

The Tablet

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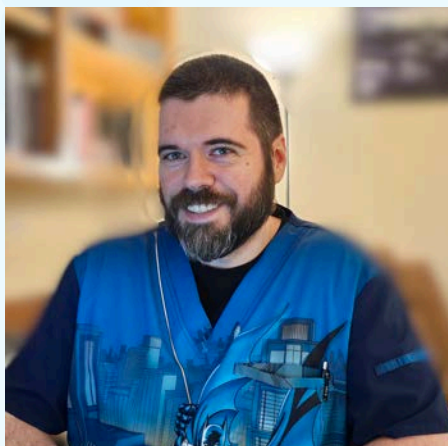
2024

WINTER



SOCIETY FOR
PRESCRIBING PSYCHOLOGY

The Editors



**Richard Sylvester,
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EDITOR-IN-CHIEF



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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.

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

Past President's Column



Steven Curtis, PhD, NSCP, MSCP

Division 55 President, 2024

Thank you for the opportunity to be the President of the Society of Prescribing Psychology (Division 55) this year. I did my best to serve the membership and others working to promote RxP in the United States and elsewhere worldwide.

This has been a tricky year for me. My presidency was initially impacted by the Change Healthcare data breach in February 2024. This breach affected over 100 million individuals, which makes it one of the largest healthcare data breaches in US history.

My wife's and my private practices were decimated for a few months, given that no insurance reimbursements were received. We are doing fine now, but it was very stressful during that time. I hope you have recovered for those of you who also went through this.

In August, we had a very successful conference at APA in Seattle. I presented, Dear Colleagues, Prescribing Psychologists are Multiplying: Have You Noticed? I aimed to provide information about RxP to psychologists who know little about this area.

Even in 2024, and with seven states that have legalized RxP, few of our colleagues know anything about RxP. We cannot obtain broader support for RxP amongst our colleagues without providing them with knowledge of what we are doing.

The presentation was well attended, and I plan to conduct this presentation multiple times in the coming years with our non-prescribing colleagues. Our APA Division 55 programming included outstanding presentations from our RxP colleagues, my doctoral students from Antioch University, Seattle, and other students from other universities. In our annual Division 55 business meeting, we recognized five honorary fellows and gave numerous awards and travel scholarships. Over the course of this year, Utah became the 7th state to legalize RxP, and New Mexico passed SB 127, which expanded the formulary, including medications, to address and prevent side effects.

This measure also allows prescribing psychologists with four years of experience to supervise trainees. I have noticed increased skill amongst our members when treatment strategies are discussed on the listserv.

There is increased enthusiasm for RxP amongst students, licensed psychologists, and community members, as evidenced by my Outlook Inbox and comments from my graduate psychopharmacology students. There are now licensed prescribing psychologists in Colorado. Our seventh MSCP program started at the University of Colorado, Denver this fall. We now have over 300 prescribing psychologists and over 1000 Division 55 members.

The research regarding RxP's safety, efficacy, and increased access has mushroomed this year thanks to the work of Phillip Hughes and Colleagues, Angela Shoulders, and Alicia Plemmons. Finally, as of December 2024, there is light at the end of the tunnel with our ABPP application. You will hear more about this in the coming year. This is a fantastic feat led by Derek PsyD, MSCP, and Lynette Pujol, PhD, MSCP.

I am grateful to all our colleagues and members who have kept RxP alive. As recently as five years ago, many thought RxP was dying. RxP is not dying; it is flourishing and will not go away. The growth of RxP may not be as rapid as many of you want. However, it is inching along, bit by bit. Every time I prescribe or deprescribe to help someone, I honor those who have made it possible for me to do so. Our progress is about to increase dramatically in the coming year. I can feel it happening.

Lynette Pujol, PhD, MSCP, has put together a fantastic team. She is organized, focused, and ready to go. I wish her and the new board members in 2025 a warm welcome and the best of luck. I will still be on the board as Past President. I am sad to see several of our board members depart. David Shearer, PhD, MSCP, will be surfacing again when he presents the new guidelines for involvement in psychopharmacology. Did you know our Secretary, Morgan Ferris-Johnston, PsyD, MSCP, just had a baby girl? I wish her the best. Have a great year, everyone!

Sincerely
Steven Curtis, PhD, NCSP, MSCP



President's Column

Lynette Pujol, PhD, MSCP

Division 55 President-Elect, 2025



As we enter our Silver Anniversary year, I want to take a moment to express deep gratitude to our outgoing president, Dr. Steven Curtis, for his outstanding leadership and unwavering dedication. His thoughtful guidance over the past year has ensured that Division 55 continues to thrive.

Please join me in thanking him for his service and many contributions to our organization.

This year marks 25 years since Division 55's founding, and our anniversary theme, "25 Years of Division 55: Celebrating our Past, Forging our Future," invites us to reflect on where we started and where we are going.

Twenty-five years ago, a group of visionary psychologists stood at the forefront of an ambitious yet controversial movement: advocating for prescription privileges for psychologists. These early pioneers faced skepticism and resistance, often from within our own profession. Yet they persevered, motivated by a belief in the value of integrated care and the unique perspective that psychologists bring to psychopharmacology profession.

Their courage and determination paved the way for the many roles our members now hold: as prescribing psychologists, as consultants on psychotropic medications, or as students and advocates deeply engaged in RxP. Think about how far we've come since those early days—how the foundation they built has enabled us to better serve our patients and strengthen our profession.

This year, as we celebrate our division's achievements, I encourage each of you to pause and reflect on your personal journey to RxP. Whether you are a prescriber, a consultant, or a student, take a moment to think about who helped pave the way. Maybe it was a mentor, a colleague, or one of the early pioneers who believed in the vision of prescription privileges long before it was a reality.

I encourage you to thank someone today who was an important part of your journey. Throughout the year, we will be giving you a glimpse of what it was like for those early pioneers. Perhaps you will take the opportunity to let them know how much their early efforts mean to you.

As we honor the legacy of those who came before us, let's also embrace the challenge of forging our future. What will the next 25 years hold for Division 55? How will we continue to innovate, collaborate, and advocate to ensure our relevance and impact in an ever-changing healthcare landscape? These are the questions that will guide our work in the year ahead.

Here's to celebrating our past and forging our future together. Thank you for being part of this extraordinary journey.

Very respectfully,
Lynette



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Students \$10 a year!

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PASTORAL PONDERINGS: TALES OF A RURALLY-INCLINED PSYCHOLOGIST



Letter from the Editor

Is it odd that I decided to pursue prescriptive authority specifically so I could **NOT** prescribe medication? Once upon a time, I was a forensic psychologist. I guess technically I still am as I continue to hold that specialty, but please don't tell anyone.

I worked at a correction center for adjudicated juveniles. In other words, I worked at a prison for children. As one could imagine, many of the residents struggled with mental health issues. Amongst the most common were trauma, but mood disorders were a close second and often co-occurring with trauma.

