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## Answers to Sylvester Learning Check ODD
We are excited to bring you the next installment of The Tablet, the official newsletter of APA’s Division 55, the Society for Prescribing Psychology. In this issue you will see several timely articles as well as a column by our outgoing president, Dr. Derek Phillips. Dr. Peter Smith, our new President, outlines his vision for the coming year. Dr. Dubro discusses the research link between LSD and schizophrenia, Dr. Pujol provides a brief on a new drug for ADHD, and doctoral candidates Benitez and Rivera discuss medications in the neurorehabilitation setting.

Dr. Sylvester reviews the current state of psychopharmacological and psychological research for the pediatric treatment of ADHD and ODD. You can test your knowledge with Dr. Sylvester’s comprehension questions following the discussion of each pediatric disorder. Dr. Finney describes her path to prescribing psychology and personal and professional growth in our Profiles in RxP column. We pay tribute to two influential professionals who each had a unique and lasting impact on the field of prescribing psychology; Dr. Steven Tulkin and Dr. Marvin Oleshansky. In case you missed Dr. Deleon’s quarterly columns you’ll get a chance to read his insights about legislation and other important happenings in the world of psychology from the past year. Also, we recommend you take a moment to peruse the impressive list of publications our members have produced since our last issue. As always, we strive to produce a professional and relevant newsletter for our membership. Please reach out to your editors if you have any suggestions or feedback to help us meet your needs and address your interests. We hope you enjoy this issue!

David S. Shearer, PhD and Judi Steinman, PhD

If you have questions or comments you can email davidshearer.rxp@yahoo.com

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Have an article that you’d like published in The Tablet? Have a case vignette that you’d like to share with Division 55 members? Please contact David Shearer, Editor in Chief at davidshearer.rxp@yahoo.com
I’ve blinked and 2021, and my presidency, have already come to their end. It was no doubt a tumultuous year with the ongoing public health emergency, not to mention the ever increasing hyper-partisanship in Washington and economic recovery from the pandemic. Nevertheless, the Division 55 Board of Directors was hard at work all year to continue to advance our priorities and goals on your behalf. Here is my attempt to adequately describe 2021’s highlights.

- In March, our Division’s name was officially changed from “American Society for the Advancement of Pharmacotherapy (ASAP)” to “Society for Prescribing Psychology.” This was done with no objections from the APA Council of Representatives after a 60-day period of open comments and with more than a 2/3 majority vote from the Division membership.
- Other bylaws changes were approved by you, including adding a fourth member-at-large to the Board of Directors, increasing the term for our student representative on the Board from one to two years, establishing criteria and a process to remove a member of the Board of Directors, providing that the bylaws shall be reviewed every 5 years, and allowing for electronic voting for future bylaw and referenda voting.
- In June 2021, Dr. Marlin Hoover and I presented to the ABPP Board of Trustees in hopes of their approving our "Brief Proposal" to create a clinical psychopharmacology specialty board. The ABPP Board’s vote ended in a tie, which means the motion failed and our proposal did not move forward. While this was disappointing, we have already been regrouping and plan to resubmit our proposal to ABPP in 2022.
- We have also applied for clinical psychopharmacology to be formally represented on the Council of Specialties in Professional Psychology (www.cospp.org) and will be following up on this in 2022.
- The Division 55 CE Council is hard at work to revamp the Division’s CE program with the goal of having our CE sponsor approval reinstated as soon as possible.
- Our Training Directors Council has also been meeting monthly this year to discuss common issues that are affecting MSCP programs. Idaho State University’s and The
Chicago School of Professional Psychology’s MSCP programs both earned APA designation in 2021 as well.

- The Division’s Diversity Council has been working and will continue to work to create a formal Division diversity policy. We have partnered with APA’s Equity, Diversity, and Inclusion (EDI) Office to help with this process.

- Thanks to the generosity of Dr. Bret Moore, the Board established this year the "John D. Preston Award for Outstanding Contributions to Clinical Psychopharmacology." The inaugural award was given to the amazing Dr. Bob McGrath! I also gave Drs. Marlin Hoover and Judi Steinman presidential citations during our annual awards ceremony during the APA Convention to highlight their incredible contributions to the Division and the field.

- Division 55 membership is exploding! Our final 2020 membership was 732 and now sits at 863, a 15% increase in one year. While many/most divisions are losing members, we are completely bucking that trend, particularly due to the influx of new MSCP students.

- Financially, we are also doing quite well. In 2020, we ended the year with a $5,000 budget surplus and were on track to do the same in 2021, although year-end financial reports are not yet available from APA Division Accounting. Our total assets sit at just over $106,000, which is a 6% increase from one year ago.

- The Division newsletter, The Tablet, returned from hiatus this year with 2 issues. You can find them on our website.

- Division 55 was a sponsor of The National Practice Conference in Washington, DC, which was co-hosted by The National Register and The Trust in early November. As part of our sponsorship, I attended the conference on behalf of the Division. It was a great success and gave Division 55 some good visibility.

- The Division has been involved in several states’ RxP efforts this year, the most visible of which have been Colorado, Washington State and Vermont. Letters of support were sent for these states and Div. 55 Board members, including myself, testified via Zoom for Vermont’s sunrise review effort with psychiatrists and state regulatory agency staff also in attendance.

I would also like to thank outgoing Board members: Dr. Judi Steinman (Past President), Dr. Deepan Chatterjee (Treasurer), Dr. Gerardo Rodriguez-Menendez (Member-at-Large), and Ms. Courtney Vaughan (Student Representative) for their service to the Division. Welcome to Dr. David Shearer (President-Elect), Dr. Julie Price (Treasurer), Dr. Lynette Pujol (Member-at-Large), Dr. Christopher Rossilli (Member-at-Large), and Mrs.
Morgan Ferris-Johnston (Student Representative), who began their terms on January 1, 2022.

It has truly been my pleasure and honor to serve this Division, the field of clinical psychopharmacology/prescribing psychology, and the RxP movement that I began advocating for over a decade ago as a graduate student. Thanks to all who came before me and those that will come after me to further this movement and specialty. Although I’m not leaving, this is my sign-off as your President. I transitioned to Past President on Saturday, January 1, 2022. Please help me welcome the 2022 President, Dr. Peter Smith!

My best,

Derek C. Phillips, PsyD, MSCP, ABMP
2021 Past-President
Society for Prescribing Psychology
Division 55 of the American Psychological Association

PLEASE PARTICIPATE!
Division 55 is surveying members and other interested Divisions about overall interest in a Board Certification in Clinical Psychopharmacology. Your participation is very important and every voice counts!
SURVEY LINK: https://forms.gle/Xx8jxA7B8QFGpT9G8
Please contact Division 55 Past President Dr Phillips at drderekphillips87@gmail.com if you have any questions.
When our editor stated that I needed to write my contribution to The Tablet, I began to think about what I wanted to share with everyone. In the time since his request the world has seen dramatic changes. The excitement I felt about writing my first column has receded and I am left reflecting upon what has been transpiring half a world away. What do I say at this time? In the midst of such horrors what is appropriate to talk about? Does it seem right to talk about the progress we’ve made, and aim to make, without addressing how our movement can address the aftermath of what’s happening in Ukraine?

Prior to finishing this column, I had posted to our listserv a request from a colleague for anyone with contacts to help obtain and deliver medications, including psychiatric medications, to the Red Cross for delivery to Ukraine. The downstream consequences of this war will be far-reaching. My colleague noted that patients and providers will require significant help with various conditions from burnout through severe trauma. Closer to home, we are still coping with a child mental health emergency and the deaths of over a million people in the last couple of years from COVID. At this time, non-fragmented care is needed more urgently than ever before and we are here to advance this as part of our mission.

I see my role as one of strengthening what we have, addressing any inefficiencies, and leaving the division in better shape so that we can continue to grow and support those who believe in Prescriptive Authority for appropriately trained psychologists. What I’ve come to determine is that as President I can help examine what we are doing, find ways to balance our desire to be effective without over-extending ourselves, and develop ways to be more efficient when needed.

I believe part of this is going to require engagement with membership that includes both recruiting new members and finding ways to provide more value to those who have remained supportive. I want to encourage members to become involved in one of the many different projects your Board of Directors is currently pursuing. We are all busy professionals, but even small contributions make a big difference in the long run. In the coming year I hope I can entice you to
consider joining a task or project that piques your interest.

Speaking of Division tasks and accomplishments, this is the first Presidential Column since our name formally changed. We are now the Society for Prescribing Psychology. This is only the latest in a long line of short- and long-term initiatives we are working on such as support for state legislative efforts, federal advocacy, and updating our clinical guidelines. If you think you can contribute, we want to hear from you.

With perseverance and effort we will continue to advance our work for the good of the public and our clients. I am humbled by your vote to be your current President and I hope I can measure up to those amazing leaders who’ve come before. I am truly touched that I’ve been entrusted to help guide us as a division for this year. Last, but not least, I hope to provide an update to you in August at the Annual APA Convention in Minneapolis.

Thank you, truly

Peter Smith Psy.D. MSCP
Pharmacologic treatments approved by the Food and Drug Administration (FDA) for Attention-Deficit Hyperactivity Disorder (ADHD) include psychostimulants and non-psychostimulants. More than 30 preparations of psychostimulants are available through extended and immediate release formulations, combinations of the two and through multiple delivery systems to include liquids, capsules, chewables, disintegrating tablets, sprinkles and prodrugs (Cutler et al., 2020). However, 25 - 30% of patients cannot use psychostimulants because: they are ineffective for their symptoms (Conner, 2015); side-effects are not tolerated; they exacerbate other co-morbid conditions (e.g., eating disorders); and/or they pose a risk of abuse or diversion (Cutler et al., 2020). Until recently, atomoxetine (Strattera®), guanfacine-ER (Intuniv®) and clonidine-ER (Kapvay®) were the only nonstimulant agents approved for ADHD (Turner, 2021). These drugs may not be efficacious or tolerated by some children and adolescents (Johnson et al., 2020).

Enter viloxazine extended-release (ER). Viloxazine (Qelbree,™ pronounced Kel’ bree) is a nonstimulant drug FDA-approved for ADHD in 2021 for children ages 6-17. Viloxazine is not a new drug. The immediate-release formulation was used in Europe as an antidepressant for two decades prior to discontinuation because the short half-life necessitated dosing three times per day and associated nausea proved untenable for patients (Cutler et al., 2020).

**Mechanism of Action**

Viloxazine is classified as a selective norepinephrine (NE) reuptake inhibitor. It is presumed to have other mechanisms of action, although they are currently unknown (FDA, 2021). Some in vitro data suggest it works as an antagonist at SHT2b, a weak antagonist at SHT7 and an agonist at SHT2c receptors (Yu et al., 2020). In vivo, viloxazine increases 5-HT levels in the prefrontal cortex and moderately inhibits the NE transporter. Additional moderate noradrenergic and dopaminergic actions have also been found (Yu et al., 2020).
Clinical Trials

The phase II safety and efficacy trial, conducted by Supernus Pharmaceuticals, studied 222 children ages 6-12 with ADHD (Johnson et al., 2020). Symptoms of ADHD were measured by the ADHD Rating Scale (RS-IV total score; Zhang et al., 2005), the Clinical Global Impression-Severity scale (CGI-S), and the Clinical Global Impression-Improvement scale (CGI-I) (Busner & Targum, 2007) scores. Safety measures monitored during the study were laboratory results, electrocardiogram (ECG) and suicidal concerns based on the Columbia-Suicide Severity Rating Scale (C-SSRS; Posner et al., 2011). Compared with the placebo group, effect sizes for the primary outcome (ADHD-RS-IV total score) were 0.547, 0.596 and 0.623 for 200mg, 300mg and 400mg/day respectively over the 8-week study. The 100mg dose did not improve symptoms significantly (p<.05) over placebo. Common side-effects (>15%) were somnolence, headache and decreased appetite (Johnson, et al.).

Four subsequent short-term randomized, placebo-controlled Phase III trials were conducted in over 1000 children ages 6-17 (Nasser, et al., 2020; Nasser et al., 2021a; Nasser et al., 2021b; Nasser et al., 2021c). Doses ranged from 100 mg to 600mg in the phase III trials. The primary endpoint in these studies was change from baseline to end of study on the ADHD-Rating Scale 5 (ADHD-RS-5, DuPaul et al., 2016). Significant improvement in the primary outcome was seen at all doses compared to placebo except for the 600 mg dose compared to 400 mg dose in an adolescent sample (Nasser et al., 2021c). Secondary outcomes varied in significance in each study. The most frequent side-effects were somnolence, headache and decreased appetite; less than 1% reported a serious adverse event (Findling, 2021). Approximately 3% of 826 subjects in clinical trials discontinued due to an adverse reaction to include somnolence, nausea, headache, irritability, tachycardia, fatigue and decreased appetite (FDA, 2021). A post hoc analyses of clinical trial data (n=1154) show improvements in executive function in treatment groups versus placebo for all doses studied (100 mg, 200 mg, 400 mg and 600 mg; Faraone, et al., 2021). In this study, the number needed to treat was 5.8 with a Cohen’s $d$ effect size of 0.31 for executive function deficit and symptoms of ADHD.

