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# The Tablet

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# A WORD FROM THE EDITORS

**W**e are excited to bring you this issue of *The Tablet* on the eve of a return to an in-person APA Convention in Minneapolis. In this issue, our Division President, Dr. Peter Smith, calls on us all to pitch in to support RxP with an “all hands on deck” mentality. Once again, Dr. Richard Sylvester delivers a great review of the psychopharmacological and psychological treatment of pediatric disorders; this time he tackles Conduct Disorder and a relatively



new diagnosis, Disruptive Mood Dysregulation Disorder. If you are hankering for big ideas about how we can move prescriptive authority and education forward you will want to read the article by the RxP veteran, Dr. Robert Ax. He discusses the need and

rationale for requiring that all APA accredited programs provide a 3-credit course in psychopharmacology.

It’s probably no surprise that the Division 55 Board voted to endorse Dr. Beth Rom-Rymer for 2023 APA President-Elect. Dr. Rom-Rymer’s contributions to



prescriptive authority are near-legendary and it is hard to imagine a candidate more aligned with Division 55. Read her statement about her candidacy in this issue and learn more about her priorities.

Did you say we need to support students’ engagement in psychopharmacology research? Well, the Division 55 Research Council, under Dr. Lynette Pujol’s steady hand, has done just that with annual travel and research scholarships for students. Get the details in this issue and tell your friends to apply.

Dr. Pat Deleon keeps his finger on the pulse of politics and legislation. As the “grandfather of

prescribing psychology” his newsletters in *The Tablet* are always informative. Dr. Jaime Wilson takes the “road less travelled” in his pursuit of an MSCP degree and enlightens and encourages us all. Read about his exceptional experiences and what he has learned in the Profiles in RxP section. Finally, if you are going to the APA Convention this year, take a look at the Division 55 programming and plan on joining us for some informative presentations and posters. We hope you enjoy this issue, and as always, value your feedback.

*David S. Shearer, PhD and Judi Steinman, PhD*

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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](mailto:davidshearer.rxp@yahoo.com)*

# PRESIDENT'S COLUMN

## Peter Smith, PsyD, MSCP Division 55 President 2022

**A**s I reflect upon the first half of 2022 as president of Division 55 I find myself thinking about the societal changes in which we find ourselves immersed. The war in Ukraine continues and the US Supreme Court has just finished its most recent term. We have continued to be informed about mass shootings and mass killings in the news. There's much grief, trauma, loss and subsequent fear and anxiety about what is going on and many of us find ourselves (along with our patients) struggling with dread, anxiety, and sadness.

Where does prescriptive authority lie within all this chaos around us? I would like to provide my perspective. While it may seem that our primary goals are not directly in line with these issues, one way we stay focused is with our goal for advocacy and empowerment.

While our primary goals and our aims remain the same - to expand access to non-fragmented care - the secondary goals of increasing our reach, supporting our members, and expanding scope of practice are just as important. Coming from the primary trunk of the prescriptive authority tree are many branches that continue to grow and showcase our increasing influence and reach. At this time that we find ourselves needing more hands-on-deck to support and nurture each branch the Board has been working to grow. As such, I am quite excited to announce many opportunities that I alluded to in my



first presidential address. As a child I was often told by my family that “many hands make light work” so I'm hoping many of you will be willing to contribute a few hours of your time and/or make a financial donation to help us strengthen our organization. In the remaining space here, I hope to flush out many of the items that will help us accomplish our primary and secondary goals. While my father said “it's nice to want things,” I'd rather see how it feels to accomplish several of these. With your help, I'm confident that we can.

In order to expand our influence within APA, and among the other divisions, we are looking for Division liaisons. While our historical alliances with divisions 18, 19 and 28 could benefit from liaisons (is anyone a member of both?) we could also use liaisons with other divisions as well. Such alliances can help us in many ways including expanding our influence, developing grants or scholarships, and advancing our shared interests.

A primary goal of ours has been to strengthen our educational opportunities through formalizing our Division as a CEU provider. We are excited to announce that several volunteers have come forward to assist in submitting our new CEU application. Thank you Stephany Hillman, Monika Kos, Ben Lesczynski and Anna Wegierke!

As part of our goal to support and stimulate research in psychopharmacology we have created research and travel awards for students. This has led to a small increase in dues starting next year. At the same time, we are developing a donation program within APA to solicit additional funds for these purposes. If you are in a position to help us financially please consider pitching in.

Your Board recently approved pursuing a 3-unit course in psychopharmacology with bio-bases as a requirement for APA accreditation. This is a prime area for advocacy within APA (see the article by Dr. Bob Ax in this newsletter)

Many states would like to begin to develop an RxP initiative but need assistance. We need help crafting and sorting through our Legislative Central Repository of historical documents and important developments.

As more and more students proceed through professional training we need help in developing and coordinating a listing of training sites for students.

Also, it is time that we update our APA practice guidelines, last published in 2011. While we have a strong team leading the charge, I'm sure they could use additional support.

For those interested in direct RxP advocacy we have two committees working to advance our RxP initiatives at the federal and state level.

There has been interest expressed in developing a mentoring program.. If you would like to be a mentor, a mentee, or aid in developing a program please reach out.

I believe with a little bit of effort from a lot of people we can begin to flush out and expand our influence and our support for each other. This is especially important as our membership surpassed 1,000 members in July! It should be noted this represents a growth of 66% in just 5 years! As President, I am happy to connect those who have an interest in helping with the proper contacts within the Board. I can be reached at [dr.smith.npa@gmail.com](mailto:dr.smith.npa@gmail.com)

With perseverance and effort we will continue to advance our work for the good of the public and our clients. I continue to be humbled by your vote to be your current President and I hope I am measuring 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 the rest of this year. Last, but not least, I hope to see many of you next month at the Annual APA Convention in Minneapolis.

Thank you, truly

Peter Smith Psy.D. MSCP

# ARTICLES

## Literature Review of Psychopharmacologic and Psychological Treatment of Pediatric Disorders: CD and DMDD

### Richard Sylvester, PhD, MSCP

This article compiles recent research and trends in the treatment of childhood disorders. In the last edition of The Tablet we reviewed Attention Deficit Hyperactivity Disorder (ADHD) and



Oppositional Defiant Disorder (ODD). In this edition we will review Conduct Disorder (CD) and Disruptive Mood

Dysregulation Disorder (DMDD). 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 included in the reviews 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.

#### **Conduct Disorder (CD)**

Lifetime prevalence rates of CD range from approximately 2% to 10% and suggest boys are more frequently diagnosed than girls are by a ratio of anywhere from 4:1 to 12:1 (Mohan et al., 2021). Consistent with several childhood mental health conditions, early onset of symptoms is typically associated with increased

functional impairment and worsening prognosis (Mohan et al., 2021; Lillig, 2018). Per the DSM-5 (APA, 2013), a diagnosis of CD or evidence of CD prior to 15-years-old is a prerequisite in the diagnosis of Antisocial Personality Disorder (APD). There is speculation that ODD, CD, and APD reside on a spectrum of impairment (Sagar et al., 2019; Mohan et al., 2021).

Research suggests CD results from a variety of genetic and environmental factors such as male sex, maternal smoking during pregnancy, but also parental substance abuse in general, parental criminal behavior, exposure to violence, abuse or neglect, poverty, familial instability, lower cognitive abilities, and harsh parental disciplinary actions or attitudes (Mohan et al., 2021; Lillig 2018; Pardini & Frick, 2012). Common comorbidities include ODD, ADHD, mood disorders, intermittent explosive disorder, and adjustment disorders (APA, 2013; Mohan et al., 2021; Lillig, 2018; Pardini & Frick, 2012).

Current guidelines and recommendations regarding the management of CD overwhelmingly recommend nonpharmacological interventions as first-line treatments (Mohan et al., 2021; Lillig 2018; Pardini & Frick, 2012; Pisano & Masi, 2019; Sagar et al., 2019; Gorman et al., 2015). The exact nature or style of intervention will vary based on availability of resources, but psychosocial, behavior modification psychotherapy, parent management training, and school as well as community-based interventions are recommended. If nonpharmacological interventions fail, symptoms or functional impairment worsens, or behaviors become dangerous, then guidelines typically recommend starting with a psychostimulant (Hambly et al., 2016; Mohan et al., 2021; Lillig, 2018; Pringsheim et al., 2015; Pisano & Masi, 2019; Sagar et al.,

2019; & Gorman et al., 2015).