I would prefer not to recall how many children I saw who struggled with extrapyramidal symptoms and/or problematic liver functioning upon intake to the facility. Children who struggled with marked irritability secondary to trauma would come in with diagnoses of Schizophrenia and Bipolar I Disorder. Children who struggled with substance abuse would come in diagnosed as suffering from schizoaffective disorder. Looking through their history, the only thorough evaluation for mental health related purposes would be the one they received on intake to the correctional facility.

Anyway, I got tired of seeing misdiagnosed and mistreated children. I decided to do something about it. Fast forward a few years from that point in time and now I'm a medical psychologist. I think about the correctional facility every time I stop a person's prescription for Depakote or an antipsychotic and instead help them via psychotherapeutic services or help them find a therapist who best meets their needs.

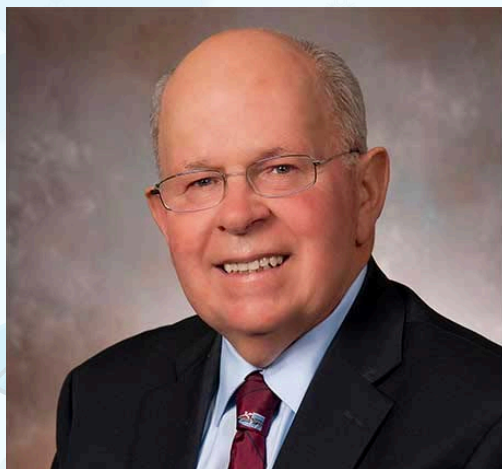
I've always lived and practiced in the rural south. How rural? Children were taken out of school by their parents to help harvest crops. Opening day of deer season was basically treated as a national holiday. If you weren't at church on Sunday morning, no less than three people would stop by your house Sunday afternoon to make sure you were still alive. "Did you remember to throw some pepper under the door to keep the bad spirits away?" That level of rural.

Rural enough that the only three psychiatrists within a 75-mile radius are all trying to retire and have been welcoming of medical psychology every time I've interacted with them. We have more in common than some might care to admit. As for myself, I see who I can and help who I can. I go out of my way to read relevant literature for practice and try to translate it into something meaningful for the people with whom I work. There are plenty of people in need, so feel free to join me.

Just don't ask what's under the gravy.

RS





The Ever Changing Healthcare

Environment: Earlier this Fall, the National Academies of Sciences, Engineering, and Medicine convened its ongoing Global Forum on Innovation in Health Professions Education (HPE) exploring “Where health professions education is projected to go with visionary thinking.”

Under the leadership of Patricia Cuff and Forum Co-chairs Zohray Taub and Jody Frost, these discussions continually highlight the similar challenges and, equally importantly, the opportunities that all of the health professions face. With the nation’s experiences during the COVID-19 pandemic and the ever increasing aging of our population, there has recently been considerable interest expressed in the importance of the behavioral health/mental health aspects of quality healthcare.

Daniel Elchert, a licensed psychologist and former AAAS Congressional Science Fellow attended the Global Forum: “As financing, technology, and workforce trends rapidly change, the nature of care itself is shifting to a learning health system model. To navigate this transition, psychologists must continue forming collaborative partnerships with other health care professionals, policymakers, and educators.

The Global Forum concluded with inter-professional dialogue focused on the scholarship of teaching and learning in health professions education. As a testament to the NAM’s leadership, over 1,000 individuals from around the world participated in person and via the online portal.”

An Integrated &

Interprofessional Experience:

Uniformed Services University (USU) psychology graduate students Elisabeth Mata (1LT, USA), Cheyenne Quilter (1LT, USA), and Airyn Nash (CPT, USA): “Bushmaster 2024 took place in early to mid-October in Pennsylvania’s cold, rugged terrain, where multidisciplinary students from USU convened to train in a simulated austere, deployed environment.

This exercise brought together medical, nursing, and mental health disciplines to form a cohesive medical element capable of addressing physical and psychological demands on the battlefield. Clinical psychology and psychiatric mental health nurse practitioner students embedded within medical student platoons offered essential combat operational stress support in role 1 aid stations. Additionally, these teams established a dedicated role 2 Combat Operational Stress Control (COSC) unit to provide comprehensive mental health support at the battalion level to actors coming in with various mental health concerns ranging from suicidality, personality disorders, and acute stress reactions, to name a few.

“The exercise highlighted the differences in care capabilities afforded by the unique constraints of austere environments commonly associated with the military. In such settings, the ability to adapt and optimize available resources becomes critical, and a key resource is the knowledge and skillset as it pertains to the ability to prescribe. A crucial component demonstrated by this exercise is how the capability to prescribe psychotropic medications in the field becomes both a force multiplier and a force sustainer. The ability to prescribe within an austere environment allows mental health professionals to address acute psychological and physiological symptoms in real time, minimizing downtime, keeping unit cohesion, minimizing evacuation rates, and preventing long-term impairment.

This underscores the importance of granting licensed and qualified clinical psychologists prescriptive authority, particularly in military and austere settings, where the primary prescriber, such as a psychiatrist or mental health nurse practitioner, may not be as readily available, creating a delay in symptom management and possibly allow service members’ to lean on maladaptive coping mechanisms to sustain their roles. As force multipliers, psychologists with prescriptive authority can address a broader spectrum of mental health concerns, ensuring sustained psychological resilience and maximizing the effectiveness of military personnel in high-stress environments.” Thanks to the vision of the leadership of the Chicago School of Professional Psychology, our colleagues are currently simultaneously enrolled in psychopharmacology classes in furtherance of their military careers, which they find meaningful and definitely “doable”.

A Bold International Vision: This summer, Jared Skillings, APA Chief of Professional Practice, participated in the U.S. Agency for International Development (USAID) Position Paper launch event Mental Health is Health: Redefining Mental Health in Foreign Assistance. Jared joined the USAID Assistant Administrator for Global Health and USPHS Surgeon General Vivek Murthy, as well as psychologist Jerome Galea, USAID Agency Mental Health Coordinator. USAID’s Position Paper focused on four underlying principles: Promote sustainable enabling

environments that support mental health; Apply contextually-appropriate approaches developed in partnership with local communities; Actively promote the use of ethics, human rights, and Do No Harm practices; and, Address key barriers to effective programming, including mental health stigma and the need to diversify and strengthen partnerships.

USAID: “Mental health encompasses emotional, cognitive, psychological, and social well-being. It affects how humans think, feel, learn, work, make decisions, and build relationships.... Mental health affects physical health (including nutrition, substance abuse, outcomes for infectious diseases, and incidences of noncommunicable diseases); child health and development; education outcomes; and workforce participation, among others. Evidence also shows that mental health conditions are higher among populations exposed to environmental stressors such as extreme poverty, war and conflict; food insecurity; high levels of community violence, including gender-based violence (GBV); and stigma and discrimination. Crucially, mental health also affects service providers, community workers, and activists who drive developmental progress. Taken together, with the growing evidence of an emergent global mental health crisis, these factors make it clear that mental health is intricately tied to USAID’s ability to meet its development objectives across sectors and should be seen as an intersectional priority for the Agency.”

