NAPPP
NATIONAL ALLIANCE of PROFESSIONAL PSYCHOLOGICAL PROVIDERS
Jan-Feb 2024
Volume 19 No. 1

The Clinical Practitioner

Is the Ketamine Party Over?

By Keith Petrosky, Ph.D., ABMP

Celebrity deaths can heighten public awareness to the dangers of certain drugs the way that Michael Jackson's death did from the intravenous anesthetic Propofol. When it was determined that the "acute effects of ketamine" were primarily responsible for Matthew Perry's death, the various spokespeople from the ketamine industry seemed to go into immediate damage control, challenging any responsibility that could be attributed to the use of this drug, particularly for physicians prescribing it in its infusion form.

For example, the American Society of Ketamine Physicians, Psychotherapists and Practitioners (I am guessing that most of us never knew they existed) announced that they would soon be publishing a set of guidelines for ketamine home use. This would only apply to patients with a specific profile who would use ketamine in conjunction with a close relationship with a physician and necessity for some "in-office" follow up. One might conclude from reaction that there is some anxiety about potential additional federal regulation that could affect the use of this drug.

Right after Perry's death various news stories addressing various "myths" about the drug were pushed forward by the various people who market information to the news industry. Many of the statements did not make a whole lot of sense. For example, it was alleged that the drug was not addictive (purportedly a "myth") since it was only mildly to moderately physically addictive (also highly psychologically addictive, which was not mentioned) and thus not addictive. If that statement confuses you, then you are in the majority. Presumably drugs that are not considered as physically addictive as opioids, amphetamines, and cocaine would be considered non-addictive to the people with vested interests in the industry generating income from ketamine.

More myth bursting responses were forthcoming. In particular, these infusions were alleged to not be involved in his death due to the short half-life of the drug of three to four hours which had worn off way before his death occurred. However, this leaves out the fact that a patient receiving infusions of this drug could become dependent on the drug both physically and psychologically and could then obtain the drug from elsewhere if they want more ketamine than the doctor is providing.

The fact that the drug has a short half-life was also stated as making it relatively easy to stop using since it is fully metabolized in about a day's time. This makes no sense to anyone trained in psychopharmacology since other short-acting and highly addictive substances like cocaine and valium and other drugs are not easy to stop

 TCP Online ISSN 2373-4787

The Clinical Practitioner
January - February 2024
Vol. 19 No. 1

Contents:

using. In actuality, the shorter half-life makes these drugs even more addictive since their effect wears off quickly and the person then wants more.

Another "myth" addressed by ketamine industry spokespeople was that the drug could be "self-prescribed". This is hardly a myth since people have been using ketamine for recreational purposes for many years and very few of them had any prescriptions for use of the drug. Regular people "self-prescribe" alcohol and cannabis and other chemical substances every day. I see lots of alcoholics in my office and not a single one has ever presented a prescription for the use of beer, wine, or vodka, or anything else. The fact that ketamine users "should" (recall Albert Ellis' caveats about the "tyranny of the shoulds") be diagnosed with depression or anxiety before using these substances, according to these experts, nonetheless does not prevent them from obtaining ketamine somewhere other than a physician's office without needing a mental health diagnosis.

For some reason ketamine industry public relations people were not as defensive in their comments regarding intranasal ketamine so one can only speculate that ketamine "therapy" does not typically involve this route of administration but rather just the intravenous route. They conceded that intranasal ketamine use could be problematic since it could cause more aggressive drug seeking behavior. Also, they conceded that a person could exceed the safe dose of the medication this way. In the same sentence they then went on to declare that ketamine can be abused like the opiates and benzodiazepines but not apparently if it is given through an infusion. This leaves out the fact that once an addiction has occurred it can be "fed" through oral ketamine readily available in the person's environment.

Ketamine was cleared by the FDA in 2019 to be used for treatment resistant depression in cases that might have been treated with something as radical as ECT as the next possible step. Clearly no one should undergo anything as radical as ECT if any other treatment is available. (I previously reported on a patient of mine in her early thirties who cannot recall anything prior to receiving thirty ECT treatments prescribed by a psychiatrist with an undeserved, positive reputation; I saw her as a teenager for more than a year and a half but she could not recall ever meeting me after her ECT treatments). However, ketamine then began to be used more broadly as an alternative to other medication treatments for depression and anxiety. This follows the model that we have seen where street drugs like LSD and psilocybin are now being used as the new psychiatric drugs since currently available drugs do not work that effectively. Ketamine has been touted as "safe when used properly" since it does not usually cause respiratory or cardiac issues. However,

this belief was contradicted about a week ago when two Colorado paramedics were convicted of causing an overdose and death when a man in an agitated state was accidentally given too much ketamine in the attempt to calm him down.

A Cascade of Medical Errors Appear to Have Caused Perry's Death

Considering the many attacks that take place from the medical establishment every time a state attempts to gain prescription privileges for properly trained psychologists, the same medical establishment seems unashamed and unaccountable for the countless medical errors that contribute to preventable deaths every day in America. In Perry's case, first one would need to question the decision to treat a back injury from a jet ski accident with an opiate that was never intended for long-term use. Using an opiate in a person prone to addiction would be another error. Continuing to rewrite prescriptions for an opiate which is only intended for short-term use would be a third error. Also, since people taking an opiate even for short-term use should be prescribed a stool softener along with the opiate, someone failed to do this. The eventual consequence of constipation caused by opiates is a bowel impaction. Again, someone failed to monitor for this predictable development and his bowel eventually burst. When this happens, it is a serious emergency since it can cause infection, shock, multiple organ failure, and death.

After Perry fortunately recovered in the hospital from his burst bowel, a second addictive drug, ketamine, was used to treat his pain as well as the accompanied depression he was experiencing. Someone also prescribed the drug Subutex which is a partial opioid agonist typically used to prevent withdrawal issues when stopping opiates but also sometimes used for pain. By binding less fully to opioid receptors than a typical opiate it helps reduce cravings for opioids without producing euphoria. One of the more frequent side effects of Subutex is that it can cause back pain which is presumably what Perry continued to suffer from after his accident. It can also create dependence like other opioids do. It can also cause respiratory depression. The American Addiction Centers states that combining ketamine with other drugs, including prescriptions and illicit drugs and alcohol, can be unpredictable and extremely dangerous [1]. The risk of combining ketamine and other drugs can range from pain and discomfort to overdose and death.

Both the ketamine and Subutex cause somnolence and Perry was alone in the most dangerous situation for a person likely to fall asleep – in a swimming pool. Brian Jones, who was the original leader of the band the Rolling Stones, also drowned in a swimming pool and in that case, drugs were also blamed for the musician's death. However, one key difference is that Jones was known for taking street drugs and drinking large amounts of alcohol (his liver was enlarged upon autopsy) while Perry's death involved the negative effects of prescriptions provided by physicians. However, in the attempt to dodge any blame, the drugs themselves were blamed rather than the medical professionals prescribing them. The various news releases seemed to attempt to avoid discussion of the many contributing factors in Perry's death such as the large number of medical errors and the health risks of polypharmacy which prescribing psychologists are trained to avoid whenever possible (see NAPPP's White Paper on prescribing guidelines for details).

As previously stated, mixing ketamine with other substances including recreational drugs and alcohol exacerbates adverse side effects. One study in London found that nine out of ten people who presented for ketamine toxicity in an emergency room had combined ketamine with a second drug or alcohol [2]. Similarly, a study of ketamine deaths in New York City from 1997 to 1999 found that twelve of fifteen deaths were attributed to polydrug overdoses involving ketamine [3]. A more recent national study of ketamine exposures reporting to poison centers over a sixteen-year period involved the use of a second drug [4]. More serious outcomes were reported in ketamine exposures involving multiple substances, including twenty deaths.

What is Ketamine?

Just as the current "Tranq" epidemic (referring to the horse tranquilizer Xylazine), has emerged as the latest newest, deadly street drug in the United

States, ketamine also began as a horse tranquilizer when it was first patented in Belgium in 1963. It was tested on humans in 1964 and was later approved by the FDA in 1970 for use as a battlefield anesthetic for soldiers during the Vietnam War. Shortly thereafter it began being used for both therapeutic and recreational purposes. The drug Ecstasy was created through tweaking ketamine slightly to give it more stimulant properties to augment its dissociative and potentially hallucinogenic properties. The chemical structure of the two drugs is similar with ecstasy containing a second methyl group (CH_3) and lacking a chloride (Cl). Otherwise, they are the same.