Psychostimulants are first-line agents in managing aggression and disruptive behaviors in children. Nonstimulant medication such as atomoxetine, guanfacine, and clonidine demonstrate efficacy in reducing those behaviors, but typically not to the level of the psychostimulants (Hambly et al., 2016; Mohan et al., 2021; Lillig, 2018; Pringsheim et al., 2015; Pisano & Masi, 2019; Sagar et al., 2019; Gorman et al., 2015). Should those agents fail or behaviors become markedly dangerous, then risperidone and divalproex sodium could be potential treatment options.

Clinical guidelines offer mixed support for other second generation antipsychotics (SGAs), such as quetiapine and aripiprazole. They are generally effective at reducing aggressive behaviors, but their side effects make them less desirable options (in the case of quetiapine) or there is a dearth of research to support their use (in the case of aripiprazole). Agents such as lithium and haloperidol have demonstrated some efficacy in the reduction of aggressive behaviors; however, the adverse effects of those agents and the availability of other less risky alternatives typically leads to them being used as agents of last resort.

Like most other SGAs, aripiprazole works primarily via modulation of dopaminergic and serotonergic receptors, but aripiprazole displays some unique agonistic actions among the SGAs (Stahl, 2013). Per Stahl (2013). Aripiprazole is a partial agonist at the D2 and 5-HT1A receptors with less potent affinities for muscarinic (cholinergic) and histaminergic receptors, which should make it less sedating, less prone to metabolic side effects, and reduce side effects of hyperprolactinemia as well as extrapyramidal symptoms (EPS). Akathisia is a common adverse effect associated with aripiprazole, but studies of

adverse effects in pediatrics are limited. There is concern regarding a lack of data of side effects of aripiprazole in pediatric populations and of particular concern is the possibility of increased suicidality, which appears to be an inconsistent finding that warrants clinical attention (Rafaniello et al., 2020). Metabolism of aripiprazole occurs via the CYP2D6 and CYP3A4 enzymes (Molden, 2006).

Lithium's mechanism of action is not entirely clear. Per Stahl (2013), lithium seems to interact with a wide variety of neurotransmission sites. It appears to decrease norepinephrine release, increase serotonin synthesis, protect against oxidative stress, modulate G-protein receptor functioning and thereby modulate cyclic AMP secondary messenger systems, modulate glutamate and NMDA receptor functioning, increase levels of GABA, modulate BDNF and promote other neuroprotective factors, and inhibit inositol monophosphatase (Stahl, 2013; & Malhi et al., 2013). Lithium is a powerful medication and powerful medications come with powerful side effects. Lithium requires close monitoring and its side effects include various renal problems, endocrine problems, EKG changes, muscle problems, tremor, hair loss, and acne. Lithium does not undergo hepatic metabolism and excretion occurs via the kidneys in urine (Hedya et al., 2021).

Haloperidol is a high potency first generation antipsychotic (FGA) that works by antagonizing the D2 receptor (Stahl, 2013). By decreasing dopamine, it elevates prolactin level, which can lead to hyperprolactinemia. This dopamine blockade increases the possibility of EPS and tardive dyskinesia. In addition, FGAs block muscarinic (cholinergic) receptors, which leads to anticholinergic problems, histaminergic receptors, which leads to weight gain and sedation, and

alpha1-adrenergic receptors, which leads to orthostatic hypotension and sleepiness (Stahl, 2013). Metabolism of haloperidol occurs via the CYP3A4 and CYP2D6 enzymes (Avent et al., 2006).

Learning Check (answers are located at the end of the Newsletter):

- 1) You diagnosed a 15-year-old boy as suffering from conduct disorder. After working with his family for several months and several medication trials, you place him on a SGA. A couple of days later his mother calls and tell you she has taken her son to the local emergency department. She states he used his medication as prescribed and suddenly "can't close his mouth or talk right." What is most likely to be the medication you prescribed that led to this reaction?
  - a) Haloperidol
  - b) Risperidone
  - c) Quetiapine
  - d) Aripiprazole
  
- 2) You have completed an evaluation on a 10-year-old girl and diagnosed her as suffering from ADHD and conduct disorder. The family is eager to begin treatment and requests a medication to support psychosocial and behavioral interventions as well as reduce her aggressive behaviors. Based on the available information, what would be the best medication to start from the options below?
  - a) Risperidone
  - b) Lithium
  - c) Valproate
  - d) Fluoxetine

- 3) During a feedback session with the parents of a seven-year-old who you recently diagnosed as suffering from conduct disorder, the parents ask you about possible risk factors for development of the disorder and common comorbidities. You tell them \_\_\_ is a potential risk factor and \_\_\_ is a common comorbidity. From the list below, select the correct potential risk factor for conduct disorder and the correct common comorbidity.
- a) Exposure to violence; antisocial personality disorder
  - b) Deletion of specific genes from chromosome seven; ODD
  - c) Maternal smoking during pregnancy; ADHD
  - d) Familial instability; dissociative identity disorder

Answers to Quiz at the end of the Newsletter

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## ***Disruptive Mood Dysregulation Disorder (DMDD)***

DMDD is a relatively new disorder but is not a new problem. Prior to the creation of the term DMDD, researchers often called the symptom cluster now known as DMDD by the name of “severe mood dysregulation” and estimated its prevalence at about 3.3% (Tourian et al., 2015). The American Psychiatric Association (2013) added DMDD to the DSM-5 to appropriately capture and promote treatment for children who experience chronic irritability and angry mood, but do not present with the traditionally episodic nature or symptoms of bipolar-type disorders. It is worth noting that although the symptoms of DMDD may present as disruptive behaviors, impulse control-type symptoms, or involving conduct problems, DSM-5 classifies DMDD as a depressive disorder. Prevalence estimates for DMDD vary, but are typically between 0.8% and 8.2%, with DSM-5 estimating between 2% and 5% (APA, 2013; Grau et al., 2017; & Copeland et al., 2013). Researchers estimate DMDD occurs more frequently in school-age males as compared to females and adolescents (APA, 2013; Grau et al., 2017; Copeland et al., 2013; & Tourian et al., 2015).

Weis (2020) suggests that children who suffer from DMDD display abnormalities of functioning in specific brain areas. He suggests that children who suffer from DMDD may experience lower than average activity within the amygdala, which could lead to problems in interpretation of social cues and lead to aggressive responses to otherwise nonthreatening stimuli. In addition, he suggests hyperactivity of the medial frontal gyrus and anterior cingulate cortex are present in children who suffer from DMDD. That hyperactivity may lead the children to experience problems in regulating negative affect.

At present, there are no FDA approved medications for DMDD and there are no widely accepted clinical guidelines available. A handful of studies investigated the use of psychotherapy to ameliorate symptoms of DMDD. Research is limited and providing a blanket statement recommending any specific intervention is risky. It appears the best approach to the treatment of DMDD will take into account symptom severity, age, emotional and cognitive functioning level of the child, physical health functioning, familial preferences, cultural factors, community resources and supports, and relevant treatment as well as diagnostic history in implementing a collaborative treatment endeavor. A cohesive, integrative approach making use of the biopsychosocial model may allow the clinical provider to set the best treatment foundation, which may then lead to desired results.

Recent studies suggest psychotherapy, behavioral interventions, and parent training can be helpful in reducing symptom severity in DMDD (Huang, 2021; Perepletchikova et al., 2017; Chen et al., 2016; Tudor et al., 2016). Empirical evidence suggests CBT and DBT-based interventions (specifically DBT-C (for children)) can reduce aggressive behaviors and irritability (Huang, 2021; Perepletchikova et al., 2017; & Tudor et al., 2016). Though the results of psychotherapeutic interventions are promising, it is worth noting that the studies utilized single-case designs or small sample sizes (Huang, 2021).

A variety of agents demonstrated at least some usefulness in treating symptoms of DMDD. Selection or recommendation of a specific agent may boil down to level of symptomatology, aggression, dangerousness, comorbid conditions, patient’s ability to

tolerate the medication, child/patient preference, and the family or guardian's preference. Efficacy of treatment often hinges upon compliance and the proper establishment of a therapeutic alliance helps to increase compliance (Muse & Moore,2012).

Research suggests that the following agents have demonstrated efficacy in reducing symptoms of DMDD; Selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), psychostimulants, nonstimulants typically used in the treatment of ADHD (atomoxetine, guanfacine, etc.), SGAs, FGAs, and mood stabilizing agents (Huang, 2021; Chen et al., 2016; Topal et al., 2021; Winters et al., 2018; Pan et al., 2018; Findling et al., 2021; Tourian et al., 2015). Of those agents listed, it makes logical sense to use an agent that would produce the least adverse effects as well as address any potential comorbid condition, e.g., selecting methylphenidate to treat DMDD and ADHD symptoms or selecting fluoxetine to treat DMDD and depressive symptoms. Per the American Psychiatric Association (2013), DMDD commonly appears with other conditions, thus using the least intrusive intervention to treat the largest number of symptoms seems appropriate.