Pharmacokinetics and Pharmacodynamics

Viloxazine may be administered with or without food, although administration with a high fat meal decreased $C_{\text{max}}$ and AUC by 8-9% and increased $T_{\text{max}}$, by 2 hours (FDA, 2021). Capsules should be swallowed, not chewed. Contents of the capsule may be sprinkled over a small amount of applesauce and swallowed without chewing. Capsules come in 100mg, 150mg and 200mg strengths. The median time to peak plasma concentration ($T_{\text{max}}$) was 5 hours (3-9 hr range) after one 200mg dose. Viloxazine is 76-82% protein bound. It is primarily renally excreted with a mean elimination half-life of 4.74 hours (FDA, 2021; Findling et al., 2021).
Viloxazine is primarily metabolized by CYP2D6 and UGT1A9 and UGR2b15 (FDA, 2021). It is a weak inhibitor of CYP2D6 and CYP3A4 and a strong inhibitor of CYP1A2 and CYP3A4 (U.S. National Library of Medicine DailyMed, 2021). Among other reactions, viloxazine may increase serum concentrations of caffeine, carbamazepine, clozapine, duloxetine, lidocaine, melatonin, propranolol, risperidone, simvastatin, and venlafaxine (FDA, 2021).

Clinical Considerations

Contraindications of viloxazine (Qelbree®) include concomitant use of monoamine oxidase inhibitors (MAOIs) or use within 14 days of discontinuation of an MAOI. Concomitant use of sensitive CYP1A2 substrates or CYP1A2 substrates with a narrow therapeutic range are also contraindicated (FDA, 2021). Heart rate and blood pressure should be monitored prior to initiation of treatment, with increases in dosage, and periodically throughout treatment. Suicidal thoughts were higher in treatment groups than in placebo groups, necessitating a black box warning for suicidal concerns. Suicidal thoughts and behaviors should be monitored, especially for patients with a family history of suicide, depression, or bipolar disorder (FDA, 2021). The clinician should also monitor mania and hypomania, especially for individuals with a personal or family history of bipolar disorder (FDA, 2021). Patients who drive or operate hazardous machinery should be advised of somnolence.

For pediatric patients ages 6-11, the starting dose is 100mg/day, increasing by 100mg weekly to the maximum dose of 400 if needed and tolerated. For patients ages 12-17, 200mg/day is the starting dose and may be titrated by 200mg increments to 400mg maximum (Lexicomp). Adverse reactions include increased HR and diastolic BP, drowsiness, mania/hypomania, decreased appetite, nausea and irritability. Animal studies showed fetal toxicities and delayed fetal development when rats were given twice the maximum human dose (U.S. National Library of Medicine DailyMed, 2021). Therefore, patients who are pregnant should discuss continued use with their provider (FDA, 2021). The dosage of viloxazine should be reduced in renal impairment. Viloxazine is not recommended for patients with hepatic impairment (FDA, 2021). Lexicomp (2021) lists the price of viloxazine as $11.96 per dose.

Conclusion

Viloxazine (Qelbree™) is a selective norepinephrine (NE) reuptake inhibitor recently approved by the FDA for treatment of ADHD for children and adolescents ages 6-17. It is a novel nonstimulant added to pharmacological treatments options for children and adolescents with ADHD. Although its usefulness in clinical practice has yet to be determined, it remains another option for nonstimulant treatment in this population.


The purpose of this short article is to provide a summary of a literature review of pharmacologic treatments used to manage the cognitive sequelae of Traumatic Brain Injuries (TBIs). TBIs present a plethora of physical, emotional, and cognitive issues. A variety of treatments exist, with the type, setting, and length depending on the severity and localization of the injury. Pharmacological treatment is often utilized to treat TBI symptomatology and lower the risk of comorbidities. The main psychopharmacological agents used to treat cognitive sequelae of TBI include NMDA receptor antagonists, cholinergics, and stimulants (Rao & Vaishnavi, 2019). The purpose of this systematic review was to examine the current literature on the integration of pharmacological interventions within neurorehabilitation and neuropsychological testing settings in patients with Traumatic Brain Injury (TBI).

This review was conducted using the following databases: Taylor & Francis, Science Direct, Google Scholar, and ProQuest Central. Inclusion criteria consisted of peer-reviewed articles published in English between the years 2006-2020. Keywords for the search included pharmacotherapy, beta-blockers, adrenergic antagonists, neurorehabilitation, neuropsychological testing, and traumatic brain injury (TBI). A total number of 14 articles were identified and 6 articles were retained. Exclusion criteria consisted of articles that did not examine TBI patients within racial or ethnic minority groups.

In cases of TBI or other insults to the cerebral cortex, patients may experience a wide array of cognitive & somatic anxiety symptomatology. The literature reviewed shows that adrenergic antagonist agents may help get patients up to a baseline performance level to obtain more accurate psychometric measurements. When not contraindicated, beta-blockers (e.g., propranolol) have the potential to be incorporated safely on an as-needed basis for patients undergoing neurorehabilitation and neuropsychological testing...
within an interdisciplinary, integrated healthcare environment. Studies show beta-blockers can lessen cognitive anxiety via a decrease in somatization, in turn yielding more accurate results of cognitive ability, deficits, or improvement. Contrary to anxiolytic sedative-hypnotic agents (e.g., benzodiazepines), which have risks of cognitive impairments, data shows that beta-blockers may be an appropriate choice in neurorehabilitative interventions and neuropsychological testing because their intake does not result in an artificially enhanced cognitive ability.

*Note: Findings have been presented at the 2021 ACRM Convention.


Alan Dubro, PhD, MS

The psychedelic drug LSD has proven to be a productive model for both the pharmacology and pathophysiology of schizophrenia. In particular, LSD has been productive in identifying catecholamines and receptor sites involved in the pathophysiology of schizophrenia. This has led to pharmacotherapies for this complex disease.

LSD As A Model For Schizophrenia

Since the first use of antipsychotic drugs for the treatment of Schizophrenia in the 1950’s, antipsychotics medications have been shown to ameliorate the positive symptoms of schizophrenia. However, lack of compliance with the use of antipsychotics medications has been associated with poor compliance secondary to numerous side effects which include neurological symptoms, some of which are irreversible (e.g. tardive dyskinesia), and weight gain associated with an increased risk for diabetes, and hypertension. While acute improvement of psychotic symptoms has been associated with the use of antipsychotic medication (e.g., hallucinations, delusions, grossly disorganized speech and thought processes), which most importantly prevent psychiatric hospitalization for acute psychosis, antipsychotic medications have not proven to be efficacious for the negative symptoms of schizophrenia (e.g. social withdrawal, apathy, anhedonia), or cognitive dysfunction. In fact, medication use to treat adverse drug effects has been associated with a worsening of some symptoms. For example, the use of anticholinergic medication may worsen cognitive deficits.

There has been a resurgence of interest in the use of psychedelic drugs (e.g., lysergic acid diethylamide or LSD, psylocibin) to treat treatment resistance depression with promising results (Reiff et al., 2020). This is an area of critical importance, with a variety of controlled studies for both the treatment of major depression and treatment-resistance depression; however, there has yet to be a pharmacological treatment for the chronic, disabling illness of schizophrenia since the first use of antipsychotic drugs in the United States.

LSD has shown promise as a pathophysiological model for schizophrenia, which ultimately can lead to more effective treatments. This is associated with LSD, particularly among vulnerable people and at high doses, which may result in acute psychosis. This characteristic of LSD inspired basic scientists and clinicians to explore the pharmacology of LSD and the transient LSD-induced psychotic-like state. LSD’s remarkable potency led psychiatrists to speculate about the existence of an endogenous LSD-like “schizotoxin” in the brain of patients with schizophrenia (Osmond & Smythies, 1952).
They wrote:

“We have now known of this illness for nearly half a century, and yet our understanding of it is slight and our useful information scanty. This is not because we have been idle, but because our efforts have been poorly rewarded. Thousands of papers are written every decade; tens of thousands of observations are made; there is no lack of opportunity for studying patients when about one hospital bed in five in this country is occupied by a schizophrenic, yet we are still entirely ignorant of the cause of this disease.”

LSD represents the first synthetic drug whose effect, particularly at high doses, mimics some symptoms of psychosis and schizophrenia, inducing a transient psychotic-like state; for this reason, much research has been performed on the mechanism of action of this drug, as its pharmacology could potentially shed light on the pathophysiology of psychosis and schizophrenia. Studies aimed at comparing hallucinogen-induced psychotic states with the early stages of psychosis have confirmed a substantial degree of overlap between LSD-induced psychosis and early symptoms of schizophrenia, such as hallucinations, conceptual disorganization, and unusual thoughts (Gouzoulis-Mayfrank et al., 1998). In individuals at genetic risk for schizophrenia in family studies, LSD may induce a real psychosis, described as panic, paranoia and distrust, suspicious feelings or delusions of grandeur, confusion, impairment of reasoning, regret, depression, loneliness and somatic discomfort (Unger, 1964). Additionally, LSD-induced psychotic symptoms were more pronounced in 18 out of 20 relatives of schizophrenics, suggesting that persons with a genetic predisposition to schizophrenia are more susceptible to an LSD-induced psychotic response (Anastasopoulos & Photiades, 1962).

Neurotransmitters and Catecholamines

The “catecholamine hypothesis of affective disorders” proposes that some, if not all depressions, are associated with an absolute or relative decrease in catecholamines, particularly norepinephrine, available at central adrenergic receptor sites. In contrast, in more complex diseases such as schizophrenia, single target drugs have turned out to be a failure, whereas multi-target drugs are much more efficient (Carbon & Correll, 2014).

Models of schizophrenia have implicated a variety of catecholamines and other neurotransmitters; the most researched have been Dopamine, Glutamate, Serotonin, and more recently Trace Amine-Associated Receptors. Other aminergic receptors (histamine, muscarinic and adrenergic receptors), GABA, nicotinic Receptors; the endocannabinoid System; and inflammation and oxidative stress have also been the subject of research studies (Stępnicki et al., 2018).

Serotonin

In both humans and rodents there is a strong correlation between the binding affinities of
LSD-like hallucinogenic drugs at the 5HT_{2A} receptor and their hallucinogenic potencies (Glennon et al., 1984). The effects of LSD on the 5-HT inhibition observed in electrophysiological studies have been correlated with their human hallucinogenic effects (Rasmussen et al., 1986).

**Dopamine**

Burt and colleagues conducted a pilot study to test the possible interaction of LSD with the dopaminergic system in 1975. They found that LSD displays highly stereospecific binding to the dopamine (DA) receptor, with the D-isomer displaying about 1000 times greater affinity than the L-isomer for both labelled 3H-dopamine and 3H-haloperidol binding sites (Burt et al., 1976). Later, the hypothesis that the dopaminergic system could be involved in the effects of LSD caught the attention of other researchers. LSD binds to the D\textsubscript{1} and D\textsubscript{2} receptors as a partial agonist (Watts et al., 1995) and the D\textsubscript{4} receptor as a full agonist (Marona-Lewicka et al., 2009).

**Glutamate**

The first experiment regarding the role of glutamate in the molecular functioning of LSD was carried out by Aghajanian and Marek in 1999 (2000). Moreno et al. have explored the effect of the chronic treatment with the mGlu2/3 receptor antagonist LY341495 (1.5 mg/kg) on the hallucinogenic-like effects induced by LSD (0.24 mg/kg). They found that the head-twitch behavior and the expression of c-fos, egr-1, and egr-2 were decreased by the administration of LY341495, revealing that the blockade of the mGlu2 receptor reduced the hallucinogenic effects of LSD due to 5-HT_{2A} receptor activation (Moreno et al., 2013).

**Trace Amine-Associated Receptor 1 (TAAR\textsubscript{1})**

Psychostimulant and hallucinogenic amphetamines, numerous ergoline derivatives including ergometrine, dihydroergotamine, and LSD, as well as the antiparkinsonian agents bromocriptine and lisuride, display agonistic activity at the TAAR\textsubscript{1} receptor expressed on HEK-293 cells (Bunzov, et al. 2001). These studies suggest that TAAR\textsubscript{1} receptor may play at least a downstream role in the response to LSD, which deserves further study since TAAR\textsubscript{1} may be a novel target for the treatment of psychosis and LSD-induced psychotic-like effects.

**Schizophrenia Pharmacotherapies**

Since the discovery of dopamine as a neurotransmitter in the late 1950s schizophrenia has been associated with changes in the dopaminergic system. However, the dopamine hypothesis of schizophrenia cannot explain all the symptoms associated with the disorder. Therefore, research has also focused on the role of other neurotransmitter systems in schizophrenia.

Patients with schizophrenia have a poor quality of life and severe functional disability despite treatment with antipsychotic agents (Lieberman &
First, 2018). This has been the case since the onset of the use of chlorpromazine; it was first used for the treatment of schizophrenia in 1955 (López-Muñoz et al., 2005). Twenty to 33% of schizophrenic patients do not have a response to any antipsychotic drug (Conley & Kelly, 2001). Antipsychotic drugs are associated with side effects that include involuntary motor movements, sedation, weight gain, increases in triglycerides, and diabetes (Huhn et al., 2019).