Ketamine is sometimes sold on the street as Ecstasy. Pharmaceutical use of ketamine is delivered either by a nasal spray (esketamine), or through an infusion (through a needle), typically in a healthcare provider's office or other healthcare facility. A psychiatrist or other medical doctor does not need to be present during the infusion to supervise but rather a nurse or social worker or therapist observes the infusion and provides verbal input to soothe the person's distress should this occur. This qualifies as "under medical supervision."

Delivering medication under medical supervision allows fees to skyrocket the way a trip to the emergency room can cost exorbitant amounts of money. For example, an evaluation for something like a kidney stone can cost upwards of ten thousand dollars for the following medical interventions – 1) a blood pressure and temperature check by a nurse upon entry to the emergency room, 2) a brief history of the person's reason for coming to the hospital, 3) a blood draw (to assess for a possible urinary tract infection or other source of the person's pain), 4) a urine sample (looking for blood in the urine), 5) a CT scan of the urinary tract area if indicated, 6) a ten minute discussion with a physician's assistant to deliver the diagnosis, 7) an infusion of sodium chloride delivered as a bag of fluid from an IV pole (to increase the person's body fluids and help get the kidney stone to flush itself out) and 8) a small amount of an NSAID like Toradol for pain. Granted this is important to a person experiencing the pain of a kidney stone but should it cost more than ten thousand dollars for these interventions taking less than two hours in total of staff time to complete all eight steps? Similarly, one can only imagine the amount of income being generated in a ketamine infusion practice with a short acting drug that wears off in a few hours after treatment.

Infusion in ketamine "therapy" (as well as infusion in chemotherapy for cancer and in delivering antibiotics in the case of serious infections), is a way to increase the amount of the drug in the person's bloodstream through bypassing the "first pass" deactivation of medications delivered by mouth as they pass through the stomach through the portal vein through the liver and into the bloodstream. If the drug had a longer half-life so that fewer infusions would be necessary then it might make a little more sense to undergo these infusions. However, the drug ketamine is not treating depression the way that an antibiotic treats an infection. Rather it is just masking any depression through boosting the person's mood state while on this short-acting drug. It is similar to self-prescribed treatment of stress through drinking alcohol or smoking cannabis which might also help to mask a person's pain and stress. However, as in alcoholism, it eventually becomes not only the treatment for the problem but also part of its cause as once ketamine infusions stop the person requires more ketamine infusions. Unless one has an unlimited source of income everyone will eventually need to stop this "therapy" but will have trouble doing so due to its addictive nature.

For those readers who recall my previous article about "Freud as Physician and Prescriber" [5] you may recall that Freud treated his psychoanalysis patients with an accompanied injection of a solution of cocaine. When patients seemed to be feeling better from the cocaine, they would stop psychoanalysis only to later return to treatment without knowing what it was that made them temporarily feel better. This helps to account for the fact that even after as many as two thousand psychoanalysis treatments (some patients were seen every day and even twice a day) some of Freud's patients still eventually committed suicide. One of Freud's fellow physicians and friends, Ernst Fleischl von Marxow, also died after using cocaine to treat addiction to morphine which eventually caused his death since the second addiction did not cure the first but only added to it, causing his health to further deteriorate. Freud

eventually confessed to Sandor Ferenczi that psychoanalysis did not help anyone but was a "good way to make a living." This material is discussed in much greater detail in Frederick Crews' book: "Freud, the Making of an Illusion" [6].

No doubt Ketamine therapy is also a great way to make a living for those involved in this form of depression "therapy." That must be why there has been such a defensive reaction to protect the interests of ketamine prescribing physicians. The immediate news stories that were published afterwards speak to the motive to protect the industry at the expense of any patients undergoing these treatments. If a prescribing psychologist had been responsible this would have spelled the death of this expansion of "scope of practice" authority. However, in reality not a single patient has ever been injured by a prescribing psychologist going back sixty years beginning in the DOD experiments in the sixties to the present (with six states now allowing prescribing authority). This has not stopped the medical lobbyists from getting RXP laws that are nearly passed to be defeated at the last minute due to bogus claims of patient safety concerns.

For physicians and their lobbyists Perry's death probably doesn't mean much as they are used to the risk of potentially harming patients with their treatments. Many patients even avoid going to the hospital because of their awareness that they may be injured during their hospital stay, for example by an antibiotic resistant bacterial infection that they acquired during their stay there. More than a hundred thousand Americans die in the hospital each year due to physician errors with prescribing medication, injuries from diagnostic procedures, and surgical errors involving the wrong patient or the wrong procedure. However, only when psychologists prescribe is it a concern for the lobbyists of these hypocritical, would-be "protectors" of the health and safety of patients who are in reality just invested in maintaining their proprietary control of the drug prescribing industry.

Public awareness of a problem can bring about fundamental changes. For example, the environmental movement and the development of the EPA was launched after the publication of Silent Spring which was written by the marine biologist Rachel Carson. Her book called into question the indiscriminate use of pesticides, in particular DDT, and the effects that these chemicals were having on the environment, including birds and other animals, and via the food chain even humans. While one might like to see the ketamine industry undergo some needed reforms in light of Perry's death, the more cynical observer will view this incident as no more important to the "powers that be" than a grain of sand on a beach. The people with financial interests do what they always do in these situations, which is to quickly shift into damage control mode and put out a flurry of news stories debunking any patient risk and then go right back to business as usual. They assume that the incident will fade away in the minds of the public over time. Only time will tell whether this ketamine party is continuing to "rev up" or if it is beginning to wind down.

You may direct any comments or questions to drkeith1@verizon.net.

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In My Opinion

Is It Time To Be Concerned About Fraud In Science?

By John Caccavale, Ph.D., ABMP

It seems that reports of scientific fraud are becoming a hot topic for those paying attention. Researchers are entrusted with the responsibility of pushing the boundaries of human knowledge contributing to the collective understanding of the world around us. However, what used to be a noble pursuit for truth has recently been marred by an alarming rise in scientific fraud. All too frequently, reports of journals retracting previously published articles due to misstated or fraudulent findings is becoming normalized. This trend not only undermines the integrity of scientific inquiry but erodes public trust in the very institutions meant to advance our understanding of the world. Even if the fraud is occurring outside of psychology, it should still be a concern for every professional practitioner.

The landscape of scientific research has been punctuated by numerous instances of retractions, revealing a disconcerting pattern of dishonesty. One glaring example is the case of Paolo Macchiarini, a once-celebrated surgeon, whose groundbreaking work on synthetic windpipes for transplantation was later exposed as fraudulent. Journals were forced to retract several of his articles, a stark reminder that even high-profile researchers are not immune to the allure of scientific misconduct. Another noteworthy example involves the field of psychology, where the infamous "power pose" research by social psychologist, Amy Cuddy, faced significant scrutiny. The study, which suggested that adopting certain power poses could influence hormonal levels and behavior, was retracted amid concerns about data manipulation and statistical inconsistencies. These instances underscore the imperative for constant vigilance and scrutiny within the scientific community.

Factors Contributing to Scientific Fraud

Understanding the factors that drive researchers to engage in fraudulent practices is essential for addressing the root causes of this pervasive issue. One significant factor is the "publish or perish" culture that pervades academia. The pressure to produce a constant stream of publishable results can create an environment where researchers may be tempted to cut corners or manipulate data to meet these demands. Moreover, the hyper-competitive nature of academia, where funding, promotions, and prestige hinge on publication records, can foster a culture where the ends seem to justify the means. Combined with the fear of professional stagnation or irrelevance, this environment may push some researchers towards unethical practices in pursuit of success. The role of flawed incentive structures within academia cannot be overstated. The emphasis on quantity over quality, coupled with the allure of high-impact publications, may inadvertently incentivize researchers to prioritize flashy results over rigorous methodology.

The pressure to conform to prevailing academic trends can further compromise scientific rigor, as researchers may be driven to produce findings that align with popular narratives rather than objective truths. Moreover, although many journal editors are unlikely to admit, reviewers know the work and interests of many of the authors who submit articles and studies. They are loathe to challenge the work of well-known researchers while at the same time making believe that the process is anonymous. Philip Zimbardo is a case in point. Zimbardo raised the value of a Stanford psychology degree even as he engaged in significant unethical behavior. He was rewarded by being elected APA President in 2002.

A Call for Systemic Change

Addressing the issue of scientific fraud requires a multifaceted approach that encompasses institutional reforms, changes in incentive structures, and a renewed commitment to transparency and integrity. Journals play a pivotal role in upholding the standards of scientific inquiry and although their commitment to retracting flawed articles is commendable it's not enough to say "sorry" and make like everything is fine. Prevention remains the key to mitigating the impact of fraudulent practices.