SSRIs are first-line agents for a variety of mental health disorders. SSRIs possess a relatively mild side effect profile (GI side effects are common) and are reasonably safe in overdose, which helps to make them appropriate choices for depressive disorders and use in children. Per Stahl (2013), SSRIs boost the availability of serotonin (5HT), which eventually leads receptors to down-regulate and this may account for at least some of their therapeutic action. SNRIs work in a similar manner but increase the availability of norepinephrine as well as serotonin (Stahl, 2013). Similar to SSRIs,

SNRIs typically demonstrate a mild side effect profile and relative safety in overdose. In regard to treatment of DMDD, Huang (2021) suggests fluoxetine, sertraline, citalopram, a combination of citalopram and methylphenidate, and imipramine reduce symptoms of DMDD. Metabolism of SSRIs and SNRIs occurs primarily via the liver and CYP450 system, but exact enzymes, inhibition, and induction varies.

Imipramine is a tricyclic antidepressant (TCA). Per Gillman (2007), imipramine blocks reuptake of serotonin and norepinephrine, but more serotonin than epinephrine. In addition to antidepressant actions, imipramine helps treat enuresis in children by relaxing the muscles of the bladder. A handful of TCAs block more norepinephrine reuptake than serotonin reuptake, such as desipramine, which is an active metabolite of imipramine (Gillman, 2007). TCAs are older antidepressants as compared to the SSRIs and SNRIs, but older does not equate to less effective. Per Ramey et al. (2014), metabolism of imipramine occurs via the CYP2C19, CYP1A2, and CYP3A4 enzymes into imipramine's active metabolite, desipramine.

Per Stahl (2013), the TCAs are about as effective as newer antidepressants, but their side effect burden is greater than SSRIs or SNRIs, and TCAs are not safe in overdose. Khalid and Waseem (2022) reported that TCA toxicity results in excessive blockade of alpha-adrenergic, histaminergic, serotonergic, and muscarinic receptors, which presents as altered mental status, hypotension, fever, tachycardia, dry skin, and dry mouth. They state the blockade of serotonin and norepinephrine reuptake can lead to seizures and heart problems. Per Khalid and Waseem (2022), in severe TCA overdose sodium and potassium channel blockade can lead to arrhythmia and

death. QRS prolongation (a finding on EKG) can result from TCA overdose, which is another potentially high yield fact as one prepares for the Psychopharmacology Exam for Psychologists (PEP). Of note, TCA overdose treatment typically involves administration of sodium bicarbonate to increase urine and serum pH as well as increase extracellular sodium levels.

Learning Check (answers are located at the close of this section):

- 1) Per DSM-5, all of the following are diagnostic criteria of disruptive mood dysregulation disorder  
EXCEPT:
  - a) Temper outbursts inconsistent with developmental level
  - b) Criteria for a manic or hypomanic episode have never been met
  - c) Temper outbursts occur, on average, three or more times a week
  - d) Criteria onset prior to 10-years-old
- 2) After a complete evaluation on a five-year-old boy, you note symptoms including temper outbursts approximately four times a week, recurrent episodes of physical aggression during temper outbursts, and persistently irritable mood. The MOST APPROPRIATE diagnosis for the child is:
  - a) Disruptive Mood Dysregulation Disorder
  - b) Attention-Deficit/Hyperactivity Disorder
  - c) Persistent Depressive Disorder

d) Other Specified Depressive Disorder

- 3) During a feedback session, you are discussing treatment options with the family of an 11-year-old boy diagnosed as suffering from DMDD and ADHD. The family would like to begin therapy/behavioral interventions and a medication. Which of the following would be your MOST APPROPRIATE response considering the family's preference and empirical evidence:
  - a) Clinical guidelines suggest a therapeutic/behavioral intervention be applied for six weeks prior to trying a medication.
  - b) A solely pharmacological intervention should be sufficient and methylphenidate is a good starting agent.
  - c) A trial of atomoxetine and DBT-C would be appropriate.
  - d) A trial of risperidone and DBT-C would be appropriate.

Answers to Quiz at the end of the Newsletter

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## PSYCHOPHARMACOLOGY IN THE NEWS

*“Genetic variants of the 5-HT<sub>2A</sub> serotonin receptor may explain why some respond to psychedelic therapies for the treatment of mental health disorders while others don’t.”*

<https://neurosciencenews.com/genetics-serotonin-psychedelics-21132/>

# Clinical Psychopharmacology Training: Getting APA Unstuck Why APA Should Require a 3 Credit Psychopharmacology Course for All APA Accredited Doctoral Programs

## Robert K. Ax, PhD

*Robert K. Ax, Ph.D., is a charter member of Division 55 and was its 2006 National Leadership Award recipient. He was a member of the PEPTO grassroots group that planned the first national RxP conference for state advocates in 1999. In 2001, he and Dr. Robert J. Resnick, former president of APA, published "An Immodest Proposal" in the Monitor on Psychology, in which they called for Level 1 training to be made a criterion for APA accreditation for all doctoral programs in clinical, health, counseling and school psychology. Available at: <https://www.apa.org/monitor/mar01/sp.html>*

## Introduction

Recently my colleagues – Drs. Michael R. Tilus, Kathy McNamara, Randy Taylor, Kevin McGuinness, and Robert J. Resnick – and I began a campaign to promote a Council of Representatives (CoR) resolution – presently in draft form – that would require a 3-credit course in clinical psychopharmacology for all doctoral students in APA-accredited health service (clinical, counseling, school, selected other) psychology programs. I've been asked to write an article for *The Tablet* about the rationale for this initiative. I'm happy to do so, noting that the opinions expressed here are my own, and not necessarily shared by everyone in our group.

*All psychologists need a course in clinical psychopharmacology because:*

The American Psychological Association said so when it published the Level 1 curriculum 27 years ago

(Kilbey, M.M., Brown, R.T., Coursey, R.G., Eisdorfer, et al., 1995).

"[A]ll providers in psychology need to have basic knowledge in the area of clinical psychopharmacology represented by the entire knowledge base delineated in all the modules of the Level 1 curriculum" (p. ii).

*The Canadian Psychological Association said so in the report of the CPA Prescription Privileges Task Force 12 years ago (Sexton, L., Broga, M., Charest et al., 2010).*

"Basic psychopharmacology knowledge should be established as a curriculum requirement for training in psychological professional practice. It is recommended that basic clinical psychopharmacology knowledge, such as could be obtained from a survey course or an equivalent experience, be made a specific Canadian Psychological Association accreditation requirement." (Recommendation #1, p. 34).

*The knowledge base is needed for licensure, i.e., on the Examination for Professional Practice in Psychology (Association of State and Provincial Psychology Boards, (n.d.; Association of State and Provincial Psychology Boards 2020).*

See Appendix A: Domain 1, Biological bases of behavior, KN 3. "Results from major trials and general guidelines for pharmacological, psychotherapeutic, and combined treatment of psychological disorders" (p. 25).

*Patients need this knowledge (Terlizzi, E.P., & Zablotsky, B. (2020).*

“In 2019, 19.2% of adults had received any mental health treatment in the past 12 months, including 15.8% who had taken prescription medication for their mental health and 9.5% who received counseling or therapy from a mental health professional.”

Although patients don’t need to get it from psychologists. Some non-psychology masters-level programs already offer this knowledge base as a requirement or elective. (See the appendix for an example.) Do we really want to be the least knowledgeable members of the treatment team with respect to psychotropic medications and substance abuse issues?

*And psychologists need it to be competitive in the health care marketplace* – to add value to their knowledge-skill set, whether self-employed or as members of treatment teams in federal, state, or local agencies. Health care psychology programs must add value to the doctorates they grant. Our profession should not be selling Chevy degrees at BMW prices.

We need a resolution because all psychologists need a basic knowledge of clinical psychopharmacology by the time they graduate, and because nearly three decades after the publication of the Level 1 curriculum, APA hasn’t ensured that they do. I consider this irresponsible.

### **Parsing the Issue Further**

*Why the specificity of a 3-credit course requirement?*

To avoid loopholes. Psychologists love to discuss, re-imagine, conceptualize, create task forces, and otherwise procrastinate. Specificity sets a clear goal: implement *this* course. No “or equivalent” loophole.

While a separate “biological basis of behavior” course is desirable *in addition* to a clinical psychopharmacology course, *it cannot be a substitute*. The resolution would set a timetable for its implementation.

