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BIOPSYCHOSOCIAL Clinical Pearls

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My reason for putting out this newsletter is to share clinical information I have gathered over 45 years in the fields of counseling, psychology, clinical biopsychology, neuropsychology, and clinical practice. Every profession builds up a collection of knowledge based on their personal and professional experiences and professional training. At this stage in my life, I have dedicated the last six years to sharing some of those experiences. I hope that what is shared in these newsletters provide some clinical insight to those who are have other experiences and those who could use additional knowledge. It is my hope that those from early career to seasoned professionals can benefit from these newsletters.

If you have information or experiences you would like to share via these newsletters, please feel free to contact me with the submissions at drrory@live.com or at P.O. Box 128, Seymour, Missouri 65746.

Sensory Memories & Ghosts of Posttraumatic Stress

Pretend for a moment that you are in tribal days and you are haunted by ghosts and memories of something horrific. The tribal medicine man or shaman who finds out about the problem you are having, perform rituals, and exorcizes the ghosts. One technique used by magi and shamans is to have the afflicted party detail the experiences that caused these ghosts, have the individuals create an image or symbol of these event/s, become ready to let go of them, and ritually burn or bury the symbol.

For a patient with Posttraumatic Stress Disorder, there are sensory memories that act as anchors and triggers. These result in nightmares, intrusive memories and flashbacks. The odor of diesel reminding the soldier of the heavy equipment during war, the sound of a backfiring car

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triggering memories of gun fire, or the image of a child just before a bomb explodes are a few of these sensory triggers. Not all sensory memories of trauma are horrific. Some can be extremely neutral except for the fact that they were present at the time of the trauma. For example, a vacuum cleaner in the back of a car where a woman died. The process used by ancient healers is very much the same as the ones used today. The turning point is to identify these sensory memories, express the emotions around them, do whatever one feels needs to occur to ***become ready to let go of the memory***, and then perform the ritual of letting go. Becoming ready to let go and walking through the steps of making peace with them is the preparation to heal. What is required to become ready is individualized and can only be defined by that which is written on the individual's heart. This does not simply mean desensitizing to the trauma. Various methods of desensitizing sensory memories so that the individual can go through daily life without profound intrusion have been developed. These include flooding, exposure-response modification, eye-movement desensitization (EMDR), and others, but these simply allow the individual to coexist with the ghosts. It is like learning to live in hell with the trauma without it bothering you. If treatment stops there, the process of empowerment of the individual may not take place. It is through the rituals, confronting, making amends or other actions, and traveling the path started by the trauma that we grow and make the experience a useful part of us. Once we have experienced a trauma or any event in life, it is a part of us. To try to make it not exist, is like taking part of our childhood or school years disappear. If we did, we would be the lesser for it.

For those of you trained in psychodrama, you can see how our creativity and imagination can be used to recreate events, provide things we did not have at that point of our life, and create the "rituals" needed to make peace with our experiences. Sensory memories are recreated and explored. The patient can interact with these memories and experiences, providing corporeal form to that which is without form. Emotions are expressed through various forms of catharsis.

It is not unusual for various sensory memories to come back repeatedly throughout our lives. The reason for this is that as we go through each phase of life (i.e., adolescence, young adulthood, becoming parents, becoming grandparents) the events from the trauma may touch us in different ways. It is not a sign that treatment did not work, but it is the opportunity to deal with a different aspect of our memories.

To be a survivor of trauma is not the end of the path. It is simply one point. When we get to being empowered by the event, this is another point. We need to stay on the path and see how far we can go. For some, it may lead to a point you did not believe existed.

Beyond Trauma

by Rory Fleming Richardson, Ph.D., ABMP, TEP, Inspired by Gazelle Nicole Richardson (my loving wife)

Once you are able to find your way passed the ghosts and the nightmares, to that point of strength and power to stand up to the source of the nightmares, taking back your power and defending that which you could not.

At that point, it is you who have the choice to be kind or be cruel.

If you choose to hold on to the anger and the pain, you tie yourself to the karmic loop.

If you forgive and let go, you free yourself to move on taking with you the strength that you gained from the ordeal.

Periodically, you may revisit the ghosts as life phases change and mature, but it is with the strengths that you have gained to that point.

At some point, we realize that the terms victim and survivor are simply points in a timeline of healing. If you elect to live at one point in the timeline, it is your choice. But if you decide to evolve past it to a new point of self, you may find you are more than you ever thought was possible.