First Generation Anti-Psychotics

The original antipsychotic drugs were happened upon largely by chance and then tested for their effectiveness. The first, chlorpromazine, was developed as a surgical anesthetic after an initial report in 1952 (Schatzberg, 2009). It was first used in psychiatric institutions because of its powerful tranquilizing effect.

The use of antipsychotic drugs, beginning in the 1950’s, provided a strategy for the biological treatment of schizophrenia (Seeman, 1987). This led to a search for a primary site for their therapeutic effect. The side effects associated with these antipsychotic drugs suggested that dopamine blockade was associated with their mechanism of action. Systematic research emerged in the 1970’s with the finding that dopamine pathways were overactive in schizophrenia (Carlsson, 1978). Conventional antipsychotics (termed typical or first-generation antipsychotics [FGAs] (i.e., haloperidol, chlorpromazine) act on the dopaminergic system by blocking dopamine receptors.

While conventional antipsychotics are efficacious in ameliorating the positive symptoms of schizophrenia (disorganized thought processes, hallucinations, delusions), they have been ineffective in treating negative symptoms and cognitive difficulties such as apathy, lethargy, social withdrawal, anhedonia, impaired attention, memory difficulties, and flat affect.

The search for antipsychotic medications to manage the positive, negative, and cognitive symptoms of schizophrenia led to a new generation of antipsychotic drugs. The atypical antipsychotics (AAP) are also known as second generation antipsychotics (SGAs). A series of SGA compounds, first used in the 1990’s, include clozapine, risperidone, olanzapine, aripiprazole, ziprasidone, and quetiapine (Fleishhacker, 1995).

Although issues regarding medication compliance associated with less adverse side effects was hoped for with SGAs, this has not been the case. As a class, they have a more favorable profile in terms of involuntary motor movements such as tardive dyskinesia, but they produce other negative side effects, including hypotension, weight gain, diabetes, an increased risk of stroke, sudden cardiac death, blood clots, and sexual dysfunction (Kane, 2006).
The atypical antipsychotics integrate serotonin, norepinephrine, and dopamine receptors in contrast to typical or first-generation antipsychotics which bind only to dopamine receptors. Theoretically, this was assumed to impact negative symptoms such as flat affect, and lack of pleasure (anhedonia), along with cognitive memory deficits, but this has not been found clinically (Stahl, 2008).

Neither the first-generation nor second-generation antipsychotics have been the “magic bullet” for the treatment of schizophrenia.

The Muscarinic Hypothesis of Schizophrenia
The muscarinic hypothesis of schizophrenia postulates that the muscarinic acetylcholine system plays a crucial role in the pathology of schizophrenia. Several lines of recent evidence suggest an involvement of a cholinergic dysfunction in the psychopathology of schizophrenia (Raedler et al., 2003). Positive and negative symptoms as well as cognitive symptoms are potential targets for cholinergic muscarinic receptors in schizophrenia.

It is interesting that betel nut chewing is a widespread practice in some Asian and Pacific cultures (Sullivan et al., 2007). In schizophrenia, betel nut chewing has been associated with fewer positive and negative symptoms. These findings are of special interest in this context as some psychoactive components of betel nut, arecoline, are muscarinic receptor agonists.

In a treatment study a combination of the muscarinic M1 receptor agonist xanomeline and the anticholinergic agent trospium (acting primarily at peripheral receptors) resulted in significant reductions in the degree of positive, negative, and cognitive symptoms in schizophrenic patients. Additionally, treatment with the combination of xanomeline–trospium was not associated with a high incidence of adverse side effects such as involuntary motor movements or weight gain (Brannan et al., 2021).

Xanomeline is an oral muscarinic cholinergic receptor agonist that has no direct effects on dopamine receptors. Trospium is an anticholinergic drug that is approved for the treatment of overactive bladder in the United States and in Europe.

To summarize, the cholinergic-muscarinic hypothesis is an addition to existing neurotransmitter theories of schizophrenia and offers a potentially new approach for the psychopharmacological treatment of schizophrenia. A long journey to find an effective treatment for a disorder that is as complex as any in medicine.


Carbon M., Correll C.U. (2014). Thinking and acting beyond the positive: The role of the cognitive and negative symptoms in schizophrenia. CNS Spectr. 19(Suppl. 1):35–53. doi: 10.1017/S1092852914000601


The following sections on Attention Deficit Hyperactivity Disorder (ADHD) and Oppositional Defiant Disorder (ODD) in childhood compile recent research and trends in the treatment of these disorders. Treatment may take the form of psychotherapeutic interventions, pharmacotherapy, or both. The author holds a preference for psychotherapeutic interventions over pharmacotherapy in most cases and discloses this potential bias to the reader. The author will attempt to provide an objective review of the empirical work reviewed in the pages below, but offers this disclosure for the sake of transparency.

Oftentimes there is a dearth of research literature regarding treatment of various childhood disorders. This may be due to several factors including but not limited to the age of the child (two to five-year-olds), the rarity of the condition being treated (schizophrenia), availability of treatment (lack of mental health medication prescribers and/or mental health service providers with specific certifications, e.g., CBT, play therapy, etc.), pay source limitations, transportation limitations, and various other factors. The author attempts to break down treatment diagnostically, but cautions the reader that overlap between disorders and treatment approaches are common in real world practice. This overlap does not lend itself well to research.

When providing services to patients it would be prudent for the provider to embrace the biopsychosocial approach to evaluation and treatment selection, consider the individual needs and preferences of the patient as well as their family, and employ caution against overlooking cultural as well as other individual differences (Muse & Moore, 2012). When providing services, numerous times patients or their families inform the author that their previous provider rarely gave them detailed, easy-to-understand information about treatment options, potential benefits or adverse effects, and a meaningful explanation of the mechanisms by which treatment potentially brings about change. Such an approach and explanation should be the rule, rather than the exception.
Attention Deficit Hyperactivity Disorder (ADHD)

ADHD is not exclusively a childhood disorder. Prakash, et al. (2021) estimate that approximately 60% of children diagnosed as suffering from ADHD continue to suffer from attention-related problems into adulthood and prevalence rates for adults who suffer from ADHD range from 0.9% - 6.3% depending upon location as well as age range. Song, et al. (2021) estimate a global prevalence rate of persistent adult ADHD at approximately 4.6%, at rate of roughly 4.7% in the U.S., and slightly higher rates among males as compared to females.

ADHD is a serious condition that may affect functioning across the lifespan. The focus of this article is limited to children, but the importance of recognizing the functional impact of ADHD across the lifespan should not be underestimated. Danielson, et al. (2018) estimate that of U.S. children ages 2 to 17 years-old, approximately 9.4%, or roughly 6.1 million, received a diagnosis of ADHD. Further, they report current rates of ADHD diagnosis as 8.4% of U.S. children 2 to 17 years-old. Over 60% of those children received medication to treat ADHD, less than 50% engaged in some form of nonpharmacological treatment, and nearly a quarter of them remained untreated.

Available research regarding treatment of ADHD in very young children, two to five-years-old, is sparse. In addition, there are limited FDA indicated medications for children in the aforementioned age range suffering from ADHD. The general consensus in the available literature recommends behavioral intervention and/or parent training over medication interventions in very young children (Wolraich, et al., 2019; Duerr, H., 2022; National Institute for Health and Care Excellence [NICE], 2018; & Krull et al., 2021).

Should symptoms reach a level of dangerousness or otherwise become markedly severe, available research indicates that a trial of a stimulant medication in addition to nonpharmacological treatment may be appropriate, typically methylphenidate (Wolraich, etal., 2019; & Krull et al., 2021). Limited research indicates very young children may be prone to experience adverse effects from stimulant medications including affective lability and dysphoric mood in addition to the adverse effects typically associated with those medications (Wolraich, et al., 2019).

Methylphenidate works by blocking the reuptake of dopamine and norepinephrine (Stahl, 2013). Per Stahl (2013), methylphenidate differs from the amphetamines in that amphetamines block the reuptake of dopamine and norepinephrine, but also release dopamine and norepinephrine thereby further increasing neurotransmitter activity. These stimulant medications are typically more efficacious than non-stimulant alternatives, but some parents prefer alternative treatments due to the stimulants'
reputation and similarities to the street drug methamphetamine. Methylphenidate is not metabolized significantly by the CYP450 system, but amphetamine is metabolized by CYP2D6 and is a mild inhibitor of CYP2D6 (Mangini, 2017).

Treatment guidelines and recommendations are more readily available for school age children and adolescents. In short, research supports the use of behavioral, pharmacological, and combinations of both interventions (Bolea-Alamañac, et al., 2014; Wolraich, et al., 2019; & NICE, 2018). NICE (2018) recommends behavior-based intervention for children five years and older with a recommendation for a trial of medication should ADHD symptoms persist after nonpharmacological intervention. In addition, NICE (2018) recommends CBT for children who received some benefit from medication intervention, but continue to struggle with problematic symptoms. For children ages six to 12-years-old, Wolraich et al. (2019) recommend medication with parent/behavioral intervention as well as school-based interventions. They specify that research evidence for use of stimulant medications is strongest, but there is also evidence for use of atomoxetine, extended-release guanfacine, and extended-release clonidine. For children ages 12-years-old and up, Wolraich et al. (2019) recommend medication and behaviorally based interventions. In regards to selecting specific types of intervention whether medication, behavioral, or both, researchers suggest it best to provide a thorough informed consent process and elicit patient as well as family/caregiver feedback in the treatment planning process (Bolea-Alamañac, et al., 2014; Wolraich, et al., 2019; & NICE, 2018). In other words, the exact or “best” treatment approach will vary based on patient variables and input, family variables and input, and communication with the prescriber during the treatment planning process.

Atomoxetine, guanfacine, and clonidine are common, empirically supported, nonstimulant treatments for ADHD (Stahl, 2013). Atomoxetine works by inhibiting the reuptake of norepinephrine, which increases levels of norepinephrine as well as dopamine. It is metabolized via CYP2D6 (Michelson, et al., 2007). Guanfacine and clonidine are alpha2-adrenergic agonists that work by increasing prefrontal cortex activity as well as modulating norepinephrine and dopamine (Stahl, 2013). Guanfacine is metabolized via CYP3A4 and clonidine is metabolized at least partially via CYP2D6 (Li, et al., 2018; Claessens, et al., 2010).

Otasowie, et al. (2014) investigated the efficacy of tricyclic antidepressant (TCA) medications in treatment of children who suffered from ADHD and tic disorder. Results suggest some efficacy for TCAs in the specified populations, with the most evidence for desipramine. TCAs were usually more
efficacious than placebo, but not as efficacious as methylphenidate. Sturman, et al. (2017) suggested that methylphenidate was efficacious in treatment of ADHD symptoms in children who suffer from autistic spectrum disorder. There is limited evidence with a small sample size to suggest aripiprazole and risperidone may reduce symptoms of ADHD in children (Razjouyan, et al., 2018). Whether considering TCAs or second generation antipsychotics (SGA), the risks associated with such medications should be strongly measured prior to their use due to the severity of their side effect profiles. Given the potentially dangerous side effects, it would be wise to consider use of such agents only in severe, treatment refractory cases or cases in which other co-morbid conditions markedly impair functioning.

Viloxazine is a selective norepinephrine reuptake inhibitor with antagonistic actions at the 5-HT2B receptor and agonist actions at the 5-HT2C receptor that was recently indicated for treatment of ADHD in children six to 16-years-old (Cutler, et al., 2021; Nasser, et al., 2021; & Faraone, et al., 2021). Originally marketed as an antidepressant medication nearly 40-years ago, viloxazine has demonstrated clinical efficacy in reducing symptoms of ADHD while maintaining a fairly mild side effect profile (Findling, et al., 2021; Cutler, et al., 2021; Nasser, et al., 2021; & Faraone, et al., 2021). Yu (2020) reports viloxazine is a substrate of CYP2D6 and a strong inhibitor of CYP1A2.

Learning Check (answers are located on page 63):

Question 1: You are asked to complete an evaluation for a five-year-old girl. Her primary care physician (PCP) referred her to you for treatment. The PCP believes she suffers from ADHD and states that otherwise she is in perfect health. While gathering relevant history from the child’s mother and father, they mention the girl’s maternal grandmother recently died. The girl’s father reports he recently lost his job and is working “odd jobs” on an unpredictable schedule while he looks for something more permanent. While working with the child you notice she attends poorly and is easily distracted. You decide your best course of action is to:

A Begin play therapy and family work to address the girl’s adjustment disorder and grief.
B Prescribe methylphenidate as it is a first-line agent for ADHD and that addresses the referral issue.
C Complete a WISC-V and TAT in order to gain a better understanding of the child’s level of functioning.
D Gather input from the family regarding the possibility of further assessment and treatment options.

