clinical Psychologists as Fellows of the Academy:*

Heather M. Anson, Ph.D., ABPP  
William J. Bobowicz, Jr., Psy.D., ABPP  
Jill E. Breitbach, Psy.D., ABPP  
Margaret A. Cramer, Ph.D., ABPP  
Donna J. Ferguson Psy.D., ABPP  
James R. Flens, Psy.D., ABPP  
Cesar A. Gonzalez, Ph.D., ABPP  
Kristina M. Hallett, Ph.D., ABPP  
Jeremy B. Harrison, Psy.D., ABPP  
Stacey H. Lanier, Ph.D., ABPP  
Alfredo J. Lowe, Ph.D., ABPP  
Susan K. McGroarty, Ph.D., ABPP  
Kevin P. Mulligan Psy.D., ABPP

Kevin P. Newgren, Psy.D., ABPP  
Alexis R. Nusbaum, Ph.D., ABPP  
Paul David Nussbaum, Ph.D., ABPP  
Oscar H. Oo, Psy.D., ABPP  
Lindsay A. Phillips, Psy.D., ABPP  
Cheryll R. Rothery, Psy.D., ABPP  
Daniela E. Schreier, Psy.D., ABPP  
Jennifer L. Scott, Psy.D., ABPP  
Paul A. Smiley, Psy.D., ABPP  
Stephen M. Timchack, Psy.D., ABPP  
Anne Marie Vorbach, Ph.D., ABPP  
Marlin C. Wolf, Ph.D., ABPP

*Congratulations on obtaining Board Certification in Clinical Psychology to our non-member colleagues:*

Patricia A. Alexander, Ph.D., ABPP  
Corey M. Arranz, Psy.D., ABPP  
Peter P. Battista, Psy.D., ABPP  
Dawn M. Brock, Psy.D., ABPP  
Robert J. Camargo, Ph.D., ABPP  
Kenneth E. Carter, Ph.D., ABPP  
Shawna M. Chee, Psy.D., ABPP  
Catherine G. Deering, Ph.D., ABPP  
Timothy M. DeJong, Ph.D., ABPP  
Gloria J. Emmett, Ph.D., ABPP  
Richard G. Frey, Ph.D., ABPP  
Roger O. Gervais, Ph.D., ABPP  
Frank A. Ghinassi, Ph.D., ABPP  
Scott C. Green, Ph.D., ABPP  
Kyle A. Grohmann, Ph.D., ABPP

James L. Harlow, Psy.D., ABPP  
Brandon M. Heck, Psy.D., ABPP  
Allison N. Pate, Ph.D., ABPP  
Emily C. Ptaszek, Psy.D., ABPP  
Sonja L. Raciti, Psy.D., ABPP  
Robert B. Rottschafer, Ph.D., ABPP  
Laura M. Saunders, Ph.D., ABPP  
Lawrence M. Sideman, Ph.D., ABPP  
Sean K. Sterling, Ph.D., ABPP  
Steven R. Thorp, Ph.D., ABPP  
Nancy S. Thurston, Psy.D., ABPP  
Ryan D. Trumbo, Psy.D., ABPP  
Anneke L. Vandenbroek, Ph.D., ABPP  
Sharlene D. Wedin, Psy.D., ABPP  
Eduardo Ysern, Ph.D., ABPP



## Call for Papers

### *Bulletin of the American Academy of Clinical Psychology*

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