The Position Paper signals USAID’s commitment to advancing mental health around the world, since it is viewed as

being central to achieving interagency objectives and long-term development goals. The objective is to address these challenges by strategically integrating mental health considerations into USAID’s programs and leveraging development diplomacy, global partnerships, expertise, and strategic guidance for a more coordinated and effective approach to this escalating issue. In almost every country, including high-income countries, gap between people’s needs and mental health systems, supports, and services remains wide, with treatment gaps of up to 90% in some countries. USAID envisions a future where mental health and well-being are universally valued such that prevention is prioritized; desirable support and services are easily accessible; a state of positive psychological, emotional, and social well-being is considered and acted upon as a crucial goal; and individuals with mental health needs are free from stigma or discrimination. The Agency is committed to adhering to principles of humility, mutuality, respect, and alignment with inclusive development, locally led development, gender, and human rights. As Jared noted in his remarks: “Mental health is the public health challenge of our time. We are here to stand together to improve the health of our communities around the world.... We want our kids, and their kids, to grow up in a world where they can be their best selves and to openly reach out and access mental health care when they need it.”

An Intriguing Perspective – Investing in Our Future:

Steve Ragusea: “One of the underlying issues about marketing has to do with psychology’s longstanding unwillingness to address the reality that there is a business involved here. Given our competition, organized psychology should be spending vastly more money on advertising our quality. Doctors of psychology vs. masters level mental health workers represent significantly higher levels of training. Other professions are much more successful advertising their expertise. Of all the health care professionals, we spend the least on this. That’s because individual psychologists are unwilling to pay the cost of being in business. More than half of all licensed psychologists don’t even pay dues to their state association or APA! It never fails to amaze me.

“For example, you may have noticed a recent advertising campaign on various cable and broadcast stations for Certified Financial Professionals. The basic closing line is: ‘Yes, I’m a CFP professional!’ They are contrasting their membership with all the other financial planners out there in the world including lawyers, accountants, etc. It’s very effective advertising. We should be doing the same.

“According to the Certified Financial Planner Board of Standards, this campaign is costing \$16.9 million just this year. They’ve spent approximately that much every year since this campaign started in 2011. How many Certified Financial Professionals are there? The answer is, approximately 98,900 in the U.S. How many licensed psychologists are there in the U.S.? 106,000. Do the math and that advertising campaign is costing each CFP \$171 a year.

“The people who understand money, financial planners, know that you have to spend money to make money. We psychologists need to grow up and put our money where our future is. We are arguably the best trained, best researched, mental health professionals in the world and neither the general public nor the health care industry knows that. Wouldn’t it be worth a couple of hundred bucks a year to your practice to tell people about it?”

Steve has also pointed out that in 2023, APA was ranked as having the 10th overall total lobbying expenditures among all healthcare professional groups, more than our psychiatric colleagues but there are only half as many psychiatrists as there are psychologists. Not surprisingly, the American Medical Association led the way with \$21,215,000. In contrast, psychology (including the National Association of School Psychologists) reported spending \$1,460,000, while the various nursing associations reported a total of \$4,501,673. Could we not collectively become more engaged in advocating for our future? “I’ve got my life to live.... I, I, I will survive” (I will survive, Gloria Gaynor).





**Questions?
Comments?
Article Ideas?
Vignettes to Share?**

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Contact Us!

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Bipolar Disorders

According to the DSM-V (APA, 2013), bipolar disorders encompass various types such as bipolar I, bipolar II, cyclothymic disorder, substance/medication induced/due to another medical condition, as well as other specified and unspecified bipolar and related disorders. In the revised edition of the DSM-V-TR, released in March 2022, changes were made to criterion B in bipolar I disorder and criterion C in bipolar II disorder. These modifications included:

- Reverting to a modified version of the DSM-IV criteria, specifically regarding the connection between mood episodes and psychotic disorders.
- Providing clearer guidelines on which mood episodes are applicable.
- Adding examples of mood episodes occurring alongside a psychotic disorder in other specified bipolar and related disorders, as well as other specified depressive disorder.

In the DSM-V, changes were made to criterion B in bipolar I disorder and criterion C in bipolar II disorder. The revisions aimed to clarify the distinction between mood episodes associated with schizoaffective disorder and those occurring alongside other psychotic disorders. The wording in DSM-IV emphasized that mood episodes should not be "superimposed on" schizophrenia or other psychotic disorders, while DSM-V shifted the focus to episodes not being "better explained by" these disorders.

The DSM-V-TR (APA, 2022) further modified the criteria to explicitly state that manic episodes in bipolar I disorder and hypomanic episodes in bipolar II disorder should not be attributed to schizoaffective disorder or superimposed on other psychotic disorders. Additionally, examples were included in the diagnostic criteria for other specified bipolar and related disorders and other specified depressive disorders to allow for the diagnosis of manic or major depressive episodes occurring alongside a psychotic disorder.

Birmaher (2022) suggests the prevalence rate of bipolar disorders in children and adolescents ranges between 1% and 3.9%, and has remained stable over time. They report that in the US, in an outpatient setting, the prevalence rate for bipolar disorder is around 1% in children and adolescents, but drops to around 0.1% within inpatient settings. Those estimates are reasonably consistent with those found in the DSM-V (APA, 2013).

Birmaher (2022) suggests children who suffer from bipolar disorder experience abnormalities in brain structure and function. They report findings that the amygdala is smaller and reductions in the size of other structures within the frontal and temporal lobes are noted. Limbic structures are described as hyperactive and children who suffer from bipolar disorder display more problems with inflammation while the prefrontal brain areas are prone to hypoactivity.

Children are going to act like children. There will be times they are highly energetic, irritable, distracted, self-centered, sad, and more; but that is childhood, which is not a diagnosable disorder. Thankfully, bipolar disorders are rare in children and it is reasonable to place them near the bottom of a given list of diagnostic possibilities, but they should not be forgotten and need to be investigated appropriately. As with many situations, disorders, and conditions, catching and treating the problem early results in a better prognosis (Bowers et al., 2019).

Treatments for bipolar disorders in children are roughly the same as those used for adults. On one hand, those who work with adults suffering from bipolar disorders may find comfort in the familiarity of those treatments, but treating children as though they are simply miniature adults is a dangerous proposition. Compared to adults, less research is available regarding the treatment of children who suffer from bipolar disorders. Thorough informed consent and treatment planning should be paramount when working with children and families. Never simply assume medication compliance as it needs to be an open topic of discussion for all parties in the hopes of improving compliance, which research suggests is problematic in nearly 50% of cases of children suffering from bipolar disorders (Abrams, 2020).

Per Abrams (2020), professionals typically consider medication a key component of treatment for pediatric bipolar disorders with psychotherapeutic and psychosocial interventions as adjunct treatments.