CHECK OUT:

Dissociation: A Functional Dysfunction

Sensory Processing Disorder & Perceptual Distortion Syndrome: Implications in Assessment and Clinical Practice

Acquired Cumulative Systemic Neurotoxic Effect: The Future of Medicine & Biopsychology

Neurobiological Fingerprints of Psychiatric Disorders: An Opportunity to Refine Diagnostic Categorization

The Problems With Treatment Guidelines & Multimorbid Conditions

There are times when our obsession with science and statistics causes unforseen complications in the world of healthcare. One of the examples of this is the unbridled application of treatment guidelines that are based on outcome studies. Outcome studies, limited by funding and scope, primarily relate to single conditions or maladies. To expand quantitative studies to a qualitative level is cost prohibited. Also, for the best research, the clarification of the diagnosis must be made by professionals with the highest level of professional expertise. The reality is that frequently the diagnoses are made by early-career professionals who do not have a wide enough scope to their experience to detect more complex details.

In understanding the limits of treatment guidelines, the article "Medication errors in elderly people: contributing factors and future perspectives" in the British Journal of Clinical Pharmacology articulates the lack of applicability of Guidelines in multimorbidity cases (cases with more than one chronic condition). It is estimated by the Center for Disease Control that one out of four Americans suffer from two or more chronic disorders. For Americans 65 years old or older, three out of four individuals suffer from two or more chronic disorders. This makes the Guidelines potentially not applicable. Despite this, physicians and other health professionals find themselves excessively constrained by them.

The unforseen complications of presenting these Treatment Guidelines include:

- minimize the complexity and role of clinical judgement needed for the practice of the art and science of clinical practice,
- mistakenly support a "one-size fits all" mentality,
- influences "risk-assessment" and professional liability which impact malpractice insurance,
- promotes the fear of professionals who treat complex cases to operate contrary to the guidelines, even when doing so is appropriate treatment,
- insurance companies, including Medicare, altering what treatment is covered based on Guidelines.

Research is based on reducing variables. If you have a patient with more than one condition, such as treatment resistant chronic pain and treatment resistant epilepsy, the patient is omitted from a study of chronic pain. If the patient suffers from chronic pain which sometimes requires use of opioids to provide any quality of life and refractory epilepsy which requires either a barbiturate or a benzodiazepine to control the seizures, the physician is faced with treating outside of the guidelines.

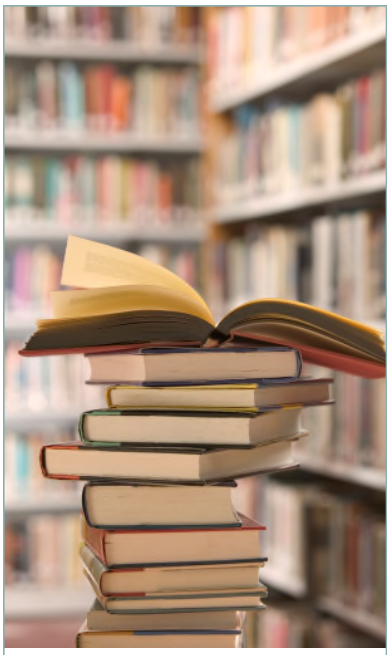
Although this combination can suppress respiration and poses specific risks, the fact is that these cases have been treated for decades with the combination of opioids and benzodiazepines. Despite this, it is difficult to find physicians who are currently willing to risk liability issues given the guidelines. The fact is that no study has been done on patients who fall into this unique category. With every medical and behavioral medicine treatment, there are risks. In today's world of limited professional time with the patient and substantial demand for services, many professionals do not take the time to discuss the benefits and risks of treatment to the extent necessary with the patient.

In 2018, President Trump instituted the "Right to Try" allowing less researched treatment options to be tried in cases where there was little hope with conventional treatment. Unfortunately, during the same time, millions of Americans who suffer from various conditions have had to face treatment that they need being withheld because of policies and CDC guidelines. The latter has caused an increase in the already elevated suicide rate for chronic pain patients and for individuals with epilepsy. The professional licensure boards and the liability insurance companies, along with various political and law enforcement entities, have created such fear among professionals that they simply do not want to practice beyond the limitations of professional guidelines even when decades of professional experience and practice would support doing so. If the guidelines limit a professional to the point of not providing care to the patient in order to maintain an acceptable quality of life, then harm is done.

These problems with treating complicated cases is amplified by the fact that the population is getting older, and the likelihood of patients having two or more chronic conditions is increasing. In addition, the introduction of various toxins into our everyday lives is likely to make this issue even more problematic.

At this point, patients who have been stabilized and maintained an acceptable quality of life and function (sometimes for decades) are being forced to try unproven and less effective treatment options. This is "doing harm" to patients.