Pharmacokinetics, pharmacodynamics, psychotropic medications, substances of abuse (legal and illegal), ethics, diversity issues (such as ethno-psychopharmacology), combined treatments – the list goes on, *and there’s always something new*. Accordingly, this course should form the foundation for career-long learning through regular continuing education.

*Why a CoR resolution?*

Because nearly three decades after the publication of the Level 1 curriculum, with no movement on the issue, it’s clear that something needs to change. A CoR resolution could be a way to cut the Gordian knot.

### **Alternatives**

*How else might this requirement be implemented?*

Hoping for the profession’s collective epiphany? Or form a task force! Study the matter and publish some articles and present the findings at the 2029 APA Convention. Give out some awards to the participants. Recommend further consideration.

I don’t think so. Optimism as a strategy is unwarranted in the face of the profession’s enduring capacity for procrastination.

This might work, though: Get enough supporters on the Commission on Accreditation and Board of Educational Affairs to ensure that such a course becomes an accreditation requirement in the next revision of the APA Standards. Such an approach could complement a Council resolution.

Certainly, whatever is to be done must involve graduate students, because this is about *their* future.

Their senior colleagues shouldn't care more about their careers than they do. APAGS should be a full partner in this initiative. I hope for their members' sake it will be.

I believe APA is stuck, but that we can get it unstuck.

### Final Thoughts

I haven't mentioned prescriptive authority so far but having a clinical psychopharmacology course requirement certainly relates to RxP. It would provide an entry point for the RxP pipeline, where graduate students could begin to self-select for pursuing RxP during or after the completion of their doctorates.

Think of this as a marketing issue. As it is, only a small percentage of psychologists take RxP training, few are expected to prescribe, even in states with enabling laws, and the available data about basic knowledge of RxP among psychologists in general is mixed. (See Curtis, Hoffman, & Sloan, 2022, for a discussion). It would be quite reasonable and appropriate to discuss RxP in a clinical psychopharmacology course.

Nearly 40 years after the first bill was introduced in Hawaii, only five states (six if you count Indiana) and Guam have implemented RxP laws. By contrast, optometrists secured the authority to prescribe therapeutic pharmaceutical agents (TPAs) in just 21 years, from their first state legislative victory in West Virginia, in 1976, to their fiftieth, in Massachusetts, in 1997 (Wolfberg, 1999).

Something needs to change. I hope that CoR will pass a resolution requiring a 3-credit course in clinical psychopharmacology as a requirement for all APA-accredited programs. It's way past time. Unfortunately, APA governance rules may preclude even the introduction of such a resolution, in which case, we'll have to look at other strategies. If it comes to that, I hope Division 55 members will support them.

Stay tuned for more details. Let's help APA get unstuck.

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### **Appendix**

Excerpts from the course listing of the Master of Social Work (MSW) program at Virginia Commonwealth University (2022):

#### **SLWK 703. Mental, Emotional and Behavioral Disorders. 3 Hours.**

Semester course; 3 lecture hours. 3 credits.

Prerequisites: [SLWK 693](#) and [694](#), or [SLWK 695](#), or [SLWK 612](#), each with minimum grade of C. This course reviews the epidemiology, etiology, classification (using the Diagnostic and Statistical Manual of Mental Disorders V) and course of a range of mental, emotional and behavioral disorders and conditions across the life span and the relevance of this knowledge to social work across practice settings. It emphasizes a biopsychosocialspiritual assessment, a risk and protective factors framework, a critical analysis of existing and emerging theory, the impact of difference and diversity, an appreciation of the lived experience of these challenges

for clients and their families, and the practical implications of this knowledge for relationship-building and treatment planning as well as interdisciplinary collaboration.

**Introduces knowledge of psychopharmacology. Required advanced clinical core curriculum course.** [Emphasis added.]

#### **SLWK 705. Clinical Social Work Practice II. 3 Hours.**

Semester course; 3 lecture hours. 3 credits.

Prerequisite: [SLWK 704](#) with minimum grade of C. Continues a multitheoretical orientation to intervention across fields of practice with emphasis on integrated family systems theory and multidimensional family assessment. Focuses on differential application of psychodynamic, cognitive-behavioral and family systems theories to a range of complex client problems and concerns with attention to diverse populations. **Introduces basic knowledge of pharmacology related to social work intervention. Required advanced clinical core curriculum course.** [Emphasis added.]

## Acceptance Statement: Dr. Beth Rom-Rymer Endorsed by Division 55 for APA President-Elect 2023

### Beth Rom-Rymer, PhD

**D**ear Division 55 Friends and Colleagues,  
You are the wind beneath my wings!! It is with great respect for you, as well as a sense of significant kinship with you, that I thank you so much for your wonderful endorsement of my candidacy for APA President-elect 2023!!



At its inception in 2000 I joined Division 55 and served as its first Membership Chair. I was then elected the fourth President of our Division in 2002 and served in 2004. I became the Division 55 representative to APA Council in 2007 and served through 2012 and, again, in

2017, after which I stepped down from that role to take on my newly elected role as Chair-elect of the APA Council Leadership Team.

In 2010, I met with Dr. Rose Weahkee, a member of the Navajo Nation, who served as Director of Behavioral Health at the Indian Health Service (IHS), about the dire need for more comprehensive mental health care on tribal lands and the availability of licensed psychologist prescribers to meet these needs. Following our meeting, the IHS gave authority to prescribing psychologists to prescribe medications on tribal lands that are federally administered by the IHS.

I have been leading the Prescriptive Authority Movement in Illinois since 2010 when I was first elected President-elect of the Illinois Psychological

Association. I served the IPA in the role of President from 2011-2012, and again, from 2013-2014. From 2012-2014 I led the successful legislative initiative for prescriptive authority. Our then-Governor Pat Quinn signed our legislation into law on June 25, 2014. From that point on I have led the successful implementation of our prescribing legislation, which has included my work with the Chicago School of Professional Psychology and Dr. Gery Rodriguez-Menendez, to create their Master's Program in Clinical Psychopharmacology for both graduate students and licensed clinical psychologists. Through my work, around the state, with hospitals and medical centers, we have been able to provide clinical rotations in 9 medical specialties for Illinois prescribing psychology trainees. We now have 13 licensed prescribing psychologists in Illinois with more than 50 additional prescribing psychologists currently in training. I expect that we will have 17 licensed prescribing psychologists in Illinois by the close of 2022. At the University of Illinois, Champaign-Urbana, there are 75 psychology undergraduate students who are concentrating in the pre-prescribing psychologist curriculum that I worked to create with the University Psychology Advising Staff. Since 2014 I have spoken annually to undergraduate students at the University of Illinois, Champaign-Urbana, giving them direction for a path that they could follow to become licensed prescribing psychologists in Illinois. Since 2019 I have organized a group of Illinois pre-prescribers and licensed prescribers to join me at this speaking event. Twice a year, since 2015, I have chaired a networking dinner event in my Chicago home, where prescribing psychologists, prescribing psychologists-in-training, and stakeholders and non-psychologist partners in the national Prescriptive Authority Movement (hospital system CEO's, hospital medical directors, University faculty and administrators, CEO's of community agencies, political leaders, IAPP

and IPA lobbyists, and representatives of the Illinois Hospital Association) meet to discuss the progress of individual prescribing psychologist trainees; prescribing psychologists; and state lobbying movements. You are all invited!! Our next networking event will be August 20<sup>th</sup> in my Chicago home and will also be streaming for remote access. Please send me your email address for a personal invitation!

In October 2018 I founded an organization in Illinois, the Illinois Association of Prescribing Psychologists, whose mission includes: implementing our Illinois prescribing psychologist statute; continuing to pass legislation to broaden the scope of practice for prescribing psychologists in Illinois; serving the most underserved, vulnerable populations in our state; creating a large and growing cadre of licensed prescribing psychologists in Illinois that is widely diverse and representative of all members of our larger community; providing consultation for all psychologists' training to become prescribing psychologists in Illinois; providing consultation for states and the international community who seek to pass prescriptive authority legislation. I am also currently writing a book on our national movement for Prescriptive Authority, under contract with APA Press, due to be published in 2023. The book is entitled: *The Revolution in Healthcare: How Prescribing Psychologists are Changing the Landscape of Mental Health Care in the U.S.*

In 2019 I co-founded, with Matheus Teles Araujo and Dr. Jury Victor Ricardo, of Brasilia, Brazil, the international Prescriptive Authority organization, IMPAP. We are closely working with psychologists interested in passing legislation that would give clinical psychologists in their countries prescriptive authority. These countries include Brazil, Argentina, Jamaica, Canada, the UK, the Netherlands, Norway, South Africa, Taiwan, Japan, Singapore, and mainland China. In February 2021 we chaired the first IMPAP International Conference on Prescriptive Authority (on Zoom). In October 2021 we participated in the first South African Conference on Prescriptive Authority. In October 2022 Dr. Judi

Steinman and I hope to participate, in person, on a panel on Prescriptive Authority in Johannesburg, South Africa, chaired by our brilliant South African psychologist partners, Drs. Joachim Mureriwa and Thabiso Rapapali.