Question 2: You have completed a full
evaluation on an eight-year-old boy and diagnosed him as suffering from ADHD. After discussing treatment options with his family, you decide that a combination approach involving medication and behavioral intervention is most appropriate. The family reports concern regarding the reputation of methylphenidate as well as amphetamines and would prefer a nonstimulant medication. You prescribe a starting dose of 1mg of guanfacine daily. A few days later, the child’s mother calls you and states he is acting tired, irritable, complains of stomach pains, feeling dizzy, and complained of a sore throat one morning last week. You ask her several questions regarding his diet, recent behaviors, and potential medical changes. The most relevant fact she reveals is:

A The family recently acquired a new puppy.

B The boy loves grapefruit juice.

C The boy is displaying signs of PANDAS.

D The family recently learned their house has a termite infestation.

Question 3: Medications used to treat ADHD typically modulate:

A GABA and Opioid receptors

B Sodium and Calcium ion channels

C Dopamine and norepinephrine

D Serotonin and endocannabinoids


Prakash, J., Chatterjee, K., Guha, S., Srivastava, K., & Chauhan, V. (2021). Adult attention-deficit hyperkinetic disorder: From clinical reality toward conceptual clarity. Industrial Psychiatry Journal, 0(0), 0. https://doi.org/10.4103/ipj.ipj_7_21


Oppositional Defiant Disorder (ODD)

Aggarwal and Marwaha (2021) report that the prevalence of ODD is difficult to pinpoint, but suggest it falls between 2% and 11% of children with males slightly more affected than females pre-adolescence, but that difference disappears in the teen years. DSM-5 (American Psychiatric Association [APA], 2013) estimated an overall prevalence rate of ODD at approximately 3.3%. The available literature suggests ODD may lead to the development of conduct disorder (CD), but is not a prerequisite for CD (Aggarwal & Marwaha, 2021; APA, 2013; Ghosh, et al., 2017). There is some evidence to suggest that ODD and CD may reside on the same spectrum, but diagnostically they are two separate disorders (Aggarwal & Marwaha, 2021; & Ghosh, et al., 2017).

Per Ghosh, et al. (2017), approximately half of children diagnosed as suffering from ODD would eventually be diagnosed as suffering from CD later in life. Aggarwal and Marwaha (2021) suggest that ODD in boys is a greater risk factor for later development of CD than in girls. Ghosh, et al. (2017) as well as Aggarwal and Marwaha (2021) suggest a diagnosis of ODD increases the risk of a child being diagnosed as suffering from CD, a depressive disorder, an anxiety disorder, and a substance use disorder.

Ghosh, et al. (2017) report irritability in ODD as potentially predictive of anxiety or internalizing disorders and headstrong behaviors in ODD as potential predictors of substance use problems.

DSM-5 (APA, 2013) as well as Aggarwal and Marwaha (2021) report symptoms of ODD typically onset during preschool years, but can appear at the beginning of adolescence, though rarely. Research overwhelmingly supports the use of nonpharmacological interventions for ODD as first-line treatments of choice (Aggarwal & Marwaha, 2021; Ghosh, et al., 2017; Gorman, et al., 2015; & Loy, et al., 2017). Should nonpharmacological interventions fail and/or ODD symptoms worsen in severity to the point of marked functional impairment or dangerousness, Canadian guidelines (Gorman, et al., 2015) strongly recommend a trial of a psychostimulant medication, methylphenidate or amphetamine, in conjunction with behavioral interventions. Those same guidelines suggest the psychostimulants reduce aggressive and disruptive behaviors.

The Canadian guidelines (Gorman, et al., 2015) provide conditional recommendations generally in favor of using atomoxetine, guanfacine, clonidine, risperidone, and valproate depending on comorbid conditions and functioning. The use of risperidone and valproate should be reserved for cases involving markedly disruptive or aggressive behaviors. Though empirical evidence suggests both agents are effective when combined with a
psychostimulant or used as monotherapy in such cases, the side effect profile should be considered carefully prior to their use. Of the two agents, there appears to be more support for risperidone in cases involving aggressive behaviors (Gadow, et al., 2014; Gorman, et al., 2015). The Canadian guidelines (Gorman, et al., 2015) appear to favor risperidone’s use, though conditionally. They conditionally recommend against use of quetiapine primarily due to the adverse effects of the agent.

Risperidone is a SGA and works primarily by modulation of serotonin and dopamine receptors; however, that is an oversimplification of its actions (Stahl, 2013). It is an antagonist at the D1, D2, D3, D4, and D5 receptors, but possesses the most affinity for D2, of that receptor group. Those antagonistic actions at dopamine receptors lead to an increase in prolactin levels, which may result in galactorrhea or gynecomastia.

Risperidone possesses a greater affinity for serotonin receptors than dopamine receptors and acts as an antagonist or inverse agonist at numerous serotonin receptors, but most notably antagonizes the 5-HT2A receptor. This antagonism is speculated to account for its efficacy in treatment of negative symptoms of psychosis (Stahl, 2013; & Muse & Moore, 2012). It acts as a strong antagonist of alpha1 and alpha2-adrenergic receptors as well as antagonizing H1 histamine receptors (Stahl, 2013). Metabolism of risperidone occurs primarily by CYP2D6 and CYP3A4 to a lesser degree (Berecz, et al., 2004).

The side effect profile of risperidone warrants caution prior to as well as during its use. Most of the SGAs are notorious for weight gain as well as metabolic problems and risperidone is no exception (Stahl, 2013). The exact mechanism by which metabolic syndromes and dyslipidemia arises by SGAs is not entirely understood, but the problem is certainly a major risk factor for potentially lowering the quality of life and markedly shorting the lives of patients (Stahl, 2013; Geller, et al., 2012; & Rafaniello, et al., 2020). Geller et al. (2012) reported that in children diagnosed as suffering from bipolar disorder, approximately 9% of kids prescribed risperidone displayed QT interval prolongation. There seems to be a common belief amongst practitioners that the SGAs are safe medications or more safe than older medications, perhaps because they are simply newer than the first-generation antipsychotics (FGAs) or due to marketing strategies by pharmaceutical companies (Stahl, 2013; Geller, et al., 2012; & Rafaniello, et al., 2020). The reality is that SGAs are powerful medications and powerful medications come with powerful side effects.

Quetiapine is another SGA and works primarily by via modulation of dopamine and serotonin receptors, but that is an oversimplification of its mechanism of action.
Quetiapine acts as a partial agonist at 5-HT1A, also antagonizes 5-HT2A, 5-HT2B, 5-HT2C, 5-HT3, 5-HT6, and 5-HT7 receptors, alpha1 and alpha2-adrenergic receptors, H1 histamine receptors, and muscarinic acetylcholine receptors (Stahl, 2013; Suttajit, et al., 2013; Srisurapanont, et al., 2004). These actions result in quetiapine being one of the most sedating SGAs, but it may produce the lowest rates of extrapyramidal side effects (EPS) of the SGAs. Quetiapine’s powerful sedative properties have led to it frequently being used off-label for sleep problems, but this practice is becoming more discouraged due to the agent’s side effect burden (e.g., weight gain, metabolic syndrome, QT interval prolongation) and abuse potential outweighing potential benefits (Modesto-Lowe, et al., 2021).

Metabolism of quetiapine occurs via CYP3A4 (Guzman, 2021).

Quetiapine’s sedative and hypnotic properties are likely the driving force behind the agent’s popularity as a drug of abuse, particularly in incarcerated or inpatient settings where other substances of abuse may be more difficult to obtain. This author recalls experiences in working with patients who suffer from substance use disorders at which time patients would refer to abuse of quetiapine as “twilight-ing,” “Quelling,” or “Q-balling” when mixing quetiapine with a potent stimulant such as cocaine (likely related to the agent’s trade name, Seroquel). Additionally, patients reported using quetiapine to help ease the process of “coming down” after using a potent stimulant and perhaps to ease the unpleasantness or paranoia brought about by withdrawal from a drug such as methamphetamine. Do not underestimate the terrifying creativity a person with substance use disorder may employ in order to obtain and misuse these potent, potentially dangerous medications.

Valproate is an anti-epileptic drug (AED) and mood-stabilizing agent, but sometimes used to treat markedly aggressive behaviors in children and adolescents (Gorman, et al., 2015). Stahl (2013) provides three potential mechanisms by which valproate exhibits therapeutic effects including inhibition of sodium channels, enhancement of GABA functioning, and downstream signal transduction regulation. Use of valproate in children and adolescents is strongly cautioned due to side effects including liver problems, pancreatic functioning problems, weight gain, sedation, hair loss, and it is a known teratogen potentially causing neural tube defects (Stahl, 2013; Gorman, et al., 2015; & Geller, et al., 2012). Inhibition of CYP2C9 is another documented issue in use of valproate, for which metabolism primarily occurs via glucuronidation and mitochondrial beta-oxidation (Wen, et al., 2001).

Learning Check (answers are located on page 64):

Question 1: You complete an evaluation on a six-year-old boy and conclude a primary
diagnosis of Oppositional Defiant Disorder. During the feedback session with his parents, they ask you about the possibility of this diagnosis leading to other problems later. Based on your current knowledge of the case, the LEAST likely future problem would be:

A. Persistent Depressive Disorder
B. Separation Anxiety Disorder
C. Childhood-Onset Gender Identity Problems
D. Childhood-Onset Schizophrenia

Question 2: After providing services for a 15-year-old male who suffers from a severe case of conduct disorder, you receive a phone call from the child's mother who is alarmed her son is "growing breasts." The most likely offending agent is:

A. Valproate
B. Risperidone
C. Carbamazepine
D. Quetiapine

Question 3: Second generation antipsychotics typically exert their therapeutic effect via modulation of what receptor types?

A. Dopamine and Serotonin
B. Alpha-Adrenergic and Histaminic
C. Dopamine and Norepinephrine
D. Dopamine and GABA


The original Council of Postdoctoral Training Programs in Psychopharmacology (CPTPP) was added to Division 55 in 2012. The mission of the council was to:

- Promote and advocate for high-quality postdoctoral training in psychopharmacology for psychologists.
- Provide a forum for exchanging views; recognizing differences; establishing policies, procedures and contingencies on training matters; and resolving issues between institutions and agencies offering postdoctoral training to psychologists in psychopharmacology for which common agreement is either essential or desirable.
- Represent the views of training programs to groups and organizations whose functions, objectives and/or actions impact on psychologists’ involvement in psychopharmacology.
- Participate in advocacy for enhancing psychologists’ involvement in the practice of psychopharmacology.

It wasn’t until the division decided to submit a Specialty Petition to APA that the council became more active. The first meeting of the Clinical Psychopharmacology Training Directors Council took place on December 1, 2016. In attendance were:

1. Alan Lincoln, Alliant International University
2. Judi Steinman, University of Hawai‘i Hilo
3. Patrick Quinn, New Mexico State University
4. Anne Farrar-Anton, Fairleigh Dickinson University

The main agenda item for this inaugural meeting was to establish the council as part of the Division 55 effort to submit a Special Petition to APA’s Commission for the Recognition of Specialties and Subspecialties in Professional Psychology (CRSPPP).

We have come a long way over the last six years. Our list of programs has changed not to mention the participants. I became chair of the council at our first in-person meeting at APA in 2017. I was officially elected to the chair position because I mentioned at the meeting that we probably needed a chair. I’ve been honored to remain in that position ever since.

The Clinical Psychopharmacology Training Directors Council is composed of the training directors of all clinical psychopharmacology training programs. Council members include directors of APA-designated programs, directors of programs seeking designation, and individuals in states where programs are being developed.
The photo shows those who attended the 2017 meeting, from left to right, Elaine Levine (NMSU), Judi Steinman (UH Hilo), Anne Farrar-Anton (FDU), Gery Rodriguez-Menendez (TCSPP) and Alan Lincoln (AIU).

The purpose of the council is to monitor, coordinate, and ensure that training in clinical psychopharmacology includes APA requirements, current clinical practice, and relevant knowledge. This group works to support each other in fulfilling the mission of providing clinical psychopharmacology training, as well as support the development of new training programs around the country.

The council monitors the issues and needs addressed by clinical psychopharmacology and suggests modifications in training to match the development trends. Additionally, we work to monitor the compliance of our educational programs to the guidelines of the APA, as well as the laws in the various states where legislation has been passed to allow psychologists trained in clinical psychopharmacology to prescribe.

Each program is unique – Alliant continues to offer live weekend lectures in a hybrid model of synchronized and asynchronized learning, TCSPP offers both pre-doctoral and post-doctoral training, FDU provides asynchronous learning with weekly live sessions and on-ground physical assessment training; ISU brings on-ground training in an allied health school and NMSU continues offering on-ground and distant learning opportunities. There is something for everyone and the council continues to grow to ensure quality education for those who seek Clinical Psychopharmacology training.