To test out medications when a patient is already stabilized requires the patient being willing to risk decompensation. If this change is mandated, it would only be right that the patient be offered at no charge a bonded, vetted, properly trained caregiver who can perform monitoring of medical status in home, provide chauffeur services if needed, and perform task the patient may no longer be able to do, because of a loss of ability



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An alternative would be for the CDC and other involved agencies to add to existing treatment guidelines a protocol for a physician to feel safe operating outside the Guidelines. In these cases, the protocol would include the following:

The physician discuss with the patient and involved family members the risks of treatment, and have the patient sign that he/she accepts the risks of the treatment. This would provide the documentation and institutional support to assure liability insurance companies, professional boards, and other that the case is being treated appropriately outside of the guidelines given the multimorbidity.

Since professional practice guidelines and various studies are being used to influence public policies and laws, it is essential that the limitations of these guidelines and studies are clearly and repeatedly emphasized. If decision makers do not understand these limitations, then:

•millions of Americans will be harmed,
•clinical practice will be even more limited,
•patients will be forced to either self-medicate, be driven to substance abuse, or to commit suicide as their only means of attaining relief.

To prevent this, the misuse of Treatment Guidelines must be corrected.

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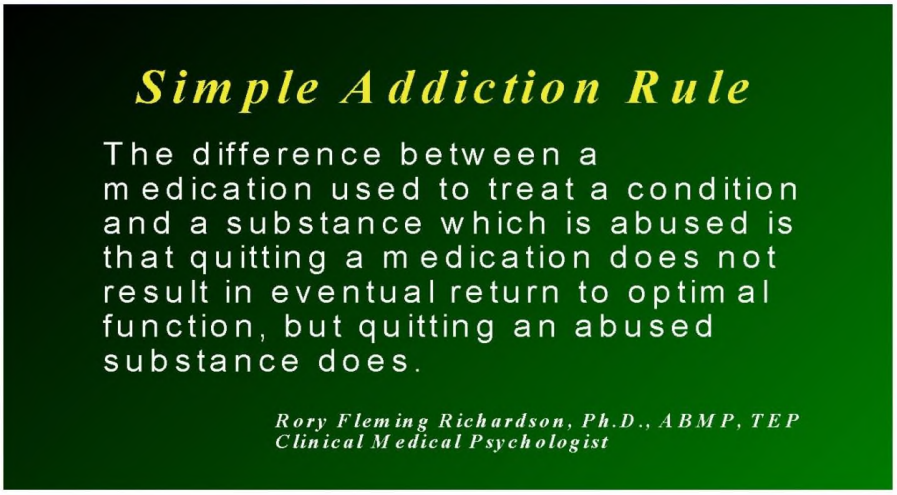
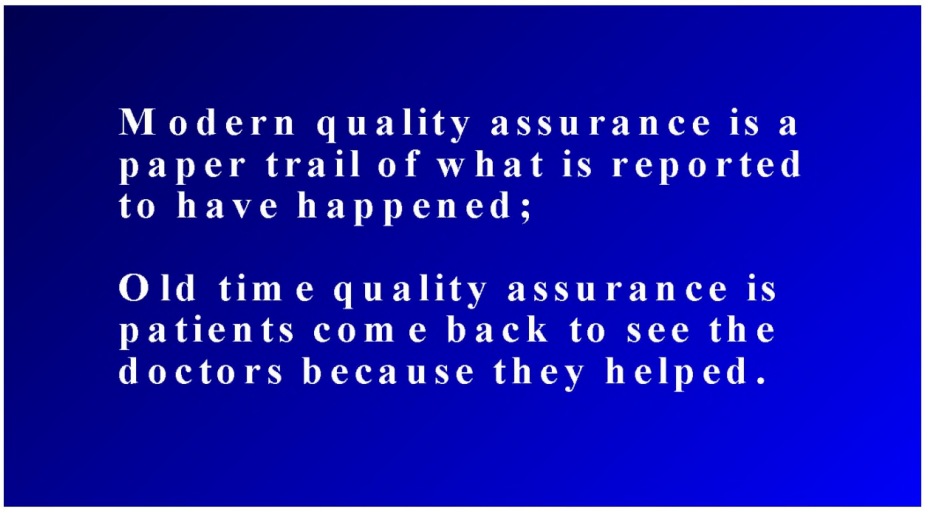


TOXIC EXPOSURE SURVEY

Over the last three decades, I have become aware of more and more individuals who have had adverse reaction to various toxins and environmental neurotoxins. Some of these cause immediate reaction and some become evident over time. I have developed a questionnaire to help discover the frequency and type of exposures, as well as, various physical and mental problems they cause. If you or someone you know has be exposed to pesticides, herbicides or other toxins, please encourage them to complete the survey found at the following link and return to me at:

Rory Fleming Richardson, Ph.D., ABMP, TEP, P.O. Box 128, Seymour, Missouri 65746 or at drrory@live.com. Thank you

Toxic Exposure Questionnaire



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The Art of Reviewing Medications Prior To Prescribing

In today's world of television advertisement about prescription medication and pharmaceutical representatives providing physicians with an overview of the medications (and free samples), the need for a more objective and thorough examination of any medication prior to a practitioner prescribing it is essential.