The rise in scientific fraud is a symptom of deeper systemic issues within academia and the knowledge industrial process. As concerned scientific-practitioners, it is our collective responsibility to advocate for a cultural shift that prioritizes transparency, reproducibility, and ethical conduct. By fostering an environment that encourages robust scrutiny, collaboration, and adherence to rigorous scientific principles, we can fortify the foundations of scientific inquiry and ensure that the pursuit of knowledge remains an honorable and trustworthy endeavor. One positive change could be journals to stop publishing so much pablum that is so ubiquitous in so many journals.

Systemic Reforms for a Culture of Integrity

To tackle the issue of scientific fraud at its roots, systemic reforms are imperative. Academic institutions must prioritize fostering a culture of integrity over quantity of publications. Implementing comprehensive training programs on research ethics and responsible conduct can equip researchers with the tools needed to navigate the complex ethical landscape of scientific inquiry. This emphasis on education can instill a strong ethical foundation and reinforce the importance of rigorous methodologies. Moreover, institutions and funding agencies should reconsider the emphasis on quantitative metrics for career advancement. Presently, quantity over-rules quality and strong ethics in academia. If a researcher doesn't bring in funding by publishing as many articles as possible, they'll wind up in Idaho or North Dakota, nice places if you like academic Siberia.

Transparent reporting and data sharing are crucial components of scientific integrity. Journals should require researchers to provide detailed documentation of their methods, data, and analyses, enabling others to replicate and validate the findings. Initiatives promoting open science, such as preregistration of study protocols and sharing of raw data, can enhance transparency and reduce the likelihood of selective reporting or data manipulation. Research institutions can play a pivotal role by establishing clear guidelines on data management and sharing. Encouraging researchers to deposit datasets in public repositories not only facilitates transparency but also allows for independent verification of results. Embracing technologies like blockchain for data provenance can further enhance the traceability and credibility of research findings.

The fight against scientific fraud requires a collective commitment from researchers, institutions, and journals alike. By addressing the underlying systemic issues, fostering a culture of integrity, and implementing proactive measures, we can work towards restoring public trust in scientific inquiry. As concerned researchers, it is incumbent upon us to advocate for these changes and uphold the principles that define the noble pursuit of knowledge. Only through a united effort can we ensure that the scientific community remains a beacon of honesty, transparency, and unwavering commitment to the truth. In my opinion, at a time when so many people within the political process are advancing any ridiculous notion that falls out of their mouth bypassing every part of their brain, it is important to raise

the status and trust of scientific findings. If the moronic anti-vaxers and conspiracy "theorists" continue to dominate the news, scientific fraud will serve to reinforce their particular form of psychopathology.

Comments are welcome and can be sent to drcaccavale@nappp.org

What are the treatment remission, response and extent of improvement rates after up to four trials of antidepressant therapies in real-world depressed patients? A reanalysis of the STAR*D study's patient-level data with fidelity to the original research protocol

The study was open label and semirandomized examining the effectiveness of up to four optimized and increasingly aggressive, antidepressant therapies in depressed adults. Patients who failed to gain adequate relief from their level 1 trial on the SSRI citalopram could receive up to three additional treatment trials in levels 2-4.

Subjects were 4041 adults screened positive for major depressive disorder. In contrast to most clinical trials, STAR*D enrolled patients seeking care (vs recruited) and included patients with a wide range of common comorbid medical and psychiatric conditions to enhance the generalizability of findings to real-world clinical practice.

STAR*D evaluated the relative effectiveness of 13 antidepressants therapies in treatment levels 2-4 for depressed patients who failed to gain adequate benefit from their level 1 medication trial.

According to the STAR*D protocol, the primary outcome was remission, defined as a score <8 on the blinded Hamilton Rating Scale for Depression (HRSD). Response was a secondary outcome defined as 50% reduction in HRSD scores. STAR*D's protocol specifically excluded all non-blinded clinician-administered assessments from use as research outcome measures.

STAR*D investigators did not use the protocol-stipulated HRSD to report cumulative remission and response rates in their summary article and instead used a non-blinded clinic-administered assessment. This inflated their report of outcomes, as did their inclusion of 99 patients who scored as remitted on the HRSD at study outset as well as 125 who scored as remitted when initiating their next-level treatment. These patients should have been excluded from data analysis. In contrast to the STAR*D-reported 67% cumulative remission rate after up to four antidepressant treatment trials, the rate was 35.0% when using the protocol-stipulated HRSD and inclusion in data analysis criteria.

Conclusion: STAR*D's cumulative remission rate was approximately half of that reported.

BMJ Open. 2023 Jul 25;13(7):e063095. doi: 10.1136/bmjopen-2022-063095.

Dr. Reinhardt: Psychiatric Times covered this with a piece titled "STAR*D Dethroned?" "For us in psychiatry, if the BMJ authors are correct, this is a huge setback, as all of the publications and policy decisions based on the STAR*D findings that became clinical dogma since 2006 will need to be reviewed, revisited, and possibly retracted." (https://www.psychiatrictimes.com/view/star-d-dethroned?eKey=cmVzZWFyY2guZHJkYXZlQGdtYWlsLmNvbQ==)

This must come as quite a surprise to many psychiatrists that trusted the chemical company shills.

Cat Ownership and Schizophrenia-Related Disorders and Psychotic-Like Experiences: A Systematic Review and Meta-Analysis

It has been proposed that cat ownership may be a risk-modifying factor for schizophrenia-related disorders and psychotic-like experiences (PLE). This study aimed to systematically review and meta-analyze publications that reported the relationship between cat ownership and schizophrenia-related outcomes.

We searched Medline, Embase, CINAHL, Web of Science, and gray literature for publications between January 1, 1980, and May 30, 2023, regardless of geographical location and language. Backward citation search methods were used to locate additional articles. We included studies that reported original data on cat ownership and schizophrenia-related outcomes. We meta-analyzed estimates based on broad definitions (cat ownership, cat bites, and cat contact) with estimates with or without covariate adjustments. We pooled comparable estimates using random-effects models and assessed the risk of bias, heterogeneity, and study quality.

We identified 1915 studies, of which 106 were chosen

for full-text review, ultimately resulting in the inclusion of 17 studies. We found an association between broadly defined cat ownership and increased odds of developing schizophrenia-related disorders. The unadjusted pooled odds ratio (OR) was 2.35 (95% CI: 1.38–4.01), while the adjusted pooled estimate was 2.24 (95% CI: 1.61–3.12). We were unable to aggregate the estimates for the PLE outcomes because of the broad range of measures.

Conclusions: Our findings support an association between cat exposure and an increased risk of broadly defined schizophrenia-related disorders; however, the findings related to PLE as an outcome are mixed. There is a need for more high-quality studies in this field.

Schizophrenia Bulletin, sbad168, https://doi.org/10.1093/schbul/sbad168

Dr. Reinhardt: These "experts" did not attempt to explore the "why", it is as if they have never read anything about toxoplasmosis (or had it mentioned in medical school) !

Not reported in the US drug "journals"?

Valproate prescribing rules will tighten from January, says MHRA

From January 2024 valproate must not be started in new patients aged under 55 unless two specialists agree that there are no alternative options or that "compelling reasons" mean that the reproductive risks "do not apply," the UK Medicines and Healthcare Products Regulatory Agency (MHRA) has said.1

The change is one of the first round of measures set to be put in place by the agency to reduce the known harms of valproate, including the "significant risk of serious harm to the baby if taken during pregnancy and the risk of impaired fertility/

BMJ 2023; 383 doi: https://doi.org/10.1136/bmj.p2836

Curb antidepressant prescribing to improve mental health, say campaigners

A group of 31 medical professionals, researchers, patients' representatives, and politicians has called on the UK government to reverse the increase in antidepressant prescribing seen in the past decade.

In a letter published in The BMJ, the authors, who include members of the Beyond Pills All Party Parliamentary Group, former health minister Norman Lamb, and several psychiatry professors, argue that evidence indicates that antidepressants benefit only people with the severest depression, and yet prescribing rates are high among those with mild and moderate depression.

"Rising antidepressant prescribing is not associated with an improvement in mental health outcomes at the population level, which, according to some measures, have worsened as antidepressant prescribing has risen," the group wrote.

They suggested that the £58m spent on antidepressants each year in England could be better spent on boosting non-pharmacological interventions for depression.

BMJ 2023; 383 doi: https://doi.org/10.1136/bmj.p2873

Dr. Reinhardt: "Suicide rates have risen by about 30% since 2000. Almost a third of U.S. adults now report symptoms of either depression or anxiety, roughly three times as many as in 2019, and about one in 25 adults has a serious mental illness like bipolar disorder or schizophrenia." (https://time.com/6308096/therapy-mental-health-worse-us/)

"Anti"depressants and depression rate, correlation or causation?