Treatment approach for bipolar disorders varies based on the phase of the illness and symptoms present. The usual suspects of the second generation antipsychotics (SGAs), antiepileptic drugs (AEDs), and lithium apply in many cases, but ECT, antidepressants, and even over-the-counter (OTC) agents demonstrate at least some efficacy in pharmacological management of bipolar disorders in children and adolescents (Abrams, 2020; Axelson, 2022; Geller et al., 2012; & Gautam et al., 2019). Abrams (2020) mentions limited available research showing omega-3 fatty acid supplements assisted in the reduction of symptoms of mania and depression in children and adolescents.

Malhi et al. (2020) offer a different approach to mood disorder taxonomy to facilitate their application in clinical practice. Their guidelines encompass both depressive and bipolar disorders as a continuum, emphasizing the importance of a spectrum perspective. This dimensional view applies to individual syndromes and the broader category of mood disorders, including specific symptoms. The guidelines introduce changes to classification, distinguishing them from the concept of a "bipolar spectrum" that includes borderline personality disorder, cyclothymia, and bipolar subtypes.

Additionally, Malhi et al. (2020) present alternative schemas to improve diagnostic formulation and align with clinical reality. They eliminate the distinction between bipolar I and bipolar II disorders, categorizing all syndromes with manic symptoms as bipolar disorder.

It introduces a new model, the ACE model, which emphasizes the domains of activity and cognition alongside emotion, groups the phenomenology of mood disorders differently and offers a more specific and sophisticated approach to diagnosis and management. The guidelines also conceptualize mixed mood states independently, alongside depression and mania, deviating from the DSM-5 and ICD-11 classifications. Malhi et al. (2020) suggest the distinction between bipolar I and bipolar II disorders are eliminated because they are considered arbitrary and not helpful for management. This approach acknowledges that some individuals experience short periods of mania, which are not captured by the bipolar II categorization. Instead, all syndromes characterized by manic symptoms are referred to as bipolar disorder, with the duration of mania specified and the degree of impairment described as mild, moderate, or severe. In terms of pediatric bipolar disorder, while early-onset bipolar disorder is rare in children, the diagnosis of bipolar disorder in young children remains uncertain, and the term "pediatric bipolar disorder" has been used inconsistently to describe different presentations. In considering prognosis and treatment, it is crucial to differentiate between unipolar depression and bipolar depression, as well as to identify mixed states involving subsyndromal mania or depression whenever present (Stahl, 2021).

While mood disorders primarily involve mood disturbances, they encompass a range of symptoms beyond mood, which are necessary for diagnosing a major depressive episode or a manic episode. The goal is to recognize and appropriately treat both unipolar and bipolar depression, regardless of the presence of mixed features, with the aim of achieving long-term symptom remission and potentially preventing progression to more challenging states.

Acute Mania

McClellan et al. (2007) recommended the use of lithium as a first-line agent in the treatment of pediatric manic episodes. The authors listed valproate and several SGAs as approved for treatment of mania in adults, but typically not first-line agents for children. Geller et al. (2012) studied the use of risperidone, lithium, and divalproex sodium in treatment of manic episodes in children. Those findings suggested risperidone displayed superior efficacy as compared to lithium and divalproex sodium in psychotic as well as non-psychotic children. In addition, risperidone appeared to be the most well tolerated agent, but metabolic problems were associated with its use.

NICE (2014) recommended the use of aripiprazole to treat pediatric mania and suggested olanzapine, risperidone, haloperidol, quetiapine, lamotrigine, lithium and valproate as off-label agents. NICE (2014) recommended the use of aripiprazole to treat pediatric mania and suggested olanzapine, risperidone, haloperidol, quetiapine, lamotrigine, lithium and valproate as off-label agents.

Grande et al. (2016) cautiously recommend the use of SGAs over lithium and valproate as first-line agents in the treatment of manic and mixed episodes in adolescents. Goldstein et al. (2017) reviewed several studies suggesting SGAs demonstrated superior efficacy to more traditional mood stabilizing agents, with the possible exception of lithium. They reported risperidone, aripiprazole, quetiapine, olanzapine, asenapine, and lithium as FDA approved agents in the treatment of mania as well as mixed episodes in adolescents.

Bernstein (2021) adds ziprasidone to that list for children and valproate for children 12-years-old and older. They list asenapine, quetiapine, and risperidone as approved for use in children 10-years-old and older. In addition, they report short-term use of benzodiazepines such as clonazepam or lorazepam may be helpful in treating sleep problems or irritability, but prefer clonazepam due to its longer half-life, which makes it less prone to dependence problems.

Woo et al. (2018) report aripiprazole and risperidone as first-line agents in the treatment of manic episodes in children under 12-years-old and adolescents, but also quetiapine for adolescents. They recommended risperidone as the treatment of choice for adolescents experiencing a manic episode. They suggested another first-line option could be a combination of valproate or lithium with one of the aforementioned SGAs in adolescents, but did not recommend either valproate or lithium for use as a first-line agent in young children.

Jochim et al. (2019) reported valproate failed to display efficacy as compared to placebo when used to treat pediatric mania.

Gautam et al. (2019) recommend olanzapine, quetiapine, and risperidone as first-line agents in the treatment of manic episodes in children and adolescents.

In general, SGAs and lithium are empirically supported pharmacotherapeutic interventions for children experiencing a manic episode (Axelson, 2022; Abrams, 2020; & Goldstein et al., 2020). After reviewing the above information, risperidone appears to be the most consistently recommended SGA, likely followed by quetiapine. Metabolic issues seem to be the most prominent side effect of concern with SGAs, especially in the case of olanzapine, but ziprasidone carries with it the possibility of cardiac changes, namely prolongation of QTc, that require appropriate monitoring. Goldstein et al. (2020) suggests the SGAs typically exert their therapeutic effects more quickly than lithium, which may lead to them being preferable in rapidly deescalating potentially dangerous manic symptoms.

Depression Episodes of Bipolar Disorder

NICE (2014) guidelines recommend CBT and IPT as first-line treatments for children and adolescents suffering from bipolar depression. Should the child or adolescent not make progress in six weeks, they then recommend reconsidering therapeutic approach and possibly applying more psychosocial and family interventions.

If the child or adolescent experiences moderate to severe depressive symptoms, Nice (2014) recommends combining therapeutic and pharmacological interventions, briefly. They do not recommend any agent specifically, but mention use of SGAs including olanzapine and quetiapine as well as the AED lamotrigine. They recommend use of antipsychotic agents for a maximum of 12 weeks in most cases, but do not mention long-term use or limitations for lamotrigine. Goldstein et al. (2017) recommend a combination of olanzapine and fluoxetine (Symbyax), lurasidone, lithium, and lamotrigine as empirically supported agents in treatment of bipolar depression in children and adolescents. They report Symbyax and lurasidone as FDA indicated in treating bipolar depression for 10 to 17-year-olds.