Sources of information which should be read prior to prescribing include:

• medication manufacturer and other information websites regarding use, side effects, warning and other information;

• patient review of the medication (positive and negative);

• any websites for lawsuits against the medication;

• fellow healthcare providers who may have experience with the medication.

By reviewing all of these information sources, the prescriber is likely to be more prudent and selective when making recommendations and can provide adequate "informed consent" information to the patient.

A good example of one medication which could be of help to some patients is Rexulti (brexpiprazole). Although it may be helpful to some, there are severe concerns. One of the more common severe side effects of this medication is "a feeling of restlessness with inability to sit still." At first glace, this does not seem to be that severe of side effect, but to witness it first hand (especially as a healthcare provider) is extremely eye-opening. This is an anxious, distressing compulsive feeling that no amount of movement or activity can sedate or resolve. The individual I observed was driven to continuously be active for days only sleeping when completely exhausted, and only for a short time. After eight days of being off the medication, the episodes of extreme driven compulsive agitation and inability to sit still continued. Anxiety and sensitivity to stressors was severe. This person was 60-years-old, a chronic pain patient, and sensitivity to medications. In reviewing law office websites regarding lawsuits relating to the medication, damages relating to compulsive gambling and hypersexuality were prominent. After observing this individual, I can imagine how severe compulsive gambling and hypersexuality could be depending on the person and on access to these options. To complicate this picture further, this atypical antipsychotic also carries with it warnings of weight gain, increased possibility of cardiac death in older people, warning regarding seizures, warning about diabetes, and several other side effects. The individual I observed was older, had a seizure disorder, had unstable glucose with history of severe hypoglycemic attacks and diabetes, and obsessive compulsive disorder. She was provided a "free sample" by her prescriber to augment an SSRI for depression. While taking the Rexulti, she also experienced palpitations (pounding heart beat), severe anxiety, and dizziness. She dismissed these as a panic attack, but in retrospect, I question this given the pseudo-manic restlessness. From examining the patient reviews, it is very possible that some of these side effects can result in extended residual problems and/or hospitalization. Some patients have had very negative life changing ef-

fects from taking this medication. In examining even the positive patient reviews, these patients are gaining excessive weight, but they are extremely happy on the medication. This reminds me of the early days of Prozac when individuals who had bipolar genetic history were started on Prozac, experiencing a medication-induced mania with compulsively spend (to thousands of dollars per day), unpredictable behavior, and other manic symptoms. It was not until some of these reactions resulted in suicide, homicide and other negative behaviors that cautions were demanded.

Neurochemically speaking, Rexulti is a "dopamine D2 receptor partial agonist and has been described as a serotonin–dopamine activity modulator." The reason for the side effects are poorly understood. Prescribers tend to prescribe a medication on one appointment and not see the patient for a few weeks. With the severity of reaction some patients experience, this is a recipe for disaster. I have been known to go to extreme lengths to intervene on potential iatrogenic disasters, to the point of calling licensing boards if a practitioner can not be reached in order to motivate finding someone to intervene prior to the development of patient damage and need for legal action.

Prescribing and/or recommending medications during a consultation with a prescriber bears a heavy responsibility. One of the reasons that many practitioners prefer to use only medications which are well known and with which they have experience is because many times new medications are put out in the market only to be found to cause severe damage. Despite the vetting of the medication, the reaction of different individuals is unknown. The public is then used a "lab rats" to ferret out the subtle and not-so-subtle problems. There are always risks in taking any medication, but we need to take the most conservative road in prescribing starting with "low dosing" and increasing it "slowly."