French pharma firm ordered to pay millions over deadly diabetes drug

A French appeals court on Wednesday ordered pharmaceutical firm Servier to pay more than $460 million in damages over a scandal involving a diabetes drug linked to hundreds of deaths.

The health scandal came to light in 2007 when a doctor raised the alert on heart risks linked to Mediator, a drug destined for overweight people with diabetes but that was also widely prescribed to others as an appetite-suppressant.

The drug, which may have caused up to 1,800 deaths, was later banned in France where millions of people took it. Known by its lab name as benfluorex, Mediator was initially licensed to reduce levels of fatty proteins called lipids, with the claim that it helped diabetics control their level of blood sugar.

But it also suppressed appetite, which meant it gained a secondary official use to help obese diabetics lose weight. In the end, it was widely sold on prescription for even non-diabetics who wanted to slim down.

https://medicalxpress.com/news/2023-12-french-pharma-firm-pay-millions.html

Dr. Reinhardt: Benfluorex, sold under the brand name Mediator, was on the market between 1976 and 2009, and is thought to have caused between 500 and 2,000 deaths.

Yes, 33 years before adverse effects were fully known and action taken. Dinitrophenol, banned by world bodies and most coutries after over 100 years of deaths, still available in the US. Phenylpropanolamine, developed in 1938, banned in 2005, causes hemorrhagic stroke.

Fenfluramine and dexfenfluramine, serotonin boosters, approved in 1973, banned 24 years later. Semaglutide, the most recent fad, was only approved 6 years ago. Do you feel lucky?

The latest marketing hype pushing "weight loss" chemicals

Significant Decrease in Alcohol Use Disorder Symptoms Secondary to Semaglutide Therapy for Weight Loss: A Case Series

Retrospective chart review was utilized to identify patients treated with semaglutide for weight loss who also had positive screenings for AUD on the Alcohol Use Disorder Identification Test (AUDIT; score >?8 considered positive) prior to initiation of semaglutide therapy. Six patients were identified who met these criteria. A paired t test was utilized to compare initial AUDIT scores with AUDIT scores after initiation of semaglutide therapy.

All 6 identified patients (100%) had significant reduction in AUD symptomatology based on AUDIT score improvement following treatment with semaglutide (mean decrease of 9.5 points, P<?001).

Conclusions: This case series is consistent with preclinical data and suggests that GLP-1RAs have strong potential in the treatment of AUD. Additional randomized, placebo-controlled clinical studies are needed to fully assess the efficacy of semaglutide in treating AUD.J

Clin Psychiatry 2024;85(1):23m15068

Dr. Reinhardt: The known adverse effects from Ozempic and other brands of semaglutide include:

Serious reactions: thyroid C-cell tumor (animal studies), medullary thyroid CA risk, hypersensitivity rxn, anaphylaxis, angioedema, acute kidney injury, chronic renal failure exacerbation, pancreatitis, cholelithiasis, cholecystitis ileus and syncope, for those who are less lucky.

The COMMON reactions are nausea, vomiting, diarrhea, abdominal pain, constipation, diabetic retinopathy, eructation, appetite decr. (PO form), hypoglycemia (pen form), dyspepsia, abdominal distension (PO form), GERD, flatulence, gastritis, amylase incr., lipase incr. and injection site rxn (pen form).

Given the effects, I doubt if most semaglutid users would feel like going to the bar.

Approval of Tirzepatide for Treating Obesity 'Exciting'

Recently, the FDA approved tirzepatide for the treatment of obesity. We're used to using tirzepatide as Mounjaro for the treatment of type 2 diabetes, but now it's been approved for the treatment of obesity. The approval basically came from data obtained during the SURMOUNT-1 and -2 trials, which looked first at the treatment of obesity in people without

diabetes and the treatment of obesity in people with type 2 diabetes. The average weight loss in those trials was 48 lb. In patients without diabetes, the rate of weight loss was 23%. In those with type 2 diabetes, it was 16%. I think it's really exciting to have another agent for use in the treatment of obesity in our patients who need such treatment. Anne L. Peters, MD,

https://www.medscape.com/viewarticle/998455?ecd=wnl_infocu1_broad_broad_persoexpansion-editorial_20231202_etid6116373&uac=19361SY&impID=6116373

Dr. Reinhardt: "Really exciting." Mounjaro, having been available long enough for post-approval reporting, not only has the "benefits" above but has also been found to cause tachycardia.

Also, why would diabetics have so much less weight loss?

Preoperative Midazolam and Patient-Centered Outcomes of Older Patients

To determine the differences in global perioperative satisfaction in patients with preoperative administration of oral midazolam compared with placebo, a double-blind, parallel-group, placebo-controlled randomized clinical trial was conducted in 9 German hospitals between October 2017 and May 2019 (last follow-up, June 24, 2019). Eligible patients aged 65 to 80 years who were scheduled for elective inpatient surgery for at least 30 minutes under general anesthesia and with planned extubation were enrolled. Data were analyzed from November 2019 to December 2020.

Patients were randomized to receive oral midazolam, 3.75 mg (n?309), or placebo (n=307) 30 to 45 minutes prior to anesthesia induction. Main Outcomes and Measures The primary outcome was global patient satisfaction evaluated using the self-reported Evaluation du Vécu de l'Anesthésie Generale (EVAN-G) questionnaire on the first postoperative day. Key secondary outcomes included sensitivity and subgroup analyses of the primary outcome, perioperative patient vital data, adverse events, serious complications, and cognitive and functional recovery up to 30 days postoperatively.

The mean (SD) global index of patient satisfaction did not differ between the midazolam and placebo groups (69.5 [10.7] vs 69.6 [10.8], respectively; mean difference, ?0.2; 95% CI, ?1.9 to 1.6; P?=?.85). Sensitivity (per-protocol population, multiple imputation) and subgroup analyses (anxiety, frailty, sex, and previous surgical experience) did not alter the primary results. Secondary outcomes did not differ, except for a higher proportion of patients with hypertension (systolic blood pressure 160 mm Hg) at anesthesia induction in the placebo group.

Conclusions: A single low dose of oral midazolam premedication did not alter the global perioperative patient satisfaction of older patients undergoing surgery or that of patients with anxiety. These results may be affected by the low dose of oral midazolam.

JAMA Surg. Published online December 20, 2023. doi:10.1001/jamasurg.2023.6479

Dr. Reinhardt: "Midazolam is a sedative from the benzodiazepine group. It is sometimes used in anesthesia to calm patients before an operation." (medicalXpress). It is unfortunate that they limited the study to next day and 30 day response. In my experience, midazolam prolongs post-operative delerium, often leading to eager psychiatrists prescribing antipsychotics, a prescription that continues to be refilled without need, ofen for years.

Midaolam is chosen specifically for its effect of inducing amnesia. If only given for presurgical anxiety a more common benzo would be used. The bigger question: if there was no measurable patient benefit, as shown in this study, why is it given at all?

Clinicians See Zuranolone as an Effective PPD Treatment With Potentially Significant Barriers

A new drug for postpartum depression (PPD) is expected to be available to prescribers by early next year, but whether clinicians will prescribe the medication, and to whom, depends on how insurers cover the drug. The expected cost of zuranolone — nearly $16,000 for a 14-day course — could make it inac-

cessible to many patients.

Some providers see the drug as promising, but they also need more information on how safe the drug will be for infants of breastfeeding parents and if the effects of treatment last more than 2 weeks.

Henson (a spokesperson for Sage Therapeutics) did not respond to questions regarding how the drug company landed on the nearly $16,000 price tag for the regimen.

The drug makers originally sought approval from the US Food and Drug Administration (FDA) for zuranolone as a treatment of major depressive disorder (MDD), but the agency denied the request.

In an August press release, Sage noted the FDA said, "the application did not provide substantial evidence of effectiveness to support the approval of zuranolone for the treatment of MDD and that an additional study or studies will be needed."

https://www.medscape.com/viewarticle/998731?ecd=WNL_mdpls_231128_mscpedit_psych_etid6103216&uac=19361SY&spon=12&impID=6103216

Dr. Reinhardt: "Zuranolone is a positive allosteric modulator of synaptic and extrasynaptic GABAA receptors and a neuroactive steroid. It functions by enhancing the activity of gamma-aminobutyric acid (GABA), a neurotransmitter that regulates mood and anxiety in the brain." (Psychiatrist.com)

Zuranolone is a GABAa receptor agonist, as are alcohol, barbiturates, and benzodiazepines. Sage managed to get the FDA to ignore that it is a tranquilizer, not an "anti"depressant. As with all GABA agonists, very addictive. Those without health insurance can always choose Jim Beam.