The current council members are:

- Steven Curtis, PhD, NCSP, MSCP (Program under consideration at Antioch University)
- Kimberly Finney, PsyD, MSCP, ABPP (New faculty member with Alliant)
- Bethe Lonning, PsyD, MSCP (Iowa branch of New Mexico’s program)
- Casey McDougall, PhD, MSCP (Program Director, New Mexico State University)
- Derek Phillips, PsyD, MSCP, ABMP (Program Director, Fairleigh Dickinson University)
- Gerardo Rodriguez-Menendez, PhD, MSCP, ABPP (Program Director, The Chicago School for Professional Psychology)
- Eric Silk, PhD, MSCP (Program Director, Idaho State University)

As a sidenote, many of the Division 55 councils and committees were borne out of necessity during the time when we sought to elevate the status of Clinical Psychopharmacology to a specialty. In some ways, our councils and committees reflect this exploratory process and have taken time to identify their purpose and function within the division. The Clinical Psychopharmacology Training Directors Council is no different; it has taken time for us to develop into the group that we are today - a strong unit that welcomes new programs and supports growth amongst our different schools.

For more information about the Training Directors Council or any of Division 55’s other organizations, go to https://www.apadivisions.org/division-55/councils
Pat DeLeon, PhD, MPH, former APA President

An Inconvenient Truth: Like many visionaries, Vice President Al Gore may have been ahead of the times; however, there can be little question that the health effects of climate change must become a major consideration for all health professions in the immediate future. Founded in 1970 as the Institute of Medicine (IOM), the National Academy of Medicine (NAM) is one of three academies that constitute the National Academies of Sciences, Engineering, and Medicine. Its mission is to improve health for all by advancing science, accelerating health equity; and providing independent, authoritative, and trusted advice nationally and globally. Its vision is a healthier future for everyone.

In 2013, the IOM Discussion Paper Health in All Policies: Improving Health Through Intersectoral Collaboration opined: “The greatest health challenges for the nation today are complex, inextricably linked, and have no easy solutions, such as chronic illness, obesity, health inequities, rising health costs, an aging population, and growing inequity. At the same time, urgent environmental problems such as climate change, water shortages, and the loss of habitat and other natural resources threaten to exacerbate existing health problems and create new health challenges. Medical services, while vitally important, play a lesser role in overall population health improvement than the social determinates of health – the environments in which people live, work, learn, and play....

“Climate change and other global environmental challenges have direct impacts on health, for example, through extreme heat events, and also threaten the life-supporting systems on which human beings depend. The direct and indirect health effects of climate change, such as declining access to clean water, air pollution, crop loss, stratospheric ozone depletion, sea level rise and collapse of fisheries all suggest that ‘environmental sustainability must itself be a key health goal, particularly because all forms of
ecosystem collapse will have grave impacts on health equity, with greater impacts on the most vulnerable communities.”

Last fall, after the conclusion of NAM’s first fully virtual annual meeting, President Victor Dzau highlighted the potential effects of climate change as a major existential threat to society and announced that Climate Change and Human Health were to be an NAM Grand Challenge. Since then, NAM has been working diligently with leaders from the federal government, industry, hospital systems, private payers, academia, and non-profits to identify a shared vision and collaborative pathway toward decarbonization of the U.S. health care sector. NAM has partnered with the Burroughs Wellcome Fund to provide “opportunity grants” to interdisciplinary teams to explore promising ideas at the intersection of climate change and human health. Further, the mental health impacts on vulnerable populations due to climate change-induced displacement, as well as systematically exploring the impact of climate change on children’s health and development have become express identified concerns.

The Continuing and Steady Evolution of PCSAS: Alan Kraut has been a tireless supporter of the Psychological Clinical Science Accreditation System (PCSAS) since its inception, first at the Association for Psychological Science (APS) and now as PCSAS Executive Director. Alan’s aim has been to ensure that our nation’s educational policy leaders, at both the national and state level, appreciate PCSAS’s potential contributions. At an early stage of his policy career, Alan was instrumental in hosting APA’s first Congressional Black Tie dinner event for then-U.S. Senator Daniel K. Inouye.

Currently, eight states formally recognize PCSAS accredited graduates for licensing. And, with the recent recognition by the State of Arizona this spring, more than 30 percent of the nation’s population now live in states that recognize PCSAS. Two of Alan’s colleagues who were the forces behind the recent change in Arizona’s licensing law, the University of Arizona’s David Sbarra and Arizona State University’s William Corbin recently wrote “Eight Lessons for Working with Legislators” in the APS Observer. A summary: Lesson #1 – If you can’t get access to your legislative affairs colleagues, or your issue can’t get ‘elevated’ enough to be on their radars, find a local influencer who can make this happen. Lesson #2 – Once you’re formally pursuing legislative parity, keep your messages as simple as possible. Lesson #3 – Identify and engage your stakeholders. Lesson #4 – It only takes one vocal opponent to derail the process. Lesson #5 – Perseverance is key. Lesson #6 – Work with your lobbyists to understand the legislative strategy. Lesson #7 – Have a theory of the case. And, Lesson #8 – Connect to something larger than your local pursuits.” To these, we would only add: Believe in your mission and Personal stories are remembered far longer than impersonal facts.

At the national level, PCSAS has been recognized by the U.S. Department of Veterans
Affairs, by the Association of Psychology Postdoctoral and Internship Centers (APPIC), and by many of the membership organizations that represent clinical psychology, including APA Division 12’s Section 3, the Society for a Science of Clinical Psychology. Last year the U.S, Congressional Appropriations Committee encouraged the Health Resources and Services Administration (HRSA) to update their eligibility requirements for the Behavioral Health Workforce Education and Training program and the Graduate Psychology Education program to “account for accreditation changes that have occurred since the eligibility requirements were established... to ensure that HRSA’s health workforce programs continue to have access to the best qualified applicants, including those who graduate from PCSAS programs.”

Alan and PCSAS Board President Robert Levenson of the University of California-Berkeley were just informed that beginning in Fiscal Year 2022, PCSAS programs would be deemed eligible to apply. A key factor in their success was the impressive and detailed responses by a number of students demonstrating they already were serving communities of concern to HRSA. Examples cited include: working with homeless Veterans and other individuals who are either currently incarcerated or recently released from prison; working in a community clinic where most clients are diverse in race, ethnicity, sexual and gender orientation, and SES; and working with rural and low-income families, as well as with immigrant families directly in school settings who would not otherwise have access to services. Our personal congratulations to Alan and his colleagues for providing our nation’s educational institutions with viable options for demonstrating educational competence.

Prescriptive Authority (RxP) Addressing Society’s Pressing Needs: Beth Rom-Rymer:

“Several of our psychologists, who are training to become prescribing psychologists, are working in hospitals that serve patients who are traditionally underserved in mental health. Derek Phillips, an Early Career Neuropsychologist and President-Elect designate of the Illinois Psychological Association, has a full-time position, and is also training to become a prescribing psychologist at Sarah Bush Lincoln Health System, serving 10 quite small, rural, east central Illinois counties. He has told me that Medicaid is his third most frequent payor and represents the payor source for 20% of his patients. At the same time, his most frequent payor source is Medicare. AMITA Health System, the largest healthcare system in Illinois and the largest Medicaid provider of mental health services in Illinois, is also the health system that trains the vast majority of our prescribing psychologist Fellows in Illinois. We are very proud that our Prescriptive Authority Movement in Illinois is making good on its commitment to provide greater access to those in our communities who have been suffering too much and too long because of the inaccessibility of mental health care! I know that all of our graduate students and our undergraduate students, who are
already studying, in the early stages of their careers, to become prescribing psychologists, are thrilled with the prospect of being a part of a new cadre of prescribing psychologists who are helping to meet the needs of the underserved and are providing relief to our health system that has been in a deep crisis for decades.” As both Alan and Beth have indicated, the voices and actions of the next generation can make a substantial and highly positive difference.

**The Long-Term Importance of PSYPACT:**

Alex Siegel, Director of Professional Affairs, Association of State and Provincial Psychology Boards: “In the last three years the professional practice of psychology has made a significant shift towards telepsychology. Prior to COVID-19, most psychologists did not know about telepsychology, much less use it, to provide psychological services to patients. As all of us are aware, during COVID most of us pivoted to telepsychology as the way to treat/assess patients. Now as the pandemic subsides and the states’ Executive Orders allowing interjurisdictional practice ends, the Psychology Interjurisdictional Compact (PSYPACT) will become increasingly important to our ability to provide psychological services to patients across jurisdictional boundaries in the United States.

“PSYPACT is an interstate compact for the professional practice of psychology. It was designed to provide psychologists with a legal and ethical pathway to conduct telepsychology and/or practice in-person, face-to-face psychological services across state boundaries without necessitating the need to become licensed in every state they intend to practice. In the future, PSYPACT will continue to administer an accessible and manageable regulatory structure for the practice of telepsychology and temporary in-person practice.

“Over the last two years, we have made significant gains in the number of jurisdictions which have enacted the legislation. There are now 25 jurisdictions with several additional states with active legislation. In those jurisdictions, for the most part, state psychological associations have been big advocates for PSYPACT. Their membership see this as increasing their ability to provide telepsychological services to patients who might move to, or live in, another state. In addition, patients welcome the benefits of increased access to care, continuity of care, and a greater degree of public protection.” “I just pick myself up and get back in the race. That’s life” (Frank Sinatra). Aloha
Our Councils

Division 55 has various councils that serve an integral role in carrying out the division's mission of increasing access to quality psychopharmacotherapy through advocating nationwide for appropriately trained psychologists to prescribe psychotropic medications. Specifically, the mission of the Diversity Council is to promote inclusion of diversity-relevant issues in the administration of Division 55, to provide information and services relating to diversity to Division 55 membership, and to provide representation within APA on the intersection of diversity and psychopharmacotherapy within APA governance. The purpose of the Division 55 Research Council is to promote dissemination of high-quality, evidence-based research related to the causes of and treatments for mental illness and substance use disorders. The purpose of the Training Director Council is to monitor, coordinate and ensure that training in clinical psychopharmacology includes APA requirements, current clinical practice and relevant knowledge. Please go to https://www.apadivisions.org/division-55/councils for more information on any of our councils and committees.
Morgan Sammons recently announced his retirement as Executive Director of the National Register of Health Service Providers in Psychology. Morgan and his U.S. Navy colleague John Sexton were the first of the Department of Defense (DOD) psychopharmacology Fellows, who, over time, have revolutionized the scope of practice of health psychology. Upon retirement from the military, he served as Dean of the Alliant International University (California School of Professional Psychology) for seven years. Morgan unquestionably is one of the field’s true visionaries. “So how many psychologists are needed to treat psychological morbidity associated with COVID? Answers are uncertain. The Association of State and Provincial Psychology Boards (ASPPB) reports approximately 131,000 licensed psychologists in the U.S. This number, however, includes those with master’s degrees who are licensed as psychologists. Sixteen states license at the master’s level; these disciplines include psychological associates, school psychologists (master’s level), and Behavior Analysts. Other estimates used by SAMHSA and related government agencies put the number at around 100,000 clinical, counseling and school psychologists. Data from the Health Resources and Services Administration (HRSA) suggest that approximately 18,500 psychologists will enter the field between 2016 and 2021, or roughly 3,800 per year (this compares with an estimated 1,080 psychiatrists and 27,200 social workers annually), for an average of 3,700 psychologists per year.

“But we don’t really know how many of these psychologists are actually health service providers. Of those, we then need to subtract part-time providers, psychologists working in specialized care settings not accessible by the general population (e.g., the Department of Defense, the VA, and the correctional system, all of which represent an increasingly large share of the psychology workforce) and those retiring annually. I believe it is accurate to state that we are in a deficit position where we are neither replacing those who leave the field nor are we accounting for increases in demand. Keep in mind that it is just not COVID that drives demand – since 1977 the number of doctoral degrees in psychology, while doubling in absolute numbers, has actually declined as a proportion of the total number of doctorates awarded in the U.S. and during this time the population of the U.S. has increased by over 40%.”

We would further note that the other professions providing behavioral health services (i.e., psychiatric nursing (DNP), physicians assistants (PA), and clinical pharmacists (PharmD) are steadily, if not dramatically, expanding their numbers and scope of practice.
The Next Generation Advancing the RxP Agenda: Jin Lee, Chair of the Colorado RxP Taskforce: “Recently the Colorado Psychological Association (CPA) had a meeting with the Colorado Psychiatric Society (CPS) to discuss the RxP initiative. As the RxP task force chair and a board member of CPA, I presented our proposal and why RxP matters here in Colorado. Colorado is ranked the third worst state for a high prevalence of mental health and poor access to care. There are less than 900 psychiatrists practicing in Colorado (including residents and fellows), while there are over 4,000 psychologists (including interns and fellows) in Colorado. Psychologists are available in 11 more counties compared to psychiatrists, and the number of mental health needs continue to increase given the ongoing challenges associated with public health and disparity.

“Given the input I’ve received from colleagues about a longstanding history of psychiatry’s ongoing opposition to RxP, I was nervous before the meeting, as if I was walking into a hornet’s nest. Contrary to my anxiety, psychiatrists were amicable and asked appropriate questions, which prompted open dialogue about how we can work together to provide the quality care. We have yet to hear the official feedback from CPS, but we continue to refine our language and data so we can provide an airtight argument to pursue RxP.