Goldstein et al. (2017) stated quetiapine failed to differentiate from placebo in treatment of bipolar depression in two studies involving adolescents. Bernstein (2021) recommends use of a mood-stabilizing agent later combined with bupropion in the treatment of bipolar depression. In addition, he states bupropion may demonstrate less chance of inducing a manic episode as compared to selective serotonin reuptake inhibitors (SSRI). Bernstein (2021) also suggested consideration of ECT, but not as a first-line treatment. Goldstein et al. (2020) recommends lurasidone as a first-line monotherapy agent in treatment of bipolar depression in children and adolescents. They suggest lithium and lamotrigine as second-line options as well as Symbyax and quetiapine as third-line choices.

Axelson (2022) recommends lurasidone monotherapy or another SGA combined with an SSRI as a first-line choice in treatment of pediatric bipolar depression. Based on the response of the patient, they go on to recommend changing either the antidepressant agent, the SGA, or adding or switching to a different mood-stabilizing agent. Axelson (2022) provides an excellent, concise treatment algorithm that these authors strongly recommend the reader peruse for detailed information regarding the treatment of pediatric bipolar depression.

In general, the above research considered use of a SGA appropriate in cases of bipolar depression. Long-term use of antipsychotic agents raises metabolic concerns and the possibility of extrapyramidal symptoms (EPS), as well as other adverse effects that may require monitoring. Some authors recommend caution in the use of lamotrigine due to its association with the development of Stevens-Johnson Syndrome. Some discouraged the use of SSRIs, with the exception of the olanzapine-fluoxetine combination, due to concerns of SSRIs triggering a manic response. Others recommended the use of SSRIs after the establishment of a mood-stabilizing agent regimen if that agent did not alleviate depressive symptoms.

Use of a monotherapy agent is generally preferable in most pharmacological cases. Lurasidone's FDA approval makes it a good first-line choice, but one could argue that another SGA could potentially be appropriate given similar mechanisms of action and a limited amount of research to suggest one SGA superior to another for this specific purpose.

If the patient experienced a manic episode and stabilized on a SGA, then one must question whether it makes clinical sense to switch them to a different SGA, unless attempting to manage adverse effects or other relevant factors. In short, one must determine whether the potential benefits outweigh the potential risks.

Whether a patient should switch from a SGA that effectively stabilized a manic episode to another SGA that might better treat an episode of bipolar depression or add an antidepressant agent to the original SGA is debatable. Such a decision would likely depend on factors specific to the individual case, family/patient preferences, and available resources. Should a SGA prove effective for stabilization of mania, but ineffective for treatment of bipolar depression (assuming the patient tolerated the agent well), it then makes clinical sense to add an antidepressant agent.

The majority of the available literature suggests SSRIs are safe to use in pediatric bipolar depression when combined with a mood-stabilizing agent, but the clinician must remain cognizant of the black box warning carried by several antidepressant agents. Should the SSRI fail to produce symptom relief, the clinician then faces the dilemma of whether to try another SSRI, try a serotonin and norepinephrine reuptake inhibitors (SNRI), backtrack and try a different SGA, or try adding or switching to a different mood stabilizing agent, such as lithium or lamotrigine.

Fornaro et al. (2019) noted the FDA's heightened concern had a notable impact on reducing the usage of effective medications, particularly antidepressants, as evidenced by a nearly 50% decline in prescriptions, especially among children and adolescents. This decline in prescriptions may also be attributed to a shift in diagnostic practices favoring bipolar disorder over major depressive disorder, along with the availability of SGAs and regulatory challenges.

Per Fornaro et al. (2019), the use of psychoactive drugs like benzodiazepines and antipsychotics increased, particularly among young females, following the FDA's black box warning. However, it is important to note that a potential worsening of adverse outcomes, including suicide or suicidal ideation, during the same period does not necessarily establish a causal link with the decline in antidepressant use.

Fornaro et al. (2019) examines two case reports, one from 2013 and another from 2017, shedding light on persistent misconceptions surrounding the black box warning even after approximately a decade after the FDA's 2007 revision. These reports emphasize that engaging in leisure activities, maintaining stable familial relationships, and having an average education level are not sufficient deterrents. Paradoxically, higher education and access to informed online resources may have unintended consequences. Many psychiatrists continue to face stigma and opposition from certain patients, their families, and colleagues, while the overwhelming amount of media information undermines adherence and patient trust.

The clinical decision-making process in treating pediatric bipolar depression is complex and requires one to take into account relevant research, patient health factors, patient/family preferences, availability of resources, potential co-occurring conditions, and other factors specific to each individual case. There is no one-size-fits-all answer in terms of pharmacological management; however, research overwhelmingly supports the use of psychotherapy as an adjunct treatment.

Maintenance

According to Grande et al. (2016), recommendations for maintenance treatment of bipolar disorder in children and adolescents are lacking, as there is not enough research available on the topic. NICE (2014) guidelines recommend psychotherapeutic and psychosocial interventions for long-term treatment of bipolar disorder in children and adolescents. Goldstein et al. (2017) suggest lithium, aripiprazole, and lamotrigine demonstrated some usefulness as maintenance treatment options as compared to placebo. In addition, they suggested empirical support of nonpharmacological interventions including family-focused therapy, family psychoeducation plus skill building, and dialectical behavior therapy. They described interpersonal and social rhythm therapy as possibly helpful, but experimental, in adolescents and children.

Bernstein (2021) recommended cognitive behavioral therapy (CBT) and family therapy for maintenance treatment in children and adolescents who suffer from bipolar disorder. Axelson (2022) recommends continuing the medication the child responded to when treating the acute mood episode. They list aripiprazole, lithium, divalproex, and lamotrigine as demonstrating efficacy in maintenance treatment as monotherapies. Further, Axelson (2022) suggests treatment continue for at least a year and application of psychotherapy as an adjunct. They echo the therapeutic recommendations of psychoeducation, family therapy, dialectical behavior therapy (DBT), CBT, interpersonal and social rhythm therapy, and motivational interviewing, in approximately that order. Logic dictates that prior to reaching the maintenance phase of bipolar disorder treatment, the child underwent treatment of an acute mood episode, at least in most cases. Research and guidelines generally recommend medication as a key component in the treatment of pediatric bipolar disorders with psychotherapy as an adjunctive treatment. That said, in most cases a child will already be prescribed medication when they reach maintenance phase treatment. If the child tolerated that medication well and it effectively treated symptoms, it then makes clinical sense to continue the medication in maintenance phase treatment given the recurrent nature of bipolar disorders.