Attention-Deficit/Hyperactivity Disorder Medications and Long-Term Risk of Cardiovascular Diseases

To assess the association between long-term use of ADHD medication and the risk of CVD a case-control study included individuals in Sweden aged 6 to 64 years who received an incident diagnosis of ADHD or ADHD medication dispensation between January 1, 2007, and December 31, 2020 was conducted, looking at cumulative duration of ADHD medication use up to 14 years.

Of 278 027 individuals with ADHD aged 6 to 64 years, 10 388 with CVD were identified (median [IQR] age, 34.6. Longer cumulative duration of ADHD medication use was associated with an increased risk of CVD compared with nonuse.

Across the 14-year follow-up, each 1-year increase of ADHD medication use was associated with a 4% increased risk of CVD (AOR, 1.04 [95% CI, 1.03-1.05]), with a larger increase in risk in the first 3 years of cumulative use (AOR, 1.08 [95% CI, 1.04-1.11]) and stable risk over the remaining follow-up. Similar patterns were observed in children and youth (aged <25 years) and adults (aged ?25 years).

Conclusions: This case-control study found that long-term exposure to ADHD medications was associated with an increased risk of CVDs, especially hypertension and arterial disease. These findings highlight the importance of carefully weighing potential benefits and risks when making treatment decisions about long-term ADHD medication use. Clinicians should regularly and consistently monitor cardiovascular signs and symptoms throughout the course of treatment.

JAMA Psychiatry. Published online November 22, 2023. doi:10.1001/jamapsychiatry.2023.4294

Dr. Reinhardt: Not just arterial disease, but neurological damage, including Parkinson's! (https://pubmed.ncbi.nlm.nih.gov/16620991/) Note: there were no adverse health effects on the teachers and parents who insisted on the chemical abuse of their children.

ADHD medication adherence: the importance of adequate prescribing

ADHD affects around 5% of children (aged <18 years) and although the rate of clinical diagnoses tends to decline in adulthood, about 2·5% of adults meet the diagnostic criteria. People with ADHD often experience impairments in psychosocial, physi-

cal, and societal functioning, resulting in an overall decrease in quality of life.

Medication, including stimulants and non-stimulants, is a crucial part of managing ADHD and can greatly improve outcomes. However, there is a persistent gap between evidence-based guidelines and their application in clinical practice, leading to uncertainty about the effective use of ADHD medication.

The Lancet November 27, 2023DOI:https://doi.org/10.1016/S2215-0366(23)00393-0

Dr. Reinhardt: Is this a page out of a drug salesman's training manual? So many erroneous and misleading statements. Not difficult to figure out who's advertising dollars control "journal" content. ADHD is not "treated". The damage done to those who are not "neurotypical" is what is treated.

Antiamyloid Gantenerumab Disappoints in Phase 3 Trials

Final results of the pivotal twin phase 3 studies of gantenerumab in early Alzheimer's disease (AD) confirm that the investigational antiamyloid agent lowered amyloid plaque burden but did not slow clinical decline in patients with early AD. Results for secondary clinical outcomes also did not support a beneficial clinical effect of the drug.

Gantenerumab led to partial removal of amyloid plaques and improvement in some soluble biomarkers of AD, but the magnitude of amyloid plaque removal was "smaller than expected," the researchers note.

Amyloid-related imaging abnormalities with edema (ARIA-E) occurred in 24.9% of participants receiving gantenerumab. Most cases were asymptomatic, with central nervous system symptoms associated with ARIA-E occurring in only 5.0%, and there were no deaths associated with ARIA-E.

https://www.medscape.com/viewarticle/998715?ecd=WNL_mdpls_231124_mscpedit_neur_etid6085283&uac=19361SY&spon=26&impID=6085283#vp_2

Dr. Reinhardt: ..."central nervous system symptoms associated with ARIA-E occurring in only 5.0%," Impressive, no one helped, 1 in 20 damaged severely enough to report.

Cutting off a diabetic's foot does not fix the foot.

Irritability, agitation and anxiety in Alzheimer's patients caused by brain inflammation

Neuropsychiatric Symptoms and Microglial Activation in Patients with Alzheimer Disease

To evaluate whether glial markers are associated with neuropsychiatric symptoms in individuals across the Alzheimer disease continuum, a cross-sectional study was conducted from January to June 2023, leveraging data from the Translational Biomarkers in Aging and Dementia cohort at McGill University, Canada.

All individuals underwent assessment for neuropsychiatric symptoms (Neuropsychiatry Inventory Questionnaire [NPI-Q]), and imaging for microglial activation ([11C]PBR28 PET), amyloid-beta ([18F] AZD4694 PET), and tau tangles ([18F]MK6240 PET).

Conclusions: In this cross-sectional study of 109 individuals across the AD continuum, microglial activation was associated with and a potential biomarker of neuropsychiatric symptoms in Alzheimer disease.

JAMA Netw Open. 2023;6(11):e2345175. doi:10.1001/jamanetworkopen.2023.45175

Dr. Reinhardt: The study did mention amyloid beta chemicals "might" help, in a bow to their advertisers. BUT, study results clearly show inflammation expressed as microglial activation was the culprit. Resveratrol has been shown to inhibit the activation of microglia and reduce the production of pro-inflammatory factors through intracellular cascades of signaling pathways such as MAPKs, phosphoinositide3-kinase (PI3-K)/Akt, and glycogen synthase kinase-3 (GSK-3) pathways.

When our chemical companies are able to convince the FDA that resveratrol should be a restricted, patented compound it may be hailed as the next magic pill for dementia.

Alzheimer's research: New study uncovers previously unknown processes in fat metabolism

A bidirectional link between sulfatide and Alzheimer's disease

The team examined VCAM1-expressing microglia in the brain tissue of AD patients. Interestingly, AD patients exhibited elevated levels of soluble VCAM1 in the cerebrospinal fluid, which suggested dysregulated VCAM1-ApoE signaling. This observation correlates with reduced clearance by microglia. Collectively, the findings of the study implicate VCAM1–ApoE signaling in the pathogenesis of AD and identify VCAM1 as a promising target for AD therapy.

Of particular interest to the researchers is the impact that diet and lifestyle may have on the disease. "Factors such as smoking can have a negative effect on sulfatide levels, whereas ensuring the body has an adequate supply of vitamin K or eating certain types of seafood can have a positive effect. These findings suggest possible approaches to developing preventive and therapeutic strategies in the fight against Alzheimer's disease,"

DOI:https://doi.org/10.1016/j.chembiol.2023.10.021

Dr. Reinhardt: A step closer to looking for CAUSE of dementia, rather than trying to suppress symptoms like the current set of chemicals. According to WIKI, "Sulfatide is a major component in the nervous system and is found in high levels in the myelin sheath in both the peripheral nervous system and the central nervous system. Myelin is typically composed of about 70 -75% lipids, and sulfatide comprises 4-7% of this 70-75%. When lacking sulfatide, myelin sheath is still produced around the axons; however, when lacking sulfatide the lateral loops and part of the nodes of Ranvier are disorganized, so the myelin sheath does not function properly. Thus, lacking sulfatide can lead to muscle weakness, tremors, and ataxia."

This research has implications for ALS and other mylin related disorders, and perhaps even for schizophrenia, autism and ADHD. Digging just a bit deaper, one possible genetic defect that could be responsible would be for the gene encoding Galactose-1-Phosphate Uridyltransferase. So many possible avenues when you are not invested in chemicals to dissolve plaques.

Association Between Diseases and Symptoms Diagnosed in Primary Care and the Subsequent Specific Risk of Multiple Sclerosis

Previous studies have reported a possible prodrome in multiple sclerosis (MS) defined by nonspecific symptoms including mood disorder or genitourinary symptoms and increased health care use detected several years before diagnosis. This study aimed to evaluate agnostically the associations between diseases and symptoms diagnosed in primary care and the risk of MS relative to controls and 2 other autoimmune inflammatory diseases with similar population characteristics, namely lupus and Crohn disease (CD).

A case-control study was conducted using electronic health records from the Health Improvement Network database in the United Kingdom and France. We agnostically assessed the associations between 113 diseases and symptoms in the 5 years before and after diagnosis in patients with subsequent diagnosis of MS. Individuals with a diagnosis of MS were compared with individuals without MS and individuals with 2 other autoimmune diseases, CD and lupus.

The study population consisted of patients with MS (n = 20,174), patients without MS (n = 54,790), patients with CD (n = 30,477), and patients with lupus (n = 7,337). Twelve ICD-10 codes were significantly positively associated with the risk of MS compared with controls without MS. After considering ICD-10 codes suggestive of neurologic symptoms as the first diagnosis of MS, 5 ICD-10 codes remained significantly associated with MS: depression (UK: odds ratio 1.22, 95% CI 1.11–1.34), sexual dysfunction (1.47, 1.11–1.95), constipation (1.5, 1.27–1.78), cystitis (1.21, 1.05–1.39), and urinary tract infections

of unspecified site (1.38, 1.18–1.61). However, none of these conditions was selectively associated with MS in comparisons with both lupus and CD. All 5 ICD-10 codes identified were still associated with MS during the 5 years after diagnosis.