“As I’m writing this, I keep thinking about RxP’s position (or hierarchy) within the prescriber field and comparing to my upbringing. As a third generation North Korean born in Japan, my family and my community have been designated as beyond underdogs. We have met with countless discrimination and shame for being ‘foreigners’ in the country where I was born. Back then, the education and career options were limited because of the nationality. But no matter how many obstacles we have faced, the grandparents and parents never gave up on their fundamental right to live and seek freedom and opportunities for their children, including myself, and for the community.

“At age 18, I came to the United States alone with a half empty suitcase to go to a college. I barely spoke English (my go-to answer was ‘YES!’) and had to learn everything from scratch. Inheriting an eternal optimism trait from my grandmother, I kept moving forward no matter what stood in front of me. It wasn’t easy, but I’m standing here because of countless support I received from my family, friends, and the community.

“As I meet the RxP task force members, many ask me how I can continue to lead the task force while I keep busy with my hospital job, private practice, the RxP practicum, and the family. I used to answer ‘I don’t know.’ But I know now that I’m following my ancestors’ steps in creating something out of (almost) nothing here in Colorado and contributing to make a difference in the community. Once again, I’m standing here because of enormous support from my family, friends, and the army of Division 55 members and the task force.
“Our movement has just begun compared to other states who have been working tirelessly for many years. We have a lot of work ahead of us, including ongoing conversations with stakeholders and legislators. We are focusing on educating our effort and the value of RxP to the community and providers. I don’t know how long it takes to pass the RxP bill, but I’ll keep moving forward relentlessly and make my ancestors proud someday.” Where psychology has been successful in enacting RxP legislation, it has always been the result of a few dedicated colleagues deciding this issue was important to them personally and to their community.

9-11 Reflections: Ruth Paige, former APA Board of Directors: “The news that morning was unbelievable, and quite literally, I did not believe it. I was at home, on the West coast, up early, showering and dressing, getting ready to go to the airport, and to board a plane to Washington, DC to attend a weekend meeting of the APA Insurance Trust (APAIT). I was thinking of the agenda for that evening, when the telephone rang. It was still very early in the morning. My daughter had called and said, ‘Do you have the television on?’ I said, ‘No, of course not – it’s too early and I am getting ready to leave for DC.’ She said, ‘The World Trade Center has been attacked and you can’t go!’ Not understanding what happened, I said, ‘Of course I am going.’ She said, ‘Go watch the television, you cannot leave.’

“When I watched the tv, it was so surreal that I couldn’t comprehend what was going on and thought ‘I am still going.’ A short while later at about 9 am PST, I received a call from the Trust canceling that meeting and letting us know they were going to reschedule. I spent most of that day at home watching the tv. In between, I called several people I knew who lived in NYC (where I had grown up) to find out if they and their families were alright, I better understood what had happened and that horrible day was over.

“The biggest changes that I could tell were that people were afraid; comfort and security they had felt about never being attacked was shattered. I remember sharing that with Ray Fowler at the end of one meeting in DC. His response was that we need to go forward and live with a new reality. Also in the months that followed there was massive prejudice against Muslim people and their businesses. Once again there were incidents of violence against outsiders, in this case Muslims. I also noticed many, many changes in procedures related to airline travel. Sometimes there were air marshals on airplanes; no one flying to Washington, DC was allowed to leave their seats the last 45-60 minutes before landing. There were many modifications related to security in getting to and boarding the aircraft. Laura Barbanel, who was also on the APA Board of Directors, discussed doing psychotherapy with many of the first responders and discussed how emotionally ripping it was to do this therapy. All in all it seemed to me that people on the West coast as well as those on the East coast were on edge most of the time. For months, several
friends and family of mine who lived in NYC or nearby, felt their emotions were upside down and out of control.”

Sally Harvey, former President and Council Representative, Division 19: “It is hard to believe that it has been 20 years since that horrific September day – a day that has become my generation’s Pearl Harbor. Where we were and what we were doing as we began to learn about the Twin Towers, the Pentagon and that peaceful field in Pennsylvania has become seared in our memory. I was stationed at Landstuhl, the main military hospital in Germany, lived in a tiny community nearby, and watched with horror, as I stood in our clinic’s waiting area, the collapse of the South Tower into a pile of rubble. Later that evening, people in our village shared their grief with us – maybe not in English, but in the universal language of sorrow, disbelief and unity – not only did America feel united, so did the rest of the world. Our grief was soon to share the stage with a sense of urgency, as our hospital began to prepare for the inevitability of war – and causalities. We transformed from a time with nine patients constituted a mass causality event to one where we routinely treated hundreds of men and women – men and women who represented all ranks, ethnicities and creeds, but shared the commonality of youth. As a psychologist, I spoke with many of these folks, held their hands, listened to them and tried – the best I could – to provide a sense of hope and normalcy in a time when both were in short supply. As most were medevaced back to the States in a matter of days, I will never know the ‘rest of their stories,’ but do have a clear memory of the cost of war that is borne by America’s sons and daughters. We must never forget those lost on September 11th 2001, nor those who fought on their behalf.” “We’d like to take you home with us. We’d love to take you home” (The Beatles, Sgt. Pepper’s Lonely Hearts Club Band).

Aloha
Pat DeLeon, PhD, MPH, former APA President

The APA Practice Leadership Conferences (PLC) are always the highlight of my professional year. This year’s 39th annual conference, which was held in a virtual/interactive format, was outstanding with more than 225 colleagues participating. APA President Frank Worrell and Chief Executive Office Arthur Evans set just the right tone—we can and will excel. The importance of embracing the ever-evolving advances occurring within the technology world, such as telehealth and virtual realities, as well as developing a global population-health perspective were highlighted. My grandchildren and I truly enjoyed the comedy presentation by Paul Draper the magician. Fostering Inclusive Leadership, Equity, and Diversity followed-up very nicely on Past President Jennifer Kelly’s historic efforts.

Katherine McGuire’s vision for pursuing reimbursement for psychological services being provided by interns and supervisees nicely responds to the Lessons Learned during the past two years under the Pandemic. Of course, there are always “problems to be solved,” this year personified by the recently enacted No Surprises Act. Responding to last year’s audience recommendations, PLC was highly focused and allowed for considerable interpersonal interaction. It will be followed later this month by a virtual Advocacy Summit Advancing Health Equity and Access to Psychological Services. We have learned that sitting too long before our computers is not healthy!

Jared Skilling, APA Chief of Professional Practice: “We have learned that we are truly in a mental health crisis. That was true before COVID... and the grief, violence, isolation, and trauma of the last two years have caused folks to reach a breaking point. It is especially true for communities of color, LGBTQ+ folks, other historically marginalized groups, and youth overall. At the same time, there is a severe shortage of mental and behavioral health practitioners. The public is reporting serious difficulties gaining access to care, and we are hearing stories of extensive waitlists for many psychological practices. We are moving along a journey to re-envision the future of the profession, rather than allowing the future to be re-envisioned for us. The battle for mental health and equity is intensifying in the states. Yet, Why am I optimistic for the future? Because I believe Martin Luther King’s famous statement that the moral arc of the universe bends toward justice.

“At the national level we believe technology and data are going to continue to play a bigger role in health care and society. We have invested more resources in our new Office of Health Care Innovation to increase access and reimbursement to mental health technologies such as digital therapeutics. We have begun to think more broadly
and update our evidence-based practices in psychology. We have been considering an updated model to incorporate elements such as Electronic Data Interchange (EDI), Health Equity, Ethics, Shared Decision Making, and Population Health. We are developing 50-state & territory legislation for telehealth and audio-only services to be reimbursed the same as the in-person rate. Pursuant to the Population Health policy just approved by the APA Council, we are planning model legislation for population health and integrated care which will allow psychologists to expand into prevention and early intervention, including annual mental and behavioral wellness checkups (a proposal voiced by Ron Levant, when he was APA President in 2005). We are excited about this work and the possibilities it raises for improving population health and health equity into the future.” As always, our sincerest appreciation for Dan Abrahamson’s support of exposing the graduate psychology and nursing students at the Uniformed Services University to their future.

Reflections of Former APA Presidents:
Rosie Phillips Davis (2019): “Poverty continues to be a major issue around the globe. The 2022 war in Ukraine is likely to add to the problem as millions of people have become refugees, now more than 2 million refugees from Ukraine, adding to the more than 82 million people who are already counted as refugees, individuals forcibly removed from their homelands. Refugees add to an already intractable poverty problem. The United States regularly feels the impact of refugees on the number of individuals living in poverty. Reflecting upon the fundamental interest-orientation organization of APA: While the focus of Division 18 (Public Service Psychology) is not on poverty or refugees per se, there are sections on community and state hospital psychologists, criminal justice, police and public safety, psychologists in Indian Country, and Veterans’ Affairs. I hope that each of these sections focuses on the impact of poverty. This means looking at how all vulnerable populations are impacted by poverty and how psychologists can use their training as scientists, practitioners and educators to help understand and ameliorate poverty and its lasting impacts.

“For example, the United Nations High Commission on Refugees reported that there are 5.5 million Syrian refugees and of that number 70% live in total poverty with little access to basic needs. More than a million U.S. Veterans live in poverty. Almost a quarter of Native Americans and Alaskan Natives in the U.S. live in poverty. And of course, the United States incarcerates far more people than most countries in the world. Poverty is a predictor and an outcome of incarceration. These examples cry out for interventions from psychologists like those represented in Division 18. The APA Deep Poverty Kit (https://www.apa.org/pi/ses/resources/indicator/2019/12/deep-poverty-initiative) can be a starting place for psychologists and other concerned colleagues to get initial ideas about what can be
done. From there concerned individuals can develop many far-reaching ideas that can impact the types of people with whom they work.”

Ron Levant (2005): “One of the standout highlights of my term as APA President was giving a Eulogy for Kenneth Bancroft Clark at his funeral. Kenneth Clark and his wife Mamie Phipps Clark conducted research showing that Black children preferred White dolls, and that some children grew distressed when asked to say which of the dolls (Black/Brown or White) looked like them. In my estimation, this study had the most profound impact on social issues of any psychological study, ever. It was used to support the Supreme Court decision in the Brown vs. Board of Education case in 1954 that desegregated schooling. ‘To separate Black children from others of similar age and qualifications solely because of their race generates a feeling of inferiority as to their status in the community that may affect their hearts and minds in a way unlikely ever to be undone’, wrote Chief Justice Earl Warren in the opinion. Kenneth Clark who had served as APA President in 1971, had asked his son, Hilton Clark, to ensure that the sitting APA President give a Eulogy at his funeral. Thus, as I was enroute from Florida to Idaho on what was a very long journey involving three planes and a van, I got a call from Hilton Clark, inviting me. The funeral, which was held in an historic Black church in Harlem, was attended by many prominent Black people, including Presidential Advisor Vernon Jordan, and the historian John Hope Franklin (who also gave a Eulogy).”

Building Upon Visionary Foundations: Beth Rom-Rymer: “We, in Illinois, now have our 13th licensed psychologist prescriber. We expect another five to be licensed as prescribers in 2022, which would bring our total of prescribers up to 18 in Illinois. Meanwhile, there are more than 50 psychologists currently training to become licensed prescribing psychologists. Our current prescribing psychologists are working in rural areas, urban areas, with older adolescents and adults ranging in age from 17 to 65, and with a full array of psychological disorders. Each of our colleagues brings to their prescribing practice their own areas of specialization, including neuropsychology, Covid sequelae, the addictions, and the deleterious effect that marginalization has on the mental health of too many of our communities. All prescribing psychologists provide greater access to mental health care for the most vulnerable who have faced, throughout their lives, a broad spectrum of barriers to care. We are currently lobbying for legislation that would give Illinois prescribing psychologists the authority to prescribe for children and adolescents, as well as for older populations.”

The Commonwealth Fund: The Commonwealth Fund recently launched a Commission to make recommendations for strengthening the U.S. public health system, building on Lessons Learned from the COVID-19 pandemic response. The Commonwealth Fund Commission on
a National Public Health System will lay out a vision for a national system that could bolster public health capacity and capabilities at the federal, state, and local levels. The chairperson is Margaret Hamburg, former Commissioner of the U.S. Food and Drug Administration and former HHS Assistant Secretary for Planning and Evaluation. She also served as Commissioner of Health and Mental Hygiene for New York City. The nonpartisan Commission is expected to publish a report with specific policy recommendations later this spring.

Long time Hill colleague Peter Reinecke: “The HHS portion of the Omnibus Appropriations Conference report includes Graduate Psychology Education (GPE). [The vision of health psychologist and former APA senior staff Cynthia Belar] -- Within the total for Mental and Behavioral Health, the agreement includes $20,000,000 for GPE. Peer Support -- Within the total for Behavioral Health Workforce Education and Training (BHWET), the agreement includes no less than $14,000,000 for community-based experiential training for students preparing to become peer support specialists and other types of behavioral health-related paraprofessionals. Mental and Substance Use Disorder Workforce Training Demonstration -- Within the total for BHWET, the agreement includes $31,700,000 for this program. The agreement continues support for grants to expand the number of nurse practitioners, physician assistants, health service psychologists, and social workers trained to provide mental and substance use disorder services in underserved community-based settings.” “Baby, there’s nothing holdin’ me back” (SING 2 – Where will your dreams take you?). Aloha
Dr. Kimberly Finney, Psy.D., ABPP, ABMP

It was Socrates who said: “Nature has given us two ears, two eyes, and but one tongue, so we should hear and see more than we speak.” I agree with this perspective. To speak less and demonstrate your beliefs with action based on reflective thought. So here is my roadmap.