I led our Division's first effort to create an ABPP for prescribing psychologists, 2005-2008. During my presidential term I initiated and co-authored practice guidelines for psychologists who prescribe and/or provide consultation on psychotropic medications. I had appointed Bob McGrath as Chair of that Committee and the Guidelines were published in *The American Psychologist* in December 2011. I am currently serving as a consultant on the Division 55 Committee that is reviewing and updating these Guidelines.

I organized our Division's first Midwinter Conference in Orlando in early 2005; assisted Elaine LeVine with her Midwinter Conference in 2006 in Santa Fe, New Mexico; and, chaired our Midwinter Conference in 2008 in Jefferson City and Kansas City, Missouri.

I have been most grateful to have received several awards from Division 55 for my leadership: 2005 (Presidential Citation), 2007 (National Outstanding Leadership Award), and 2014 (Outstanding Contribution to the Advancement of Pharmacotherapy at the National Level). In addition to multiple awards for my national leadership in the Prescriptive Authority Movement I received, in 2021, the "Inspiration and Dedication" Leadership Award from PASCAP, the Psychopharmacology Association of South African Clinical Psychologists, chaired by Drs Joachim Mureriwa and Thabiso Rapapali, two of our newest Division 55 members.

In 2016, I created annual scholarship funds, The Beth N. Rom-Rymer Scholarships, in partnership with the American Psychological Foundation (APF), for nine licensed clinical psychologists and psychology graduate students to embark on their training in Clinical Psychopharmacology. These scholarships facilitate psychologists' earning prescribing licenses in states throughout the United States. To date this

Scholarship Fund has awarded 63 scholarships of \$5,000 each.

As your APA President I will have the bully pulpit to continue to advocate for Prescriptive Authority for Psychologists, in each of your states, as well as federally and globally. Many of you already know that I am eager to partner and collaborate with you all as we navigate the challenging legislative waters. I hope to see many of you at Convention this year in Minneapolis. I will be chairing and speaking on a panel entitled “Prescriptive Authority around the Globe” on the main stage at Convention, at 1:00 pm CT on Saturday, August 6<sup>th</sup>. Our colleagues, Matheus Teles Araujo, Dr. Thabiso Rapapali, Dr. Judi Steinman, and Dr. Diana Velikonja will be speaking on the panel. I hope to see you there wearing your Vote for Beth campaign buttons!

For more campaign information please visit my campaign website: [drbeth4apapresident.com](http://drbeth4apapresident.com). Please contact me if you would like to actively campaign for me. I have a great variety of campaign materials to send along to you!!

With warmest wishes,

Beth

## PSYCHOPHARMACOLOGY IN THE NEWS

*A study of more than 300 participants, randomly assigned to either Vitamin B6 or B12 supplements showed that “Vitamin B12 had little effect compared to placebo over the trial period, but Vitamin B6 made a statistically reliable difference” in reducing feelings of anxiety and depression*

<https://www.reading.ac.uk/news/2022/Research-News/Vitamin-B6-could-reduce-anxiety-and-depression>

# Updates from the Board

## **Survey Results Suggest Strong Support for the Creation of an ABPP in Clinical Psychopharmacology**

A recent survey of 278 psychologists and students across four APA divisions (18, 19, 28, and 55) revealed strong support for an ABPP in clinical psychopharmacology. Fifty-eight percent (58%; n=160) of respondents said they would definitely be interested in pursuing an ABPP and an additional 26% (n=73) said they would consider it. Thirty-five percent (35%; n=98) of the sample identified as early career psychologists, while 32% (n=90) identified as mid-career and 19% (n=53) as late-career. Another 10% (n=28) were doctoral students. Sixty-one percent (61%; n=170) of the sample had obtained a master's degree in clinical psychopharmacology, a prerequisite for the proposed ABPP. Twenty-six percent (26%; n=72) have passed the PEP and another 51% (n=143) plan to take it in the future. Almost half of the sample (49%; n=137) indicated willingness to be included in the first cohort to seek an ABPP in Clinical Psychopharmacology and included their contact information if and when they are able to apply.

Other demographic questions indicated 55% identifying as female, 42% identifying as male, and 1.5% as non-binary or non-conforming. Nearly 81% reported white/Caucasian as their race, 10.5% as Hispanic/Latin(x), 9% as black/African American, 4.7% as Asian, 1.8% as American Indian or Alaska Native, 0.7% as Middle Eastern or North African, and 0.4% as Native Hawai'ian or other Pacific islander. Nearly 56% of respondents reported Division 55 as their primary divisional affiliation, while 15.5% reported Division 19 (Society for Military Psychology), 12.9% reported Division 18 (Public Service), and 5.4% reported Division 28 (Psychopharmacology and Substance Abuse). Just over 10% reported none of these as their primary

division. Nearly 95% of respondents supported RxP. Three percent reported not supporting RxP and 2.5% were unsure.

Over 40% of respondents reported not having been in or completed an MSCP program. Approximately 35% are completing or have completed their MSCP at Fairleigh Dickinson University, while 13% did at Alliant International University, 5% did at New Mexico State University, and 2% did at both Idaho State University and The Chicago School of Professional Psychology. There were also few respondents who attended Nova Southeastern University, University of Hawai'i at Hilo, and the Massachusetts School of Professional Psychology. There were also 12 respondents who practice through the Department of Defense.

## **Announcing New Funding for Student Research in Clinical Psychopharmacology**

Did someone say research funding? Yes! And travel awards too!

The Division 55 Board of Directors accepted a proposal from the Research Council to fund 2 grants of \$2000 for student research in psychopharmacology intended to lead to publication and 4 grants of \$250 for travel for students presenting at APA.

What do you need to do?

- 1) Apply! Apply for funding for your thesis, dissertation or research project. Applications for grant money are available on the Division 55 website on the Research Council page.

- 2) Present! Present research at APA. The first travel awards will be presented to students who have a winning presentation or poster on psychopharmacology accepted by APA Division 55.

Research Council members, Drs. Alan Lincoln, Dave Shearer, Andris Skuja, Judi Steinman and Chair, Lynette Pujol are enthusiastic supporters of student research and encourage interested students to apply. We want to see your great ideas turn into publishable research. Questions can be directed to Dr. Pujol ([lynette.pujol@gmail.com](mailto:lynette.pujol@gmail.com)).

Are you interested in psychopharmacology research but no longer a student? Consider joining the Research Council! Please contact council chair Dr. Pujol at [lynette.pujol@gmail.com](mailto:lynette.pujol@gmail.com) for more information or to attend our monthly meetings.

# LEGISLATION AND ADVOCACY

## “SHE HAD A DREAM ABOUT THE KING OF SWEDEN” (June 2022)

### Pat DeLeon, PhD, MPH, former APA President

**E**ngaging the Next Generation in the Public Policy Process: In reflecting upon the two worlds of politics and academia, former APA Congressional Science Fellow and subsequently



Congressional staffer Neil Kirschner opined in 2003: “More often than not, research findings in the legislative arena are only valued if consistent with conclusions based upon the more salient political decision factors. Thus, within the

legislative setting, research data are not used to drive decision-making decisions, but more frequently are used to support decisions made based upon other factors. As psychologists, we need to be aware of this basic difference between the role of research in science settings and the legislative world. It makes the role of the researcher who wants to put ‘into play’ available research results into a public policy deliberation more complex. Data needs to be introduced, explained, or framed in a manner cognizant of the political exigencies. Furthermore, it emphasizes the importance of efforts to educate our legislators on the importance and long-term effectiveness of basing decisions on quality research data.... If I’ve learned anything on the Hill, it is the

importance of political advocacy if you desire a change in public policy”.

At the Uniformed Services University (USU), Khalilah McCants has consistently strived to bridge this philosophical gap by systematically exposing graduate school of nursing (GSN) students to elected officials on the state and national level during her classes. Khalilah: “The purpose of teaching graduate nursing students about health policy stems from the rapidly changing healthcare landscape. Students must acquire skills in advocating for policy development or improvement based on evidence-based practices to help shape policies that favorably impact health outcomes. Doctorate-prepared nurses are critical to presenting qualitative data or interpreting quantitative results to help legislators pass bills that significantly impact the nursing practice.