Conclusions: We identified 5 health conditions associated with subsequent MS diagnosis, which may be considered not only prodromal but also early-stage symptoms. However, these health conditions overlap with prodrome of 2 other autoimmune diseases; hence, they lack specificity to MS.

Neurology December 12, 2023 issue 101 (24) e2497-e2508 https://doi.org/10.1212/WNL.0000000000207981

Dr. Reinhardt: This study illustrates the problem with the way modern medicine approaches health issues. Rather than thinking this is early MS, there seems to be no consideration that these early issues may caused by a common factor, such as a virus, environmental toxin, a drug, a nutritional deficiency, food additives, or treatable factors.

Symptoms associated with later MS diagnosis (and perhaps MIS-diagnosis) include depression, constipation, cyctitis and UTIs. All of these symptoms can be caused by antidepressants, for example. On review, this study did not control for drug adverse effects.

Alternate Approaches

Research demonstrates the potential of natural compounds to treat gastrointestinal disorders

Chronic gastrointestinal (GI) disorders are becoming increasingly common throughout the world, but many of them still lack effective treatment. Researchers have now turned to natural compounds, such as those present in traditional medicines, to search for potential drug candidates for difficult-to-treat diseases. The latest issue of the Journal of Pharmaceutical Analysis (JPA) features three articles that report promising findings and could pave the way to treatments for complex diseases affecting the liver and intestine.

https://medicalxpress.com/news/2023-11-potential-natural-compounds-gastrointestinal-disorders.html

Dr. Reinhardt: The three natural herbs covered included Amomum compactum, aka round cardamom or Bai Dou Kou in Traditional Chinese Medicine (TCM), Panax notoginseng aka steamed ginseng or San qi in TCM, and Fructus Ligustri Lucidi aka Glossy privet fruit or Nu Zhen Zi.

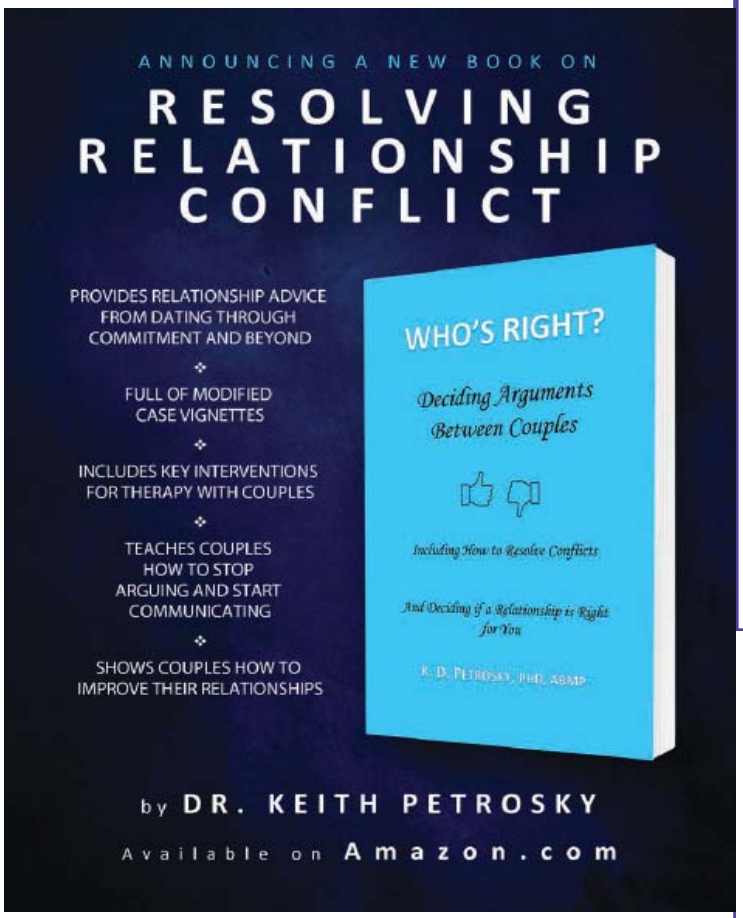
Amomum compactum for treating ulcerative colitis (UC): Researchers investigated the anti-inflammatory mechanisms of this compound in the context of UC. The findings revealed that this molecule inhibits the binding between heat shock protein 90 (HSP90) and nucleotide-binding and oligomerization domain-, leucine rich repeat-, and pyrin domain-containing 3 (NLRP3), thereby inhibiting the activation of the NLPR3 inflammasome and the M1 polarization of macrophages. This prevents the activation of inflammatory pathways and promotes the recovery of the intestinal wall. Amomum compactum is commonly used alone or in combination with other herbs for GI inflammation, abdominal pain, nausea, and chest congestion. According to WebMD, in addition to use as a spice, Amomum compactum "contains chemicals that might kill some bacteria, reduce swelling, and help the immune system. Cardamom is used for diabetes, high cholesterol, build up of fat in the liver in people who drink little or no alcohol (nonalcoholic fatty liver disease or NAFLD), and other purposes."

Panax notoginseng for treating liver inflammation: A bioactive component found in steamed ginseng (Panax notoginseng), was investigated for its potential as a treatment for alcoholic liver disease (ALD). This herb contains ginsenoside Rk2, which could ameliorate liver inflammation. Moreover, Rk2 also restored intestinal barrier function by enhancing NLPR6 signaling in the intestine, demonstrating the multifaceted nature of its therapeutic potential. According to WebMD, "Panax notoginseng might relax blood vessels, which might improve blood flow and reduce blood pressure. Some of the chemicals in Panax notoginseng might also reduce swelling and protect the heart. People use Panax notoginseng for

chest pain, stroke, heart attack, bleeding, high blood pressure, and many other conditions."

Fructus Ligustri Lucidi for for strengthening the gut microbiota: Researchers found it could modify the makeup of the gut microbiota and fungal groups, and also had the potential to inhibit colorectal tumor growth. It to tonify the liver, tonify the kidneys and clear heat. Nu Zhen Zi benefits digestion and supports vision health. It has anti-inflammatory effects, antibacterial effects, boosts the immune system, antioxidant effects, benefits circulation and protects the liver.

Reliably processed Bai Dou Ko and San qi can be purchased from Dr. Reinhardt at Center for Health Science, 714-886-9026. Nu Zhen Zi can be purchased from Sun Ten, a reliable brand, on Amazon.



National Alliance of Professional Psychology Providers

Failure To Serve

A White Paper on The Use of Medications As A First-Line Treatment And Misuse In Behavioral Interventions

This report was prepared by:
The National Alliance of Professional Psychology Providers

http://www.nappp.org/
admin@nappp.org

The Executive Summary can be read at
http://nappp.org/Exec_summary.pdf

Read the complete report at
http://nappp.org/White_paper.pdf

Continuing Education Credit

By Gary Traub, Ph.D.

Get one hour of CE credit by reading this edition of TCP and completing the following questions. E-mail your answers to Dr. John Caccavale, NAPPP, at *doctorjc1@ca.rr.com*

1. In the lead article, Dr. Petrosky cites research showing that ketamine is not physically addicting. True/False

2. Ketamine has a _____ (short / long) half-life.

3. Shorter half lives make a drug more addicting. True/False

4. Ketamine was cleared by the FDA in 2019 for the treatment of _____.

5. What drug was created by tweaking ketamine to give it more stimulant properties?

6. To date, how many patients have been injured by a prescribing over the past 60 years?

7. In the article by Dr. Caccavale, he mentioned the "publish or perish" culture in academia significantly contributes to _____.

8. STAR*D evaluated the relative effectiveness of 13 antidepressants and found that the cumulative remission rate was approximately _____ of that reported.

9. In the article on cat ownership and psychosis, a positive association was reported. True/False

10. Valproate prescribing rules in the UK, but not US, will tighten starting January 2024. True/False

11. A group of 31 medical professionals has reported to the UK government that rising antidepressant prescribing is associated with a small but significant reduction in depression. True/False

12. Ozempic has proven to be safe and effective treatment. True/False

13. In the comment by Dr. Reinhardt, he mentioned that Mounjaro has shown some efficacy in reducing symptoms of tachycardia. True/False

14. The new drug for postpartum depression is _____ and its expected cost is nearly _____!

15. A case-controlled study in Sweden found no association between long term exposure to ADHD medications and risk of CVD's. True/False

16. In a Lancet article, dated November 27, 2023, it was reported that ADHD affects around ___% of children and ___% of adults.