Realistically, any decision-making process regarding a change in medication would be dependent upon the reason the clinician or child/family desired or needed change. Without that context, recommending any specific medication becomes difficult, but a SGA, particularly aripiprazole, would be a reasonable first-line choice. Agents such as lithium, lamotrigine, and divalproex demonstrated efficacy in maintenance treatment, but their potential adverse effects or monitoring requirements might lead to them appear less desirable as first-line choices. Research indicates application of adjunctive psychotherapy in maintenance phase treatment of pediatric bipolar disorders is typically appropriate and recommended. Some of the research discussed above recommends continuation of pharmacotherapy for at least a year, but one could argue that pharmacological treatment should continue indefinitely, especially in cases involving a history of severe symptoms or multiple mood episodes. If a decision to cease medication proved appropriate, it makes clinical sense to reduce the medication slowly, monitor the patient closely, and continue psychotherapeutic support. A thorough discussion of the potential risks and benefits of such a treatment decision should take place with all relevant people prior to the implementation of that change. Such a change warrants a detailed safety plan with appropriate support for the child and family throughout the process.

The decision-making process regarding how long medication should be continued, or whether medication should ever be discontinued in maintenance phase treatment of pediatric bipolar disorders, is complex and best considered on a case-by-case basis with input from the child/family being a key factor. Ultimately, the decision as to whether medication use follows the prescriber's directives belongs to the child and their family, not the clinician. Per Stahl (2019), olanzapine is a SGA also used as a mood stabilizer and works by antagonizing neurotransmitters at D2, 5HT2A, and 5HT2C. Stahl reports olanzapine as one of the worst offenders in terms of metabolic problems in its class, possibly due to its antagonistic actions at H1 and M3. Metabolism occurs via CYP1A2 and CYP2D6 (Prior & Baker, 2003). Stahl reports asenapine is another SGA, also used as a mood stabilizing agent and works by antagonizing D2, 5HT2A, 5HT2C, 5HT7, and alpha2. Stahl speculates that asenapine's actions at the latter three sites partially explain its antidepressant properties. Metabolism of asenapine occurs via CYP1A2 and it mildly inhibits CYP2D6 (Guzman, 2015). Stahl (2013) reports ziprasidone is a SGA, also used as a mood stabilizer and works by antagonizing 5HT2A, 5HT2C, D2, and partially agonizing 5HT1A. Stahl states ziprasidone causes fewer metabolic concerns than most SGAs, but it may have cardiac effects, which warrant monitoring. Metabolism of ziprasidone occurs via CYP3A4 (Prior & Baker, 2003).

Per Stahl (2019), lurasidone is another SGA also used as a mood stabilizing agent and works by antagonizing D2, 5HT2A, 5HT7, alpha2A, and alpha2C. In addition, he reports it displays partial agonist actions at 5HT1A, which when coupled with its actions at the three previously specified sites may help explain its efficacy in treating depression and anxiety. He says lurasidone's limited actions at D1, M1, and H1 likely contribute to it causing less weight gain and less sedation than most other SGAs.

Metabolism of lurasidone occurs via CYP3A4 (Greenberg & Citrome, 2016). Lamotrigine is a sodium channel blocking antiepileptic drug that is also a mood stabilizer (Stahl, 2013). Per Stahl (2013), lamotrigine lowers levels of glutamate, an excitatory neurotransmitter. Schwartz (2017) cautions that lamotrigine requires a slow, specific titration to reduce the risk of Stevens-Johnson Syndrome. Metabolism of lamotrigine occurs via glucuronidation and glucuronic acid conjugation (Werz, 2008).

In order to adequately treat bipolar disorders, a practitioner must begin with an accurate diagnosis. Establishing the correct diagnosis of bipolar disorder is crucial, as it helps guide the appropriate treatment plan (APA, 2013). Misdiagnosis is common, with many individuals initially receiving a diagnosis of major depressive disorder before their bipolar disorder is correctly identified (Hirschfeld et al., 2003).

Once a therapeutic focus is established, the practitioner must work with the patient and their family to address concerns about side effect profiles and

discuss treatment strategies that will work best for the patient's needs. Medication management is a key component of bipolar disorder treatment, but patients often have concerns about potential side effects (Sajatovic et al., 2010). Engaging the patient and their support system in shared decision-making can help ensure the treatment plan aligns with the patient's preferences and values (Sadock et al., 2015).

In addition to medication management, psychotherapy is an essential component of comprehensive bipolar disorder treatment (Miklowitz & Chung, 2016). Cognitive-behavioral therapy (CBT) and interpersonal and social rhythm therapy (IPSRT) have been shown to improve mood symptoms, reduce the risk of relapse, and enhance medication adherence in individuals with bipolar disorder (Deckersbach et al., 2014; Frank et al., 2005). Psychoeducation, which involves educating patients and their families about the nature of bipolar disorder and effective self-management strategies, has also been linked to better treatment outcomes (Reinares et al., 2014). By addressing the psychological, social, and lifestyle factors that can influence the course of bipolar disorder, psychotherapy can work in tandem with pharmacological interventions to promote long-term stability and well-being (Miklowitz, 2008). Pharmacological interventions are a cornerstone of bipolar disorder treatment, with second-generation antipsychotics (SGAs), anticonvulsant mood stabilizers, and traditional mood stabilizers playing key roles (Malhi et al., 2017).

SGAs like aripiprazole (Abilify) have been shown to be effective in treating both the manic and depressive episodes of bipolar disorder, with a relatively favorable side effect profile compared to first-generation antipsychotics (Keck et al., 2003). Antiepileptic drugs (AEDs) such as lithium, valproate, and lamotrigine have also demonstrated efficacy in stabilizing mood, reducing relapse risk, and preventing recurrence of bipolar episodes (Geddes & Miklowitz, 2013). Additionally, combination therapy with a mood stabilizer and an SGA can provide enhanced symptom control and improve long-term outcomes for many patients with bipolar disorder (Tohen et al., 2002). By tailoring pharmacological treatment to the individual's needs and clinical presentation, clinicians can help patients manage the complex and often unpredictable course of this chronic condition.

Anxiety Disorders

For the sake of clarity, this section defines anxiety problems as symptoms consistent with diagnoses of social anxiety, generalized anxiety, separation anxiety, specific phobias, and/or panic. Anxiety problems are some of the most prevalent difficulties experienced by children and adolescents. In addition, researchers (Racine et al., 2021) speculate the stressors associated with the Covid-19 pandemic are contributing to increasing rates of depressive and anxiety-based symptoms. Racine et al. (2021) suggest approximately 20.5% of children and adolescents reported clinically significant levels of anxiety. Further, they suggested nearly 25.2% reported clinically significant levels of depressive symptoms.

They stated females tended to report more problems than males and older adolescents reported more problems with depressive symptoms. Other sources estimate the prevalence of anxiety disorders amongst children and adolescents at even higher levels, nearly 32% overall, roughly 38% in females, and 26.1% in males (Any Anxiety Disorder, n.d.). Differentiating anxiety from depressive problems may prove difficult at times, but the treatment of the two often overlaps, fortunately.