“As a teaching strategy, approximately 75 graduate students were invited to observe Congresswoman Sheila Jackson Lee in the Galleries on Capitol Hill. This opportunity served as a tangible policy experience. Nursing students gained valuable insight and exposure to legislation development’s inner workings impacting access, quality, cost of care, and public health crisis. Congressman Jamie Raskin, who represents the USU district, discussed his platform on healthcare matters. He also highlighted how influential nurse practitioners are in health policy.”

“Additionally, Congresswoman Lauren Underwood served as a guest speaker to share her pathway to advance from a registered nurse to a Member of Congress. The Congresswoman also provided guidance on best advocacy practices for nurse

practitioners and how she prioritizes health care issues to address when brought forward by healthcare advocacy groups such as the American Nurses Association (ANA). For example, cost determined the delay or deferment of recommended treatment before COVID-19 for more than half of Americans. Therefore, private insurers were required to cover COVID-19 testing and associated costs through the Families First Coronavirus Response Act (FFCRA). Finally, State Senator Clarence Lam, a physician who had previously served on the House Congressional staff, was a guest speaker for the subsequent cohort of graduate nursing students to describe the role of health care professionals in elected office as it relates to influencing practice. Feedback from our students was overwhelmingly appreciative and demonstrated that the faculty met the objectives for the health policy component of the course. One student stated: ‘The guest speakers from Congress... policy makers... were very impactful. I appreciated the policy research assignments... These exercises [created] the environment... [to prepare] healthcare leadership.’

The Department of Psychology and the GSN co-offer another health policy seminar which encourages students (and with Zoom, other interested colleagues) to informally interact with various administrative, legislative, and organizational leaders, as they share their personal stories. A regular attendee, Stephen Behnke: “Including the voices of ‘lived experience’ is essential to the policy-making process, a point Elyn Saks and I brought home to our policy seminar this April. Colleagues for nearly four decades, we organized a presentation in which Elyn, a law professor at the University of Southern California and winner of the MacArthur (‘Genius’) award, told how she managed to find a life worth living following a diagnosis of paranoid schizophrenia in her 20s. I then moderated a discussion in which USUHS students, faculty, and seminar visitors explored the policy implications for Elyn’s first-hand account of a psychotic illness. Implications included pathways to integrate talk therapy and medication in the treatment of

individuals with serious mental illness, avenues to enhance consumer decision-making competence, and strategies to increase awareness of how a diagnosis of mental illness and/or involuntary commitment may limit an individual’s career choices. The presentation was well-received and impressed upon all the importance of voices like Elyn’s and her allies in combating the stigma of mental illness that may still (unfortunately) be found among policy makers at all levels.”

Victor Dzau, President of the National Academy of Medicine (NAM): “I am saddened and outraged by the recent unconscionable acts of firearm violence in Uvalde, Buffalo, and Laguna Woods. To cite a particularly devastating statistic, in 2020, the Centers for Disease Control and Prevention announced that firearms had surpassed car accidents as the number one cause of death for children and adolescents. Firearm violence is a public health crisis. Our inaction has allowed it to spread through this nation like a deadly virus. We must find the courage – and the creativity – to stop it.

“The scientific and health communities have worked hard to address this crisis. There has been some incremental progress in the past few years; it is simply not enough. We need more funding to develop evidence-based approaches to violence prevention and learn from effective strategies in other nations. We need to aggressively pursue research into the mental health drivers of violence and effective interventions. Now is the time to create technologies to track and predict the escalation of violent behaviors. And now is the time to build bridges with industry leaders, educators, policy makers, the media, and others across sectors to achieve more productive discourse and collaborative solutions. We need to develop scientific evidence to support policy decisions and speak up to advance evidence-based interventions. As scientists and health leaders, we must continue to speak up. We must not let our work be twisted to achieve political ends. We must not allow ourselves to be muzzled. We can and must help to end the national paralysis around firearm violence

prevention. Please, let us all – today – step forward to protect our children, families, and communities.”

**Interdisciplinary Vision:** Lisa Kearney, Executive Director, Department of Veterans Affairs Veterans Crisis Line: “VA just launched Mission Daybreak – have you heard about it? VA Suicide Prevention, in collaboration with the VHA Innovation Ecosystem, is inviting innovators across the Nation to participate in Mission Daybreak – an up to \$20M challenge to save lives by reducing Veteran suicide. Suicide has no single cause, and no single strategy can end this complex problem. That’s why Mission Daybreak is fostering solutions across a broad spectrum of focus areas. A diversity of solutions will only be possible if a diversity of solvers – including Veterans, researchers, technologists, advocates, clinicians, and health innovators – answer the call to collaborate and share their expertise ([www.missiondaybreak.net](http://www.missiondaybreak.net)).”

**Reflections from Psychology’s Past:** It was just a short 25 years ago that Norman Abeles was President of the APA, 1997. He was Professor of Psychology and Director of the Psychological Clinic at Michigan State University. As was customary, APA Presidents selected initiatives for their terms of offices and perhaps beyond that time. Norm helped advance the cause of Aging and developed three initiatives.

The first was a Taskforce to develop a brochure on aging to be distributed to members of APA interested in this area. It was titled “What the Practitioner Needs to Know about Working with Older Adults.” 5,000 copies were initially distributed with an additional 3,000 printed based on increased demand. Sara Qualls and Norm were editors of a book titled *The Aging Revolution*. This book was published in 2000 and was based, in part, on presentations given at the APA convention in 1997. In 2003, the first Guidelines for Psychological Practice with Older Adults were approved by the Council of Representatives for APA. These were renewed again 2014.

The second initiative involved the Committee on Aging which was staffed by Deb Digillio. This

committee was helpful in facilitating the guidelines and also helped to develop and revise existing Resolutions on Aging. In addition, APA began an Office on Aging.

The third and final initiative was developing guidelines for the Assessment of Age Consistent Memory Decline and Dementia, approved by the governance in 1998. Staff member Geoffrey Reed provided support and assistance and James Yungjohan drafted the original version based on task force discussions. Appropriately, Norm was twice appointed to the White House Conference on Aging which meets every ten years. Norm’s visionary contributions have positioned psychology well for an era in which, by the year 2035, there will be more adults over 65 than there will be youth in our country. And, when approximately 80% of older Americans will live with at least one chronic disease and nearly 70% will have at least two chronic diseases, for which healthy behaviors and holistic care can make a significant difference. “Hidee hidee hidee hi. Hoooh whoaa oh oh whoa” (Minnie The Moocher, Cab Calloway). 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.

# PROFILES IN PRESCRIBING PSYCHOLOGY

## On Stormfronts, Deaf Gain, & Teamwork

### Jaime A. B. Wilson, PhD, MSCP, ABN, ABPP

There's a storm coming through my area, and we might get disconnected from our Zoom session," the professor related, "If we get kicked off, I'll have to record the lecture for you to watch later." These words appeared on my second monitor as the weekend class kicked off for the first



of two full-length days of lecturing on pharmacology and pathophysiology. What happened later that same day would be something that I'll never forget – a classic example of teamwork in action. But first, a little background on myself.

I enrolled in the Alliant University postdoctoral master's in clinical psychopharmacology (MSCP) online program in November 2019. Little did I know that within a matter of weeks, the rest of the world would be joining our little cohort in the use of video conferencing and other online learning technology resources to access their academic classroom.

The COVID-19 pandemic turned the world upside down for many of us. No one anticipated how the pandemic would impact specific minority

populations, especially those with hearing loss. With at least 15% of adults reporting some hearing difficulty, and with a dramatic increase in hearing loss prevalence with advancing age (> 50% of those aged 75 years or older experience hearing difficulty), the impact was significant. As an individual with a profound bilateral hearing loss (the severest form of hearing loss), I experienced this impact firsthand. For example, the mask mandate made access to communication via lipreading essentially impossible. I especially worried about how I would complete the MSCP-required community-based practicum with patients and attending alike wearing masks.

Fortunately, I was able to find a clinic where the physician and his medical staff were willing to accommodate me by wearing clear transparent masks. Clear masks could be described as just one of the many positive outcomes arising from Deaf Gain. *Deaf Gain* is the concept that the majority hearing world gains from the cultural diversity and human capital of individuals with hearing loss. The use of text messaging – another feature strongly influenced by the Deaf community and now omnipresent in the hearing world – is an additional example of Deaf Gain and one that I utilized as an added means of communicating with medical staff as needed.

Deaf Gain would flex its mighty arm again in the next challenge of accessing communication from patients presenting in the medical clinic. Created in a laboratory founded by a man who was married to a Deaf woman and had a Deaf mother (Alexander Graham Bell), automated speech recognition (ASR) software generates real-time speech-to-text captions that can provide supplemental access to communication. Using my iPad or iPhone to read patients' responses to questions regarding

background history and review of systems allowed me to follow along with every patient encounter.