17. Final results of a phase 3 studies of gantenerumab in early Alzheimer's disease found that it did reduce amyloid plaque burden but did not slow clinical decline. True/False

18. Lacking sulfatide can lead to muscle weakness, tremors, and ataxia. True/False

19. Three natural herbs were discussed as being possible helpful in managing gastrointestinal disorders. True/False

Continuing Education Opportunities Through NAPPP and AMP

By Keith Petrosky PHD, ABMP

Napppsubscribers Postings

One of the benefits of being a member of NAPPP is daily access to the most up-to-date information in the field in which we practice. John Caccavale's uncanny ability to sort through the plethora of scientific news articles to identify the important and interesting pieces from the mundane and irrelevant is remarkable. His steady pipeline of daily updates enables us to demonstrate our cutting-edge knowledge to our patients who may wonder how we know things that are so far ahead of the curve that they have not yet been announced in the news. Whether it is a new pharmaceutical side effect warning, a research study comparing different interventions for a disorder, or some new scientific breakthrough we will know about it before most others, including fellow professionals in our field of practice.

NAPPP Home Study Programs

NAPPP's home study programs are wide-ranging and excellent and a source of free CE credits to NAPPP members. These programs are very helpful in gaining whatever portion of relicensing credits are allowed via home study by our various state licensing boards. These programs are periodically updated and improved and new programs are added on a periodic basis.

NAPPP Educational Conventions

If you have attended any of NAPPP's educational conventions you know the high quality of instruction that is provided typically over a three day weekend. Being able to earn 18 APA approved CE credits for one of these programs has been very helpful for helping our members with licensing renewal.

Covid's Continuing Effect on Live Training

After several very successful conferences in San Antonio Texas, Covid 19 caused the cancellation of NAPPP's most recent conference which was intended to be held in Nashville. Unfortunately, just as this program was being finalized Covid 19 emerged. At that time, it was uncertain how dangerous the virus would be but the NAPPP board decided (correctly in retrospect) to cancel the convention. Until Covid 19 with its many variants is better controlled it would probably be prudent to continue to avoid being crowded into even larger educational training rooms.

Video-Based 'Live' Training

While NAPPP has been considering offering half or full day video training seminars (through Zoom or some other platform) we recognize the unique challenges for participants who may find it difficult to insulate themselves from family and household responsibilities sufficiently to give their full focus to the training being presented. Also, viewer fatigue is likely to be an issue with longer programs in comparison with "in vivo' training in an educational convention where the "live" nature of the training is more compelling. We are continuing to explore ways of presenting these video-based training options to see if we can find some practical options for our members.

The Crisis in Psychopharmacology: The Case for Medical Psychology

Edited by John Caccavale. This is an important resource for our members to ensure that they are up to date with a myriad of topics pertinent to psychological treatment. It features 13 chapters and covers such important topics as pediatric practice, lifestyle medicine, addiction assessment and treatment, primary care medicine, nutrition and genetics, pain management, laboratory studies, psychological assessment, epigenetics and neuroplasticity, and evidence based therapies, among others.

New AMP Video-Based 'Live' Training

The Academy of Medical Psychology has begun offering a one hour, APA approved (1 CE credit unit) live Zoom training session each month. These monthly programs will be offered free of charge to AMP members. NAPPP members can join AMP at a discounted rate of just sixty dollars for the year. This discount is offered for the dual membership in the two

(associated, but independent) organizations.

After piloting this training for several months, the AMP board offered the first program to AMP members on December 9th on Ethics in Medical Psychology. The next program is tentatively scheduled for January 13th on Relational Psychotherapies and Stress Physiology. If you can set aside one hour each month to attend these sessions, you can earn a significant amount of "live" virtual training for your next licensing renewal.

It should be noted that there is a wider variety of program content than might be anticipated under the umbrella of "medical psychology" and programs have utility even for practitioners who have limited involvement in medical psychology practice. We are hoping that some of the authors of our new textbook will be able to present highlights of their chapters as part of this training.

AMP's goal is to provide these programs each month on the second Thursday of the month at 6 PM Pacific Time (US and Canada). This translates to 9 PM EST, 8 PM CST, and 7 PM MST. These programs also offer an opportunity for some social interaction with colleagues which is important in this Covid based. social distancing dilemma that we continue to find ourselves in.

If you do decide to join AMP, you will also be able to access the research paper Archives and read the newsletters providing up to date new information about medical psychology. This may even inspire some NAPPP members to begin the process of preparing to apply for future board certification by the American Board of Medical Psychology. AMP's website address is – https://academyofmedicalpsychology.com.

You may direct any comments or questions to ***drkeith1@verizon.net***.

National Alliance of Professional Psychology Providers

Failure To Serve

A White Paper on The Use of Medications As A First-Line Treatment And Misuse In Behavioral Interventions

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Read the complete report at
http://nappp.org/White_paper.pdf

Current Listing of Free CE Courses

The following courses are now available free with NAPPP membership. CE credit is provided by NAPPP. The National Alliance of Professional Psychology Providers is an approved sponsor of continuing education by the American Psychological Association. The National Alliance of Professional Psychology Providers maintains responsibility for all programs and its contents. Many states require specific courses for licensure and license renewal. NAPPP courses are designed to meet these requirements. However, members should check with their state statutes to determine specific CE requirements.

- **THE PSYCHOLOGY OF WORKPLACE VIOLENCE: 4 CE Credit Hours** This course examines the motivation behind violent crimes from a Focus Theory perspective. Describes two major types of violent crime with very different motivation and goals. Shows that workplace violence, domestic violence, political assassination, school related violence, and terrorist activities, are all similarly related. Five stages of violence are examined, several landmark cases are presented, along with the essentials of a case work-up from a Focus theory/risk factor perspective, and an example case report. Both experienced clinicians and those new to the field will find considerable useful information in regard to dealing with perpetrators of non-object focused violence.
- **Introduction To Lifestyle Medicine: 6 CE credit Hours** This course provides a foundation of theoretical and practical knowledge and skills, as well as an opportunity to plan strategies and practice techniques for assisting patients with positive health behavior changes through lifestyle changes.
- **Introduction To Behavioral Health Consulting: 6 CE credit hours** This course is an introduction to how clinical psychologists can learn about practice as behavioral health consultants. Reasons for integrating psychology into medical venues are discussed along with treatment models and the different aspects of practice in these settings.
- **Issues in Substance Abuse: 6 CE credit hours** This CE course is designed to give a basic understanding of diagnosing and treating patients with substance abuse problems. Primarily, the course focuses on alcohol abuse But does give coverage to the abuse of other substances including prescription drugs.
- **Refresher Course On Evaluating and Preventing Suicide: 6 CE credit hours** Refresher course that is being mandated in many jurisdictions for initial licensing and renewal.
- **Treatment of Narcissistic Personality Disorder: 6 CE credit hours** This course looks at diagnostic and treatment of narcissistic personality disorder (NPD). Relevant research is reviewed along with signs and symptoms, prevalence, characteristics, subtypes, comorbidity, and treatment options. This treatment-focused course will help you learn the skills to successfully work with, and manage, the NPD patient.
- **Pharmacotherapeutics: 10 CE credit hours** This course presents the integration of the principles of psychology in the application of pharmacological agents in the alleviation of mental health concerns.

- **Neuropsychological Evaluations: 10 CE credit hours** This course will take you through the selection, administration and integration of neuropsychological data into a comprehensive report. Sample report included.
- **Custody Evaluations: 12 CE credit hours** This is a complete course on the major issues confronting psychologists in doing custody evaluations. It contains all the presentations from the Broken Family Court Conference that was sponsored by The Cummings Foundation and NAPPP.
- **Domestic Violence - Treatment and Assessment: 10 CE credit hours** This program reviews the assessment and treatment of domestic violence. Discussion of group and individual treatment is included.
- **Ethics & Risk Management: 10 CE credit hours** This course that discusses the newest issues facing psychologists ethically. A thorough discussion of prescription privileges and pharmacopsychology ethics is included. This course qualifies for an additional 10% reduction in liability insurance cost by NAPPP insurer.
- **Physiology For Psychologists: 10 CE credit hours** Upon successfully completing the course, psychologists will achieve a basic understanding of critical concepts in human physiology, including being aware of indications for referral to other health care providers for treatment and interrelationships between organs/systems, psychopharmacology, and psychopathology.
- **Interpreting Blood Panels: 6 CE credit hours** As clinical practice has become more medicalized, it is important for psychologists to have a general knowledge about the content and interpretation contained in routine blood panels.
- **Issues In Postpartum Disorders: 10 CE credit hours** A review of the evaluation and diagnosis of postpartum disorders. A review of the relevant literature is included.
- **Doing Pre-Marital Counseling: 10 CE credit hours** Dr. Sandra Levy Ceren details how to do pre-marital counseling. This course is built upon Dr. Ceren's many years of experience and is replete with case studies.
- **Mastering Medical Terminology For Psychologists: 10 CE credit hours** This course is designed for psychologists who want to learn and master medical terminology. Since collaboration is so ubiquitous in clinical practice, this course will allow clinicians to communicate effectively with medical practitioners. A must for clinicians who regularly work with medical practitioners.
- **Caring For The Elderly: 10 CE credit hours** This course is a basic course designed for psychologists who want to learn Additional skills related to diagnosing and treating the elderly patient. Particular attention is devoted to dementias.
- **Ethics II: 6 CE Credit hours** This course is a 6 unit course for those psychologists who do not require the more extensive 10 unit course. Designed for BOP licensing and renewal.
- **Introduction To Medical Psychology: 10 CE Credit hours** This course is a basic course in medical psychology for psychologists. Reading materials focus on the understanding and treatment of diseases and illnesses that psychologists can treat.
- **Primary Care Psychology: 10 CE Credit hours** This course is an introduction to how clinical psychology is practiced in a primary care setting. Reasons for integrating psychology into