Walter et al. (2020) recently put forth empirically supported guidelines for the treatment of anxiety problems in children and adolescents. They recommended the use of CBT in treatment of the aforementioned anxiety problems. Specifically, they reported the benefit of CBT outweighed the potential harm of using CBT, but classified the strength of the evidence in favor of CBT's efficacy as low.

They also recommended the use of SSRIs in the treatment of anxiety problems, reporting the benefits outweigh the harms and the strength of evidence for use of SSRIs fell within the moderate range. They stopped short of recommending any specific SSRI for any specific anxiety problem, but mentioned fluoxetine, fluvoxamine, paroxetine, and sertraline possessed the most research in their use, which allowed them to undergo investigation more easily than other SSRI agents. They urged caution regarding the SSRI's side effect profile, particularly the possibility of increased suicidality and induction of manic or hypomanic symptoms. Leonte et al. (2019) cautioned that use of serotonergic agents might increase anxiety or agitation in children and adolescents.

In addition, Walter et al. (2020) offered suggestions for the use of a combination of CBT with SSRI and monotherapy involving SNRIs. They discussed research combining sertraline and CBT, which proved superior to sertraline alone, but that finding appeared inconsistent and did not replicate across use of other SSRIs. Again, they stopped short of recommending any specific agent, but mentioned venlafaxine and duloxetine possessed the most research in their use, which allowed them to undergo investigation more easily than other SNRI agents. They point out that the side effect profiles of SNRIs are similar to SSRIs, but venlafaxine may possess greater risk for increases in suicidality and less safety in overdose than other SNRIs. Further, they report duloxetine may possess a greater risk of liver problems than other agents. Per Leonte et al. (2019), fluoxetine, sertraline, fluvoxamine, paroxetine, and venlafaxine demonstrated efficacy in treatment of various anxiety disorders in children and adolescents. They suggest TCAs (primarily imipramine) demonstrated efficacy in the treatment of some anxiety disorders, but discourage use of those agents due to side effect burden. They reviewed trials of buspirone, benzodiazepines, psychostimulants, SGAs, and TCAs as augmenting agents, but found little to no support for their use. They reviewed evidence regarding use of benzodiazepines as monotherapy and reported some efficacy, but concern regarding side effects.

If a clinician prescribed benzodiazepines, agents with a long half-life would be preferable in most cases, such as clonazepam. They reported limited support for use of guanfacine in treatment of pediatric anxiety, but that appeared to stem from a single pilot study. Leonte et al.(2019) suggest use of CBT as an efficacious augmentation strategy in the treatment of pediatric anxiety disorders.

They also recommended the use of SSRIs in the treatment of anxiety problems, reporting the benefits outweigh the harms and the strength of evidence for use of SSRIs fell within the moderate range. They stopped short of recommending any specific SSRI for any specific anxiety problem, but mentioned fluoxetine, fluvoxamine, paroxetine, and sertraline possessed the most research in their use, which allowed them to undergo investigation more easily than other SSRI agents. They urged caution regarding the SSRI's side effect profile, particularly the possibility of increased suicidality and induction of manic or hypomanic symptoms. Leonte et al. (2019) cautioned that use of serotonergic agents might increase anxiety or agitation in children and adolescents. In addition, Walter et al. (2020) offered suggestions for the use of a combination of CBT with SSRI and monotherapy involving SNRIs.

They clarify that those suggestions indicate the benefit of using those interventions probably (a lower degree of certainty than the above paragraph) outweighs the risk of harm, but the strength of evidence for use of each was low.

They discussed research combining sertraline and CBT, which proved superior to sertraline alone, but that finding appeared inconsistent and did not replicate across use of other SSRIs. Again, they stopped short of recommending any specific agent, but mentioned venlafaxine and duloxetine possessed the most research in their use, which allowed them to undergo investigation more easily.

Leonte et al. (2019) described mixed results when attempting to determine whether therapy proved more efficacious than medication. They described a combination of therapy and medication as generally more efficacious than either intervention alone when treating anxiety problems in children and adolescents, but later seemed to suggest this applied to more severe anxiety symptoms than mild to moderate anxiety symptoms. It makes logical sense that adding two items together produces a larger total product or gain, but such does not always hold true in research or clinical practice.

In regards to first-line treatment of mild to moderate symptoms of anxiety in children and adolescents, Leonte et al. (2019) recommend CBT. Should that fail, they recommend adding a SSRI to CBT, which is also their recommended first-line treatment for severe symptoms of anxiety in children and adolescents. Should that fail, they recommend considering another SSRI, then a SNRI, and then perhaps use of a benzodiazepine, short-term.

In applied clinical practice, selection of treatment approach will likely depend on available resources, whether that be financial, transportation, clinicians certified in CBT, and family treatment preference.



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

1) A mother brings her 16-year-old son to your office. She reports a family history of bipolar disorder and is convinced her son is showing symptoms of bipolar depression. She states he is sleeping more than usual, wanders around as though he is in a fog, has been eating more and gaining weight recently, spends a lot of time in his room, and has been cleaning his room frequently, as it usually smells of air freshener.

What is the LEAST APPROPRIATE course of action?

- a) Complete a clinical interview with the family and ask the son to complete a drug screen.
- b) Complete a clinical interview with the family and ask the son to complete a personality inventory.
- c) Discuss a trial of lamotrigine with the family.
- d) Discuss a trial of CBT with the family.

2) You arrive at the local emergency department for the purpose of a consultation. The patient is a 13-year-old female. Her family brought her in due to erratic behavior. The family reports that for the past several days she has been sleeping a couple of hours at night, talks quickly, and has cleaned the entire home several times. The medical doctor on staff would like your opinion on administering a dose of haloperidol IM.

What is your MOST APPROPRIATE course of action?

- a) Offer to help hold the girl down during the haloperidol administration.
- b) Offer to speak with the girl and her family and ask whether she would be willing to take a pill to help her calm down.
- c) Offer to help find long-term psychiatric placement as bipolar disorder is a life-long condition.
- d) Offer advice to the medical doctor that haloperidol is not the best option and discuss a trial of another agent with the doctor.

3) Which pairing of medication and side effect is LEAST CORRECT?

- a) Lamotrigine – Stevens-Johnson Syndrome
- b) Olanzapine – Weight Gain
- c) Lithium – Acne
- d) Lurasidone – Sedation

1) A mother and daughter arrive at your office for medication consultation. The mother reports a long history of anxiety problems and that the daughter is beginning to struggle with similar problems. The mother states her doctor prescribed imipramine for her anxiety and she has taken it for 20-years. She would like you to prescribe that medication for her daughter. What is your MOST APPROPRIATE response?

- a. Decline to prescribe imipramine and explain to the mother that there are safer medication options.
- b. Prescribe imipramine as that is the reason for the consultation and there is research to support its use in children.
- c. Prescribe fluoxetine as that is the reason for the consultation, you are the expert, and fluoxetine is a more appropriate first-line agent.
- d. Decline to prescribe imipramine, explain your reasoning, and discuss the benefits vs harms of various therapy and medication options.