As past president of the Association of Medical Professionals with Hearing Loss (AMPHL), I have been fortunate to meet and work intimately with physicians, ARNPs, and other prescribing providers with hearing loss that work in diverse fields across the U.S. It has been an incredible experience to learn from these deaf colleagues who have “been there, done that.” Generally, patients are either neutral or positive about having a deaf clinician – even with providers who rely 100% on an American Sign Language (ASL) interpreter to foster communication (Aldalur, Hall, & Andrea-DeLazarus, 2022).

As a severely underserved population, the needs of the Deaf community primarily drove my journey to pursue board certification as a neuropsychologist. It was also a driving factor in my decision to pursue the MSCP degree, as it allowed me to fulfill some of my continuing education hours needed to maintain board certification (though, admittedly, an expensive way to obtain CEs!). The opportunity afforded by the MSCP degree to expand the repertoire of services that could benefit individuals with hearing loss was an added bonus.

Pursuant to part of my passion for serving individuals with hearing loss, I established a private practice in Tacoma, WA, immediately after licensure in 2009. As may be noted on the Wilson Clinical Services, PLLC website, the mission statement reads, “*Neuro & Psychological Health Care Services For All, With A Specialty In Deaf, Hard of Hearing, DeafBlind, and Blind.*”

The other part of my passion is associated with learning, studying, and working hard for patients to allow me the privilege of being someone that listens to and walks with them on their journey. It is this aspect of healthcare to which I am most attracted. The patient is a driving source of motivation and why I chose to pursue this sometimes long and arduous commitment of lifelong learning.

I started this article with the stormfront forewarning from my professor. My classmates and I were

fortunate to be inconvenienced by only a few minor technical disruptions during the two full days of lectures. However, I admit that these disruptions served as an additional reprieve on top of the built-in breaks. You see, for a person with hearing loss, keeping up with virtual lectures can be akin to watching a virtual tennis match. The eyes go back and forth, reading the captions on one screen, with the slides and professor on the other. It is exhausting, and yet, I cannot plug into headphones, get up and walk around, or stretch. I also cannot close my eyes while listening. I can only obtain information by keeping my eyes trained on my two computer screens. Even lipreading proves challenging. The most skilled lipreaders in English can discern an average of 30 percent of what is being said. It’s funny to me that the word “lipreading” implies reading, like reading a book. The problem is that the human face isn’t a book, and lipreading is not as simple as reading clear, legible text. People mumble, talk fast, ... or even have facial hair like porcupines! That’s why the number is so low in terms of comprehension of a conversation for the best lipreaders in the world.

The text from the lecture abruptly stopped flowing across my screen. A technical disruption cut off the professional stenographer’s transmitted captions during the last 90 minutes of class time. I quickly alerted one of my classmates to what had just occurred. What happened next led to an unforgettable experience and reminder of the importance of teamwork for success. This colleague immediately began typing the professor’s words in the Zoom chat feature for the remainder of the class that day. I’ll be forever grateful for the willingness of this classmate to go the extra mile to ensure a colleague could at least have a fair chance of accessing the essential and much-too-technical-for-ASR lecture information.

Teamwork allows for diverse and inclusive environments and leads to innovation, workplace satisfaction, and – most importantly – better patient care. As we anticipate upcoming changes as the RxP movement rolls ahead, teamwork will only help us meet these challenges head-on.

*Dr. Wilson received his Ph.D. in clinical psychology from Brigham Young University, Provo, UT and completed a predoctoral internship at the University of Miami School of Medicine, Miami, FL. He then completed a postdoctoral fellowship residency at Madigan Army Medical Center in Tacoma, WA. He recently graduated (May 2022) from the MSCP program at Alliant International University. Dr. Wilson currently resides in Olympia, WA with his wife, three kids, and a King Charles Spaniel named Pepper Jack.*

*Editor's Note: As this issue of The Tablet goes out for distribution, we are thrilled to announce that Dr Wilson passed the PEP exam! Onward and Upward, Jaime! – Judi Steinman*

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Aldalur, A., Hall, W. C., & DeAndrea-Lazarus, I. A. (2022). No Taxation Without Representation: Addressing the "Deaf Tax" in Academic Medicine. *Academic Medicine: Journal of the Association of American Medical Colleges*.

## PSYCHOPHARMACOLOGY IN THE NEWS

**U.S. Senators Cory Booker (D-NJ) and Rand Paul (R-KY) introduced legislation to clarify that the Right to Try Act should allow terminally ill patients to have access to Schedule I drugs for which a Phase 1 clinical trial has been completed. Specifically, the Right to Try Clarification Act would remove any obstacle presented by the Controlled Substances Act with respect to Schedule I substances when they are used by doctors and patients in accordance with the federal Right to Try law. Companion legislation will be introduced in the House by Representatives Earl Blumenauer (D-OR) and Nancy Mace (R-SC).**

<https://www.booker.senate.gov/news/press/booker-paul-introduce-bipartisan-legislation-to-amend-the-right-to-try-act-to-assist-terminally-ill-patients>

## **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.**

# APA 2022 Convention

## Division 55 Program and Schedule

### THURSDAY August 4th

Session	Title	Time	Location	Presenters
1065	<b>The Great Masquerade: Medical Disorders that Look Like Psychological Disorders</b>	9-10:50 am	Minneapolis Convention Center, Level One, Room 102 F	David Shearer
1113	<b>What's New in Psychopharmacology: FDA Approvals and Treatments on the Horizon</b>	11-11:50 am	Minneapolis Convention Center, Level One, Room 102A	Lynette Pujol
1148	<b>Incarceration: An Unrecognized Public Health Crisis</b>	1-1:50 pm	Minneapolis Convention Center, Level One, Room 102A	Robert Duwors
1231	<b>Neurological and Neuropsychological Findings in Pediatric Populations as a Result of Early Child Maltreatment</b>	3-3:50 pm	Minneapolis Convention Center, Level One, Room 102A	-Gerardo Rodriguez-Menendez -Samantha Taylor -Rachel Hoadley-Clausen

# APA 2022 Convention

## Division 55 Program and Schedule

### Friday August 5th

Session	Title	Time	Location	Presenters
2039	<b>Predoctoral Education and Training in Clinical Psychopharmacology: What have we Learned</b>	8-9:50 am	Minneapolis Convention Center, Level Two Room 208B	Gerardo Rodriguez-Menendez
	<b>Student Poster Presentations</b>	10-11 am	Minneapolis Convention Center, Level One, Exhibit Halls BCD	
2163	<b>Early Intervention and Treatment of Commonly Occurring Childhood Psychiatric Disorders</b>	1-1:50	Minneapolis Convention Center, Level Two, Room 204AB	Stephany Hillman (Chair), Leigh A. Ford, Alexandra Miller Clark
	<b>Division 55: Presidential Address</b>	4-4:50 pm	Hilton Minneapolis, Third Floor, Minneapolis Grand Ballroom A	Peter Smith
	<b>Division 55 Social Hour Food and Drinks Provided</b>	5-6:50 pm	Hilton Minneapolis, Third Floor, Minneapolis Grand Ballroom A	

### Saturday, August 6th

Session	Title	Time	Location	Presenters
3106	<b>Prescriptive Authority Around the Globe</b>	11-12:30	Minneapolis Convention Center, Level One, Ballroom B	-Beth Rom-Rymer -Diana Velikonja -Joachim Mureriwa -Matheus Teles - Judi Steinman (Discussant)

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



# DIVISION 55 NEWS



## **Division 55's Membership Passes the 1,000 Mark**

Division 55's membership is at 1,009 as of the publication of this issue of *The Tablet*! This is a first for our newly renamed Society for Prescribing Psychology and is a testament to our significant growth in the past decade.

## **Pennsylvania's RxP Drive**

Dr. John Gavazzi writes: In the Commonwealth of Pennsylvania, the RxP Work Group of the Pennsylvania Psychological Association has been very active. Representative Wendi Thomas (R) introduced House Bill 2607 earlier this year. The bill is currently in the House Licensure Committee. The Task Force had a formal meeting with the Licensure Committee, hoping for a vote soon. HB 2607 has 40 bipartisan cosponsors. The Task Force is currently working with other policy makers in the Commonwealth. The Task Force is creating a White Paper to support RxP legislation in Pennsylvania.