primary care are discussed along with treatment models and the different aspects of practice in a primary care setting.

- **Forensic Practice: 10 CE Credit hours** This course is an introduction to the practice of forensic psychology for psychologists who want to expand their services into this area of practice. Topics include psychological evaluations for the court (child custody; competency; insanity), psychological factors in eyewitness testimony, trial consultation, and criminal investigation.
- **Clinical Supervision: 6 CE Credit hours** Clinical supervision is the foundational educational experience to acquire clinical skills. Most states now require that supervisors receive specific training in this important role. Clinical supervision, while appearing on the surface to be similar to psychotherapy and counseling, is a different relationship with unique qualities and characteristics that set it apart. It requires the development of new knowledge and expertise. Ethically and legally, supervisors are responsible for patient care as well as the training and development of their supervisees. Supervision becomes a balancing act between the needs of the patient population and the needs of the supervisee. This course will help you do your job better and give you skills to rely on in your supervision of interns.
- **Neurology For Psychologists: 10 CE Credit hours** This course is designed to introduce clinical and neuropsychologists to basic neurological practice. It provides participants with a thorough understanding of the structure of the nervous system. Students will learn how to identify important structures and their functions. Topics include: performing a competent neurological work-up, basic description and components of typical neurological disorders, behavioral neurology, muscle disorders, sensory disorders, and ethical issues in practice.
- **Entrepreneurship For Psychologists: 10 CE credit hours** This is an introductory course for psychologists who want to expand their knowledge about the opportunities and benefits of becoming an entrepreneur in mental health. With the new Affordable Care Act now law, there are many opportunities for psychologists if we can learn the concepts and success behind entrepreneurship. This is what has been missing from graduate psychology education.
- **Crisis Management Intervention Training and Consulting: 10 CE credit hours** This course is designed for clinical psychologists who want to develop a significant and workable knowledge base to provide crisis management consulting services to municipalities and private organizations. It will also serve the function of providing practitioners with a good knowledge base to understanding crisis management interventions.
- **Mood Disorders: 10 CE credit hours** Mood disorders are among the most prevalent, recurrent,and disabling of all illnesses. This course examines the important issues in understanding and treating mood disorders.
- **Forensic Evaluations: 10 CE credit hours** Introduction to the field of forensic evaluation. Focus is on assessment,methods, psychometrics, report design and samples and a survey of frequently used objective and projective measures. Ethical standards and evaluations with special populations are covered.

- **Neurology For Psychologists: 10 CE Credit hours**
  This course is designed to introduce clinical and neuropsychologists to basic neurological practice. It provides participants with a thorough understanding of the structure of the nervous system. Students will learn how to identify important structures and their functions. Topics include: performing a competent neurological work-up, basic description and components of typical neurological disorders, behavioral neurology, muscle disorders, sensory disorders, and ethical issues in practice.
- **Entrepreneurship For Psychologists: 10 CE credit hours**
  This is an introductory course for psychologists who want to expand their knowledge about the opportunities and benefits of becoming an entrepreneur in mental health. With the new Affordable Care Act now law, there are many opportunities for psychologists if we can learn the concepts and success behind entrepreneurship. This is what has been missing from graduate psychology education.
- **Crisis Management Intervention Training and Consulting: 10 CE credit hours**
  This course is designed for clinical psychologists who want to develop a significant and workable knowledge base to provide crisis management consulting services to municipalities and private organizations. It will also serve the function of providing practitioners with a good knowledge base to understanding crisis management interventions.
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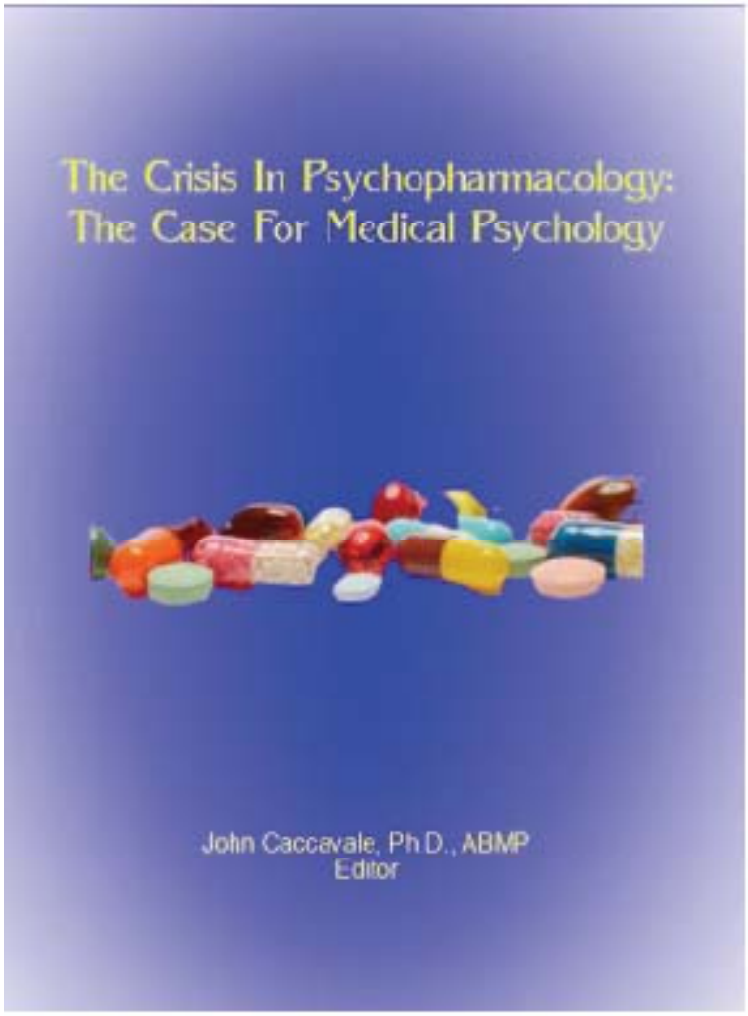

TABLE OF CONTENTS

"There is a crisis in clinical psychopharmacology because the non-marketing data that does exist demonstrates these medications and drugs provide improvement in only those patients who have a high expectation that they will work. Technically, this is a placebo response and can run as high as 70% when explaining improvement rates of most psychotropic medications. Moreover, drug companies have not produced a single, novel medication in years. While medications are the problem, Medical Psychology is the solution.

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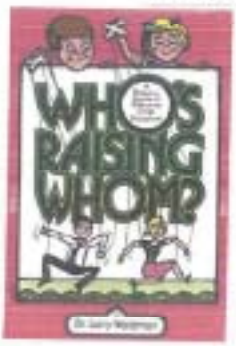

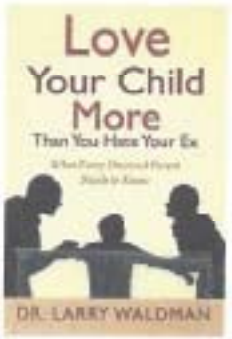

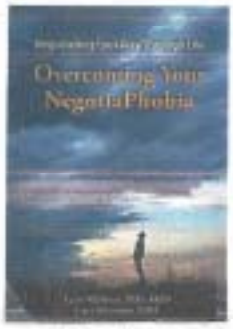

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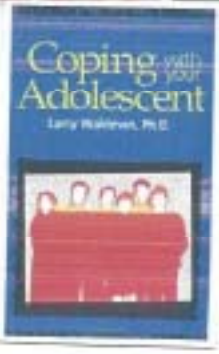

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