As a military psychologist, clinician, and educator my professional commitment has always been centered on the concept of continuous improvement and growth of the self. I believe my resume accurately reflects a practice of continuous improvement. So, my hope is that my words will highlight to the reader the roads traveled in cultivating my understanding and compassion related my identity as a psychologist with prescribing privileges.

My undergraduate degree is in biological science, and I completed a fellowship in Immunohematology, which latter served me well as a prescribing psychologist. This degree further pollinated my passion of medical science and I spent several years working in blood compatibility laboratories. In addition, this experience and knowledge helped me get recruited into the United States Air Force (USAF) where I spent the next 6 years developing blood transfusion programs and building donor centers. However, little did I know that the United States would be at war with Iraq in a quest to deter Saddam Hussein from further invading Kuwait; this was known as the Gulf War. It was here that I learned that blood is like bullets in combat - if we run out of bullets, we lose the war and if we run out of blood to help the wounded, we lose the war. We won the war.

Shortly after the end of the Gulf War I left active duty and joined the United States Air Force (USAF) Reserve to complete a Doctor of Psychology degree. This was followed by a USAF Psychology Residency Program at Wright Patterson Air Force Base (AFB) in Dayton Ohio. This was an opportunity to grow, and I spent the next 13 years providing...
mental health services to military service members and mastering my skills as a military psychologist.

In my role as a military psychologist I worked with the very best social workers, psychologists, psychiatrists, and mental health technicians. My next duty station after completing my residency was Eglin AFB, Florida, and I served as the clinic director. My first responsibility was to develop a strong working bond with the mental health clinicians and staff. I believe this first step was important due to the high operation tempo that existed because again the United States was at war again, this time it was due to the attack on September 11 2001. Some of you may remember this war was linked to several commercial airliners filled with passengers crashing into the Twin Towers in New York, the Pentagon in Washington D.C. and an open field in Pennsylvania. The attacks killed over 3,000 civilians, sparking the beginning of the war in the Middle East which finally ended in Jan 2022. There have been over 2 million deployments and many wounded to include the deaths of thousands of sons, daughters, fathers, and mothers.

What I learned is, that in addition to deaths, there were thousands of service members who survived but experienced challenges accessing mental health service; and so they suffered in silence. There were also thousands exposed to toxic chemicals and extreme violence and carnage who also needed psychological services. It is here where my knowledge and assessment skills as a psychologist became invaluable. I was proud to use these skills to serve and support those in need.

In 2002 I was given orders to another mental health clinic in Florida, Patrick AFB, and again assumed the position of the clinic director. At this point, the suicide rates in the military were exponentially increasing as well as military deployments. This duty assignment was very intense because mental health providers were also participating in deployments during a time of increased need for mental health services and suicides. Moreover, we needed those providers in the clinics. To battle the unbelievable provider shortages my clinic designed a program to decrease the gap between suicidal service members and accessibility to mental health services, which helped some.

In 2006 I completed a post-doctoral psychopharmacology program designed to train licensed psychologists to become prescribing psychologists. This was another professional growth opportunity. This training allowed me to provide a holistic approach to the treatment of mental health illness. My patients in need of psychotropic medications and therapy would receive both services from one clinician, as opposed to two different clinicians in two different locations. While serving at Hickam-Pearl Navy Harbor Base in Hawaii, I adopted a bio-psycho-social-pharmacological lens that became the standard template for assessments and trained 8 post-doctoral licensed psychologists (military and civilian) to prescribe. In addition, I
learned that the military communities like many civilian communities experience a daily shortage of psychiatric appointments for medication evaluations. As a result, individuals who were in desperate need of medication received inadequate treatment due to the wait times for appointments. For instance, during this period, average wait times for a psychiatric appointment was at least three months, which resulted in the overuse of emergency room services. As a prescribing psychologist I was able to contribute by shortening wait times.

My last duty station was completed at Los Angeles AFB in California. Again, I served as the clinic director of mental health services. I treated hundreds of service members using both psychotherapy and psychopharmacological interventions. As clinical director, I developed a behavioral health component which allowed primary care patients to receive psychopharmacology interventions during their appointment with their primary care provider. This partnership helped in two ways; (1) patients who needed a psychopharmacological intervention received treatment in one visit, and (2) rendered aid to the primary care providers who lacked the training to adequately assess and treat mental health disorders. This was a win-win outcome.

In summary, my goal is to continue to grow as a psychologist and to motivate and support others in their professional growth. Currently, I live in California and hold a visiting professor appointment and am co-program director of the MSCP program at Alliant International University, California School of Professional Psychology. I have learned that continuous growth occurs through continuous self-improvement, compassion, and a desire to continue to teach and train our future psychologists and prescribing psychologists. We need both at the front of this fight for mental health wellness.
Congratulations to the 2021
Recipients of Division 55’s Awards!

DISTINGUISHED CONTRIBUTION TO THE ADVANCEMENT OF PHARMACOTHERAPY AT THE NATIONAL LEVEL
Sophie Friedl, MPH

DISTINGUISHED CONTRIBUTION TO THE ADVANCEMENT OF PHARMACOTHERAPY AT THE STATE LEVEL
David Shearer, PhD, MSCP, ABMP

PATRICK H. DELEON PRIZE FOR OUTSTANDING STUDENT CONTRIBUTION TO THE ADVANCEMENT OF PHARMACOTHERAPY
Ryan Cooper, PhD, JD

MAJOR CARAVEO NATIONAL SERVICE AWARD
Bret Moore, PsyD, MSCP, ABPP

John D. Preston Award for Outstanding Contributions to Clinical Psychopharmacology
Robert McGrath, PhD, MSCP

Presidential Citations:
Judi Steinman, PhD
Marlin Hoover, PhD, MSCP
OUR MISSION

Division 55 of the American Psychological Association, was created to enhance psychological treatments combined with psychopharmacological medications.

The division promotes the public interest by working for the establishment of high quality statutory and regulatory standards for psychological care. Division 55 encourages the collaborative practice of psychological and pharmacological treatments with other health professions. The division seeks funding for training in psychopharmacology and pharmacotherapy from private and public sources such as federal Graduate Medical Education programs. Division 55 facilitates increased access to improved mental health services in federal and state demonstration projects using psychologists trained in psychopharmacology.
Dr. Steven Tulkin passed away on January 17, 2022.

Dr. DeLeon: Steve Tulkin hosted my only APA Presidential candidacy event at Susan Chandler’s home in San Francisco. He was a pioneer in psychopharmacology training, providing the CSPP-Alliant University training for Louisiana and a number of other states and countries. Judi Steinman estimates that 473 MSCP students graduated under his tenure. Thanks to Russell Lemle, over 300 of us were able to honor his memory during his Zoom memorial, with Beth Rom-Rymer providing a moving tribute to his professional contributions.

Dr. Lemle (2015): Steve has been enormously successful in many realms of mental health. He is truly a quadruple threat, with expertise in clinical, administrative, research and education capacities (I can’t say that about too many others). He’s been recognized by his peers with American Psychological Association and California Psychological Association divisional awards. He has published prolifically. His cutting-edge work in integrated care occasioned me to invite him 17 years ago as a keynote speaker at a national VA Psychology conference I was running. He has presented scores of other times, both nationally and internationally, including on the subject of pain management. He is a gifted teacher. He has been one of the most popular teaching faculty at CSPP Alliant University, and has also been in charge of curriculum development for decades. He has a knack for imparting a vast array of scientific and clinical knowledge in an easily digestible manner. He is keenly interested in his students, with an unusual degree of warmth and humanity.

Dr. Rom-Rymer: I first met Steve, just after taking office as President of our Division 55 (the Society for...
Prescribing Psychology), in January, 2004. I was struck by his warm, welcoming smile and twinkling eyes. Almost immediately, he offered to be my advisor and mentor by sitting in my ‘kitchen cabinet.’ Of course, I quickly accepted his offer! That was the auspicious beginning of our decades-long (and too short) professional partnership and personal friendship.

From 1978-1999, Steve was Program Director/Chief Psychologist of Behavioral Medicine at Kaiser Permanente in Hayward, California. In the 1980s, he created the construct of integrated health and, in the Kaiser Health System, implemented programmatic changes aligned with this innovative construct. He will best be professionally remembered for his tenure as the first Director of the Postdoctoral Master of Science Program in Clinical Psychopharmacology at Alliant International University. It was, in part, because he lobbied for this Program, that in 1998 Alliant established the first MS clinical psychopharmacology postdoctoral training program in the U.S. Steve, along with Morgan Sammons (then-Dean of Students at CSPP/Alliant) established cohorts of trainees in Louisiana, as well as in many other states, and for colleagues from South Africa. This past November, Steve received an Award of Excellence from the Pharmacology Association for South African Psychologists.

Always the visionary, in 2007, Steve helped to create the APA Division 18/Alliant partnership to annually fund five Native psychologists’ training in Clinical Psychopharmacology. As part of our partnership, in 2010 we co-chaired a half-day APA Program with prominent Native psychologists and lawyers, talking about the need for greater psychological and legal resources on Native lands. Throughout his career, Steve was very active within APA, including as Chair of the APA Designation Committee on postdoctoral Programs in Clinical Psychopharmacology. Even in his last year, Steve continued, as best as he could, his vital work with his patients and his clinical supervisory work, as adjunct faculty at Stanford. He was helping his patients to heal even as he was finding it so difficult to heal from his own critical illness.

We will remember Steve as an innovator, teacher, mentor, APA leader, and astute clinician. I will always appreciate Steve for his many profound insights, his curiosity, his sharp intellect, his charm, his excitement about our field of Psychology, his generous mentoring, and his heartfelt kindness and love for all of us. We have lost a giant in our field and I have lost a true and loyal friend. May his memory be a blessing.
Dr. Marvin A. Oleshansky passed away on January 20, 2022.

He was an Army psychiatrist stationed at the Walter Reed Army Institute of Research when he volunteered in early 1991 to be the primary supervisor for the first iteration of the Psychopharmacology Demonstration Project (PDP). Although he faced significant opposition from his psychiatric colleagues, he believed that the skills for effective psychotropic use should be more broadly taught, and he eagerly took on the role of supervisor. A skilled psychopharmacologist, he brought his astute clinical judgement and scientific knowledge to the nascent training program. His vision was amply rewarded when during the first year of training a shortage of psychiatric residents threatened inpatient services at Walter Reed Army Medical Center. Marvin’s mentorship of the first class of PDP allowed them to take their places alongside the remaining psychiatric residents and provide vital inpatient services. Dr. Oleshansky retired from the Army after 25 years of service at the rank of Colonel. He will be missed by all he supervised, psychologist and psychiatrist alike.
Join Division 55 on social media!

Twitter: @division_55

FaceBook: www.facebook.com/division55

How do you like our new logo? Many thanks to Derek Phillips for creating it!
APA and EDI

Division 55 leadership is actively working on setting up a meeting with APA’s new Equity, Diversity and Inclusion Office (EDI) to better incorporate these principles into our Division and support the broader goals of the Association.

APA and Division 55 Advocacy Priorities

Division 55 completed an APA survey to highlight our advocacy priorities as part of the broader association advocacy goals for 2022 and beyond.

Re-envisioning the APA Council

The APA Policy and Planning Board has begun facilitating dialogue about Re-Envisioning APA Council. Due to the pandemic, they delayed this discussion the past few years, but this year they are requesting engagement in this process. The Division 55 BOD has a representative attending sessions on this topic and will be providing feedback and input.

Division 55 Research Council

The Division is grateful for Dr. David Latini’s excellent leadership of the Div 55 Research Council. He is handing over the reins to the very capable Dr. Lynette Pujol, who will be working on solidifying the goals of the Council.

Update for RxP APA Guidelines

The Division 55 BOD voted to designate Dr. Bret Moore and Dr. David Shearer to lead a Taskforce to update the 2009 APA Prescribing Psychology Guidelines (See the guidelines as they were published in 2011: American Psychological Association Division 55 (American Society for the Advancement of Pharmacotherapy) Task Force on Practice Guidelines (2011). Practice guidelines regarding psychologists’ involvement in pharmacological issues. The American psychologist, 66(9), 835–849. https://doi.org/10.1037/a0025890

APA’s Statement on Ukraine

A motion on the Ukraine conflict was adopted by APA Council of Representatives in February 2022. The motion states:

“The American Psychological Association is an organization that stands for human rights and the psychological and physical health and well-being of all people worldwide. The recent military invasion of Ukraine threatens the life, liberty, physical, and psychological well-being of people in Ukraine and surrounding nations.