## **The Colorado RxP Task Force Hosts a Virtual CE Webinar in July**

Dr. Jin Lee writes: The Colorado RxP Task Force supported by Colorado Psychological Association has been going strong to bridge the critical gap of behavioral health unmet needs since 2020. As the task force plans to introduce the CO RxP legislation in 2023, CPA recently hosted a 2-day virtual CE webinar event on 7/14 and 7/15 as part of the fundraising events to educate the benefits of RxPs. We had 14 speakers across the country offering 7

CEs. They discussed their own journey to become prescribing psychologists and shared their expertise.

Despite the first summer post-pandemic and many people traveling, we had approximately 15 psychologists registered, and the event was well received and interactive. With two sponsorships for the event, we raised \$3,500 from the event. As we prepare to introduce legislation next year, we are planning to hire additional lobbying team to maximize the chance of success in passing the bill.

Please contact Dr. Jin Lee

at [drjinsoonlee@gmail.com](mailto:drjinsoonlee@gmail.com) to support the initiative and CPA website to register for additional CE webinars. All proceeds will go towards hiring the lobbying team. You can visit the CPA website at: <https://www.coloradopsych.org/calendar-of-events>

## **Antioch University's Proposed MSCP Program**

Dr. Steven Curtis writes: Recent permission has been granted by the Academic Assembly of Antioch University, Seattle to offer the first course in our proposed MSCP program. *PSYC*

*7690: Introduction to Prescriptive Authority for Psychologists (RxP): History, Research, and Practice (3 quarter credits; SE)* will be offered remotely Winter Quarter 2023. This course is for current doctoral students in APA-approved health service psychology programs, and licensed psychologists, who are interested in learning more about RxP, but who are not yet committed to complete the full MSCP degree. In this course, participants will learn about the history of the RxP movement, major milestones, current successes, critiques of the field, the APA model curriculum, RxP State laws, pathways to prescribing, a brief overview of psychopharmacology, and current practices of today's prescribing psychologists. With the recent announcement that Antioch University is forming an affiliation with

Otterbein College in Ohio, we are excited about the potential opportunities this news might create for the proposed MSCP program overall. Our hope is that if this initial course generates enough interest, then the full program could be offered soon. Few psychologists are versed in the details of the RxP movement (Curtis et al., 2022). We hope that this course will achieve three goals: 1) to help interested psychologists, and doctoral students, to become more aware of the RxP field; 2) to help those “on-the-fence” with their decision whether to, or not, pursue a MSCP with a goal to obtain prescriptive authority for themselves; and 3) demonstrate the demand by our colleagues to offer further training in psychopharmacology. This course will be posted the Fall 2022 on the Antioch University Seattle website. If you need further information, please contact me at [scurtis@antioch.edu](mailto:scurtis@antioch.edu). Curtis, S. E., Hoffman, S., & Sloan, M, O. (2022). Prescriptive authority for psychologists: The next step. *Psychological Services*. <https://doi.org/10.1037/ser0000667>

### **Drake University’s New MSCP Program**

Dr. Ryan Ernst reports: “Since psychologists can now prescribe medications in Iowa, Drake University in Des Moines is offering a distance-learning master’s degree in psychopharmacology. The first class is set to begin this August so *time is of essence* if you are interested. Most of the faculty members have a Pharm.D., making this program different than most others as it is housed within the university’s department of pharmacy. Also, this is a “blended” program incorporating both live and recorded content, reducing the weekend in-class hours required for completion of the program. I was hired on recently as the training director for this program so if you have any questions, please feel free to email me or call me at 402-318-6340. Here is link to the program website:

<https://online.drake.edu/master-of-science-in-clinical-psychopharmacology/curriculum/>

### **Let’s Not Forget the Aloha State:**

Judi Steinman reports that Resolution SR 149 was submitted towards the end of the Hawai`i state

legislative session to request that “the Department of Commerce and Consumer Affairs convene a task force to provide recommendations for a pilot program that grants prescriptive authority to qualified psychologists in the counties of Kaua`i, Maui and Hawai`i.” The resolution passed out of the senate but the companion house resolution did not move forward. Nonetheless, this is a novel way that state legislators who seek RxP on their islands sought to streamline the process. See <https://www.capitol.hawaii.gov/session2022/bills/SR149 .HTM>

### **Division 55’s Board Votes to Increase Annual Dues by \$5 to Cover the Cost of Student Research Scholarships**

The Division 55 Board of Trustees voted to increase the annual dues for membership by \$5. This will bring the total dues to \$45 per year. First year members continue to receive a free membership and student dues will remain at \$10 per year. The dues increase will offset the cost of the new Research and Travel grants for students totaling \$5,000 annually. (See the *Updates from the Board* section in this *Tablet* for more information on the scholarships).

### **Division 55 Announces Awardees of the First Annual Travel Scholarships from the Research Council**

The following students received travel scholarships for \$250 each for the 2023 APA Convention in Minneapolis. Congratulations!

Erinn C. Cameron  
Morgan Ferris-Johnson  
Matheus Teles  
Michelle Woods

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### **ARE YOU A MEMBER OF DIVISION 55 YET?**

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For more information visit us at

<https://www.apadivisions.org/division-55/membership/index>

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## ANSWERS FOR QUIZ ON CONDUCT DISORDER

1. Answer: B: Based on the information provided, the child is suffering a type of EPS termed an acute dystonic reaction. If the reader is unfamiliar with different types of EPS (akathisia, dystonia, pseudo-parkinsonism, & tardive dyskinesia), the author strongly recommends becoming familiar as they may be high yield information on the PEP. Haloperidol's D2 blocking can cause such reactions, but it is not a SGA. Quetiapine is a SGA, but research suggests the risk of it inducing EPS is amongst the lowest of the SGAs. Aripiprazole's partial agonistic actions at the dopamine receptor should lead it to a reduced risk of EPS. Aripiprazole is more commonly associated with akathisia in terms of side effects. The most likely culprit in this case is risperidone.

2. Answer: A: Of the choices listed, risperidone is the best option to treat the aggressive behaviors and ADHD. There is limited research evidence to support risperidone's use in children who suffer from ADHD and comorbid behavioral disorders. The BEST medication option would be a psychostimulant such as methylphenidate, but that is not among the answer options. Lithium and valproate have demonstrated some efficacy in reducing aggressive behaviors in children, but their side effect profiles prohibit them from use as first-line agents and the author is unaware of any research that would suggest usefulness in ADHD. Fluoxetine is an antidepressant and is not relevant in this scenario.

3. Answer: C: Exposure to violence is a risk factor for the development of CD, but antisocial personality disorder is not a common comorbid condition, as DSM-5 prohibits that diagnosis in the case of a seven-year-old child. ODD is a common comorbid condition, but deletion of specific genes from chromosome seven is associated with Williams Syndrome, not CD.

Familial instability is a risk factor for the development of CD, but dissociative identity disorder is not a comorbid condition. Maternal smoking during pregnancy is a risk factor for the development of CD and ADHD is a common comorbid condition, which makes this the best answer choice.

## ANSWERS FOR QUIZ OF DISRUPTIVE MOOD DYSREGULATION DISORDER

1. Answer: B: Diagnostic criteria for DMDD allow for a child to experience full symptom criteria for a manic or hypomanic episode (without the duration criteria) for one day and still be diagnosed as suffering from DMDD. The other answer choices are diagnostic criteria for DMDD.

2. Answer: D: The symptoms in the brief vignette are consistent with DMDD, but DMDD is not an appropriate diagnosis due to the child's age. DSM-5 states that a diagnosis of DMDD should not be assigned to a child under six-years-old. Further, as DSM-5 classifies DMDD under the heading of depressive disorders, other specified depressive disorder (in practical use one could addage *criteria for DMDD not yet met* to identify the specifier) is the most appropriate diagnosis. There is not enough information available to diagnose ADHD or a persistent depressive disorder.

3. Answer: C: There are no clinical guidelines to suggest a nonpharmacological intervention should be applied for six weeks prior to starting a medication. A trial of methylphenidate would be supported by research and is appropriate for ADHD as well as DMDD, but does not consider the family's preference, which makes it a less appropriate response. A trial of risperidone and DBT-C is supported by research and follows the family's preferred treatment route, but due to risperidone's side effect profile, it is typically not a first-line agent. It could be argued that it would be a first-line agent for DMDD, but risperidone is not a first-line agent for ADHD and there is a better option that may treat both. A trial of atomoxetine and DBT-C is the most appropriate answer as it considers the family's treatment preference and atomoxetine's use in ADHD and DMDD is supported by research. Atomoxetine's

side effect profile is typically milder than risperidone, which makes it more a more desirable first-line choice in this situation. It could be argued that a trial of methylphenidate and DBT-C would be better and that may be true, but that was not among the answer choices.