One of the ways of decreasing likelihood of adverse side effects is to gather the most information a practitioner can about the patient's history. For example, an individual who has had adverse reactions to some medications may have primary immunodeficiencies (Immune Deficiency Foundation, 2013) such as Omenn's Syndrome (Elnour, Ahmed, Halim, Nirmala, 2007) and Hyper IgE Syndromes (Freeman, Holland, 2008). There are always reasons for adverse reactions to medications, but they may not be well understood. Also, exposure to neurotoxins such as pesticides and herbicides can result in sensitivities which can provide cautions. If we look at the whole patient (history of illness, sensitivities, genetic factors, comorbid conditions, etc.), the risks of prescribing a medication can be better assessed and clinical determinations made.

"The secret of all successful leadership which can endure is that the leader actually is a part of the team continuing working at the level of service, and seeking to serve others at the highest possible level of caring, understanding, balance, and wisdom. "

Rory Fleming Richardson

IMPORTANT THINGS THAT SOMETIMES ARE NOT NOTED IN YOUR MEDICAL RECORDS

- Different supplements, amount and how taken by the patient. Why? When labs are taken, the supplements (i.e., vitamins, minerals, caffeine, other) can alter the lab results and must be taken into account to determine if there are deficiencies.
- Patterns of repeated conditions or problems experienced over years. Why? The onset, course and patterns of illnesses can sometimes suggest a less identified condition. The actions of a retrovirus is a good example of a recurring infection which will appear to get better only to reemerge again and again.
- Possibly interconnected conditions. Why? A good example is the presence of chronic anxiety and extremely agitated state triggering the HPA Axis resulting in increase cortisol in the body system which will tend to make depression more enduring.
- Time of day labs are drawn with reference to current sleep-wake cycle and other potential factors. Why? Lab levels will change during a 24 hour cycle. This cycle can also be impacted by an irregular sleep pattern, food intake, taking of medications, supplement intake, and other factors.

Oxidative Stress: The Other Plague of the 21st Century

According to the World Health Organization, the current viral plague is a pandemic, but there is another plague which has snuck up on civilization. Unfortunately, this one is obviously of our own creation, oxidative stress, and carries with it profound resistence to being stopped because of the monetary and political dynamics feeding it. We have created defoliants, pesticides, cellular communication, electronic pollution, and chemical combinations which have all contributed to a rampant spread and intensification of oxidative stress. Unfortunately, the spread of knowledge to fight oxidative stress has been given significantly less attention that the purchase and use of things causing it. The other unfortunate aspect is that there is a concomitant pandemic of screen and electronics addiction which creates even more resistance to eliminating these pollutants. Everyone has heard of Gulf War Syndrome and Agent Orange, but few understand the connection of these maladies to oxidative stress.

I have always held that if one suffers from either a physical or psychiatric disorder, adding toxins is unlikely to make it better, and most likely make it worse. If we change term toxins to oxidative stress, anything that causes it is a potential negative factor which can affect the maladies we suffer from. Rather than debate if this factor or that factor impact the malady, it may be of more value to ask if it contributes to oxidative stress. It is curious (and insightful) that N-acetylcysteine reduces oxidative stress and it also has been shown to improve a multitude of psychiatric and medical conditions. Several other approaches (which are less than well known) have been found to do the same. One of these is called "earthing" or "grounding" where the human body is put in contact with the earth. We forget that every molecule has positive and negative poles, thus an electronic dynamic. Our earth also has the same. During a billion years of evolution, we have made contact with the ground, but in 1960, we elected to insulate ourselves from the earth with rubber soul shoes. We have only recently discovered how much of a mistake this has been. The term biophysics is relatively unknown to current medical practices, but is well known in the research world. It acknowledges the fact that life, like all other things in the universe, has a physics to it. We have become so narrow sighted in medicine, that we *poo-poo* anything that is not mainstream. These are only two of the methods of reducing oxidative stress.

Shearer, F. M., Moss, R., McVernon, J., Ross, J. V., & McCaw, J. M. (2020). Infectious disease pandemic planning and response: Incorporating decision analysis. PLoS medicine, 17(1), e1003018. https://doi.org/10.1371/journal.pmed.1003018

Telepsychology Consultation Services

If you are interested in scheduling a consultation, please contact me at drrory@live.com for details. Please see Forms section.

Consultation services usually fall into either:
Case Consultation upon referral from a physician, nurse practitioner or other healthcare provider
or
Direct service assessment and treatment.
These cases frequently will include one or more issues:
• complex conditions with psychiatric disorders resistant to treatment,
• clarification of diagnoses,
• nutritional aspect of psychiatric conditions,
• eating disorders, bariatric complications & post-surgical complications,
• differential/concomitant issues relating to attention and behavior,
• chronic conditions, pain & psychiatric issues,
• dual diagnostic, addiction and psychiatric issues,
• Electromagnetic hypersensitivity (EHS), neurotoxicity & psychiatric issues.

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