The American Psychological Association stands in solidarity with the National Psychological Association of Ukraine, the Ukrainian people, and colleagues in the Eastern European region, as the Ukrainian nation defends itself against military invasion. We are gravely concerned about the immediate and long-term trauma and psychological impacts on people of all ages, families, communities, and the environment. We deplore the human cost of such aggression, including violations of human rights, adverse humanitarian consequences, deep psychological distress, and the loss of dignity and freedom. We stand in solidarity with all who are raising their voices and working tirelessly to protect and safeguard human life.”
**Psychopharmacology Board Specialty**

Division 55 continues to work to create a clinical psychopharmacology board specialty with ABPP. This will require that the narrowly unsupported first proposal be resubmitted to the ABPP Board. As part of the plan to resubmit the proposal, Division 55 has sent a survey to their members and allied APA Divisions to further assess the support and interest in a psychopharmacology specialty board. Please participate in the survey here: [https://forms.gle/Xx8jxA7B8QFGpT9G8](https://forms.gle/Xx8jxA7B8QFGpT9G8)

**STATE LEGISLATIVE UPDATES**

**Colorado:** Dr. Jin Lee reports that Colorado now has a bill sponsor and plans to introduce an RxP Bill in January 2023.

**Florida:** Dr. Chris Rossilli tells us that Florida’s RxP Bill did not get a hearing in committee this year, but they expect to run the bill again next year.

**Hawai`i:** Dr. Judi Steinman continues to serve as chair of the Hawai`i Psychological Association’s RxP Subcommittee. Two bills were submitted to the state Senate in 2021, but they failed to move over to the House. Community support of RxP on various neighbor islands needs to be heard next year when the new session starts.

**Illinois:** Dr. Beth Rom-Rymer reports: In Illinois, we now have our 13th licensed psychologist prescriber. We expect another 5 psychologists to be licensed as prescribers in 2022, which would bring our total of prescribers up to 18 in Illinois. Meanwhile, there are more than 50 psychologists currently training to become licensed prescribing psychologists. Our current prescribing psychologists are working in rural areas, urban areas, with older adolescents and adults ranging in age from 17 - 65, and with a full array of psychological disorders. Each of our colleagues brings to their prescribing practice their own areas of specialization, including neuropsychology, Covid sequelae, Substance Use Disorders, and the deleterious effect that marginalization has on the mental health of too many of our communities. All prescribing psychologists provide greater access to mental health care for the most vulnerable who have faced, throughout their lives, a broad spectrum of barriers to care. We are currently lobbying for legislation that would give Illinois prescribing psychologists the authority to prescribe for children and adolescents, as well as for older populations.

**Pennsylvania:** Dr. Jennifer Collins reports: Our RxP bill has a prime sponsor, Rep Wendi Thomas (R), who put out a cosponsor memo last week (early March). We are busy reaching out to our legislators urging them to cosponsor the bill. We would like to get at least 20 cosponsors at which point Rep Thomas would introduce the bill (no bill number yet) within the Professional Licensure Committee of the House. Unfortunately, Rep Thomas is not running for re-election so we have limited time to keep our current momentum going.

**Texas:** Dr. Cheryl Hall reports: Our Texas RxP Legislative Workgroup meets every month and has been working on a new website that we will unveil soon and be happy to share with Division 55 when it is ready. We have also been making in-depth and short videos of practitioners: three prescribing psychologists, three psychiatrists, a pediatrician, LPCs, family physicians and consumers. We are hoping to add a legislator to our video collection as well. We have a FB page now and are working on boosting it’s activity. Both the website and the videos are aimed at the goal of garnering more grassroots support and education of the public, psychologists and other professional groups, both in mental health and other health specialties.

In 2021 the RxP leaders conducted Local Area Society presentations to educate our colleagues and listen to concerns, providing an open forum for discussion. Texas has 16 active LASes and we received positive feedback about these opportunities. Our goal was to lay out our training in detail and the facts about prescribing psychologists, along with the ever-present need. Attendees were better informed and said so. We corrected some misinformation as well!

Through our group’s coordination with Sam Houston State University, graduate students are collecting research on the dearth of mental health prescribers in the state prisons and juvenile justice centers. They are collecting data on the numbers and types
of prescribers that are providing mental health medications in these settings. We are going to use this data for legislative and grassroots advocacy.

Legislatively in 2021, we had several challenges. Both of our sponsors from 2019 retired and we started over. (Texas has legislative sessions every two years from Jan.-May). Fortunately, in 2020 we found an excellent sponsor in the House, Rep. Vikki Goodwin! We hope to get a Senate sponsor soon. Rep. Goodwin really cares about mental health and access to quality prescribing! Even though we had a good sponsor, the legislative session, a la COVID, was not good to us as we were unable to get a hearing in the House Public Health Committee. Last legislative session in 2019, we testified at a Public Health Committee hearing and the three prescribing psychologists did a fantastic job. The psychiatrist that represented the Federation of Psychiatry did not fare well. We were hopeful, but our bill did not get a vote or out of committee to the floor.

At TPA Convention this year we hosted a symposium about RxP similar to our LAS presentations, The Road to Prescriptive Authority. It did not focus on legislative advocacy, but instead targeted the need, myths and truths, research and experiences of prescribing psychologists in TX that have to prescribe in other states or the military. We had a full house for this event and it was a positive experience. We also had a presentation by an RxP trained psychologist that teaches Family Medicine residents about psychopharmacology and prescribing (but ironically cannot prescribe them himself).

At our annual RxP division meeting at convention we decided to work on widening our membership by asking one simple question: Would you like the opportunity to work with or refer to a prescribing psychologist some day in Texas? If the answer is Yes, then you are an RxP supporter and ally and we would like you to join our division! We had 40 more people sign up by asking that question and deciding to eliminate the $10 annual dues. Without the logistical barrier of paying dues, we signed them up with a simple email. Our group has some creative and effective ideas!

Texas is looking forward to the day when we have an RxP bill that has traveled to the Governor’s desk for a signature! Until it does we will not give up!

Vermont: Dr. Rick Barnett reports: I spoke with Office of Prof Reg today who spear-headed a "Sunrise Review" Process. The report that was to be submitted to House Gov Ops Committee in January has not yet been completed. The word is that it will be a favorable recommendation with several caveats and it will be kicked to the next Biennium (this will be Vermont’s 4th Biennium - 2 yr legislative cycle) with an RxP bill. So the work continues into next year. In the meantime, more discussion and addendums (will be) written that will focus on regulatory oversight process (for example, proposing a subcommittee of prescribers be created to serve as needed on Board of Psych Examiners), beefed up clinical training requirements (a hybrid of Illinois and Idaho and not modeling NM or LA), and getting realistic expectations on the long-term uptake of this new workforce (citing those currently enrolled in the various RxP training programs across the country). This likely means a new bill (but not necessarily)....Not bad news at all! And we are in this for the long haul. We stand on the shoulders of giants who have gone before us with vision, persistence, and conviction. Much gratitude to all of you who guide and inspire us along the way!

Washington: Dr. David Shearer reports that the Washington RxP bill did not get a hearing in the House Healthcare and Wellness Committee, but that the sponsor plans to run the bill again next year during the longer legislative session. The short session, last minute switch to a virtual session, and ongoing issues related to COVID drastically reduced the number of bills that were heard this session. Washington continues to gain traction and support for an RxP bill and recently secured the support of Washington NAMI. We believe this is the first time a state NAMI association has supported an RxP bill. With NAMIs partnership and other stakeholders we will continue to build grassroots support.

Efforts to Establish an Organization for Medical Psychologists in Michigan

Dr. Jocelyn Markowicz is a fully licensed psychologist in Michigan and California. She currently operates a
private practice in Michigan where she provides neuropsychological testing and therapy services for children, adolescents, and adults. Her career has spanned working in forensic settings such as the correctional system in California, working with veterans at the Saginaw VA medical center, and providing state psychological disability evaluations for children and adults. She is currently pursuing her MSCP through the NMSU program in New Mexico.

Dr. Markowicz shares her thoughts below about establishing an organization in Michigan for Medical Psychologists.

In 2018 Satiani, Niedermier, Satiani, and Svendsen, conducted a quantitative analysis of the projected workforce of psychiatrists in the United States through 2050. It was determined, based on population growth data, that the current psychiatrist workforce will continue to shrink if no intervention is employed. Gaeta (2020) recently concluded that the COVID 19 pandemic has further increased the service burden of providers trying to meet the needs of their communities. This burden illuminated the greater need to enact prescriptive authority law across all fifty states. As you are aware, however, Michigan does not currently have established law allowing appropriately trained psychologists to prescribe psychotropic medication. As of the FY 2020 Annual Report Board Activities (Board of Psychology), there were a total of 11,303 licensed psychologists in our state. However, as of 2018, there are only 1,180 licensed psychiatrists. Appropriately trained psychologists can meet the current need to have more prescribing providers in my state. My desire to create an organization for medical psychologists, in partnership with Michigan Psychological Association, is to contribute to current efforts to work towards enacting law across all fifty states for psychologist prescriptive authority. While I am not the first psychologist in Michigan to work towards this goal, I am impassioned to continue efforts by reigniting psychologists, in my state, to resume efforts through my proposed organization. This organization would then move towards contributing to established grassroots efforts to mobilize psychologists, in unison, to help each state organization to effectively enact law. Dr. Markowicz can be contacted at dr.jocelynmarkowicz@gmail.com


[This was a report of two studies investigating the relationship of acculturation to the military culture and attitudes toward mental health as well as substance abuse. These were the dissertations of the first two authors. The Chair is listed last here. For this study, Dr. Ganz developed a scale for assessing identification within the military culture (GIMC). Dr. Yamaguchi utilized the GIMC in her study, and now 3 other students of Dr. Berger’s used or are using the scale in their dissertations.]


[This was a study of crime scenes investigators (CSI), the emotional stress they experience and the coping mechanisms they use to deal with the stress. This was the dissertation of the first author. The Chair, Dr. Lopez, is listed second here.]


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Don’t miss out on your opportunity to share your successes with your colleges and the Division. Send us your recent publications and we’ll make sure to get them in the next edition of The Tablet! Email citations to davidshearer.rxp@yahoo.com

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Stay tuned for the APA Convention Schedule in our next issue of The Tablet!

Convention registration begins April 26th
ANSWERS TO ADHD QUIZ

Question 1:

Answer – D: Play therapy and family work may be appropriate, but there is not enough information available to diagnose an adjustment disorder. While grief-related problems are likely, more information regarding the family unit and cultural factors would shed further light upon the impact of the loss on the child and family. Methylphenidate is a first-line agent for treatment of ADHD in school-age children, but may not be appropriate as there is not enough information to make a diagnosis of ADHD, nor is there information regarding the treatment preference of the family. Completion of a WISC-V and TAT might be appropriate, but could also be unnecessary. Gathering more information and input from the family prior to developing a treatment or assessment plan is the most appropriate option.

does not fit PANDAS and experiencing sore throat lasting one morning does not necessarily indicate a streptococcal infection.

Question 2:

Answer – B: Guanfacine metabolism occurs via CYP3A4. Grapefruit juice is an inhibitor of CYP3A4. Inhibition of CYP3A4 would increase the level of guanfacine in the body. Fatigue, irritability, stomach pains, and dizziness are adverse effects associated with guanfacine, which are more likely to occur with high levels of guanfacine. Answers A and D are distractors. Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) may present with abrupt onset of obsessive-compulsive disorder or tic disorder–like symptoms following a streptococcal infection. The symptom report

Question 3:

Answer: C: Most medications for ADHD directly or indirectly modulate dopamine and norepinephrine.
ANSWERS TO ODD QUIZ

Question 1:
Answer: D: The risk of developing depressive disorders and anxiety disorders increases with a diagnosis of ODD. Childhood-Onset Gender Identity Problems are extremely rare with a prevalence rate roughly estimated at 0.5% (Zucker, 2017). Schizophrenia is a rare condition with a lifetime prevalence rate generally estimated at 1%. A diagnosis of Childhood-Onset Schizophrenia (onset of diagnostic symptoms of schizophrenia prior to 13-years-old) is exceedingly rare and one of the rarest mental health conditions with a prevalence rate of approximately 1 in 40,000 or 0.00000025% (Gochman, et al., 2011). Note: the author received feedback describing this item as “unfair” or “mean,” to which the author responds, so is the PEP. Prepare yourself accordingly.

Question 2:
Answer: B: Though a possible side effect of both SGAs listed, risperidone is the most commonly associated with gynecomastia. In addition, risperidone is potentially appropriate for severe cases of conduct disorder, while research does not support the use of quetiapine and carbamazepine in such cases. Gynecomastia is not commonly associated with valproate.

Question 3:
Answer: A: SGAs exert most of their therapeutic effects by modulation of dopaminergic and serotonergic receptors. Many SGAs possess strong affinities for alpha-adrenergic and histaminic receptors, but this is unlikely to account for their efficacy. Norepinephrine and GABA are distractors.