2) You are completing an evaluation on a 17-year-old obese male. He endorses numerous physical symptoms of anxiety including dizziness, nausea, chest pains, and tingling sensations in his fingers.

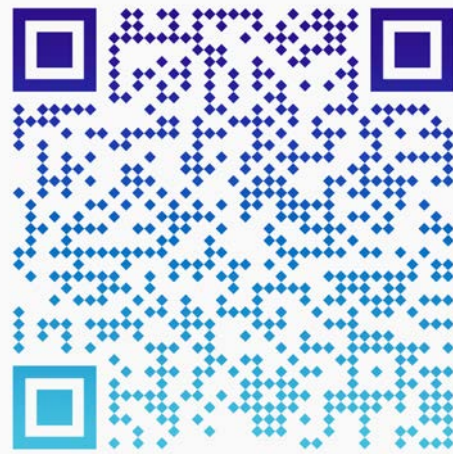
What is your MOST APPROPRIATE course of action?

- a. Discuss his cultural background, family situation, and treatment preferences.
- b. Discuss the potential benefits of diet and exercise along with a regimen of CBT.
- c. Refer him to the emergency department immediately.
- d. Refer him for lab work due to his physical health status.

3) All of the following pairs of medications and their primary mechanisms of action are correct EXCEPT:

- a. Sertraline – Inhibition of serotonin reuptake
- b. Clonazepam – Enhancement of glutamate functioning
- c. Venlafaxine – Inhibition of serotonin and norepinephrine reuptake
- d. Buspirone – Agonistic actions at 5HT_{1A}

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SOCIETY FOR
PRESCRIBING PSYCHOLOGY

APA Division 55

2024: A Year in Review

Twas the Night Before Prescribing

Twas the night before prescribing, and all through the lab,
Not a creature was stirring, not even a tad.
The journals were stacked by the bedside with care,
In hopes that new findings soon would be there.

The psychologists nestled all snug in their beds,
While visions of therapies danced in their heads.
And I in my lab coat, with notes all around,
Had just settled in for some knowledge profound.

When out on the desk there arose such a clatter,
I sprang from my chair to see what was the matter.
Away to the window I flew like a flash,
Tore open the shutters, and threw up the sash.

The moon on the crest of the new-fallen charts
Gave a glow to the data that warmed all our hearts.
When what to my wondering eyes should appear,
But a sleigh full of studies, and eight tiny peers.

With a little old driver, so lively and spry,
I knew in a moment it must be our guy.
More rapid than eagles, his findings they came,
And he whistled and shouted and called them by name:

“Now, Freud! Now, Jung! Now, Skinner and Beck!
On, Rogers! On, Adler! On Ellis and Watson! Let’s give it a tech!
To the top of the charts! To the top of the pile!
Now dash away, dash away, let’s do it in style!”

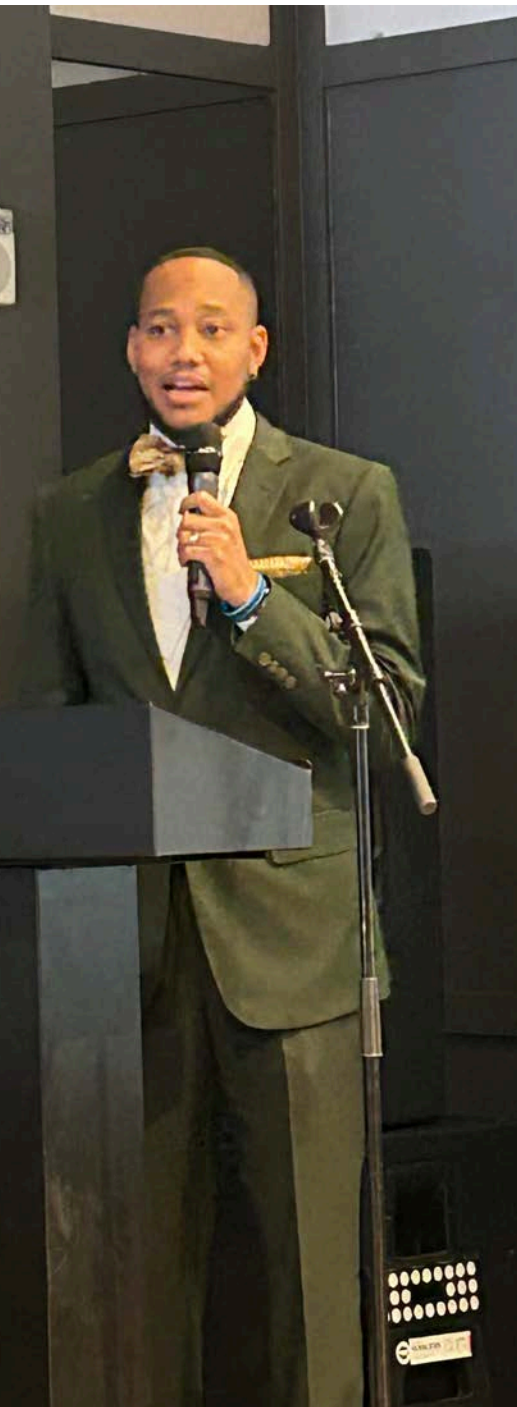
So, as we reflect on the year that has passed,
Let’s celebrate progress, and make it last.
With laughter and science, we’ll take on the night,
Happy prescribing to all, and to all a good night!

J. Riser, 2024











Page 31 Pictured:

- 1) 2024 President of Division 55 Steve Curtis (seated), current 2025 president Lynette Pujol (standing) at the 2024 APA convention in Seattle
- 2) President Elect and Chair of Research Council Lynette Pujol awarding a Research Travel Grant to Ashley Whitworth at the 2024 APA convention
- 3) RxP Debate Panel, seated left to right, Judi Steinman, Derek Phillips, David Shearer, and Daniel Goldberg at NJPA convention 2024 october. Dr. Goldberg, who served as the opposition to RxP speaker, holding microphone. Note that after the NJPA convention the NJPA Board voted to pursue RxP as a legislative priority.

Page 32 Pictured:

- 1) Judi Steinman presenting at RxP panel debate at NJPA conference. Seated left to right: Derek Phillips, David Shearer, and Daniel Goldberg
- 2) From left to right: Keith Peterson, David Shearer, and Steve Curtis
- 3) David Shearer presenting at the New Jersey Psych Association Conference October 2024

Page 33 Pictured:

- 1) David Shearer presenting a panel debate about RxP at the NJPA conference. Seated behind Shearer, left to right, Judi Steinman, Derek Phillips, and Daniel Goldberg
- 2) At dinner during APA 2024 in Seattle. From left to right, David Shearer, Roger Clark, Jane Curtis, and Steve Curtis.
- 3) At APA 2024, Steve Curtis, Division 55 President (far right) awarding Conwell Smith (center) with an Outstanding Work in Expanding Prescriptive Authority for Psychologists Award. David Shearer, past Division 55 President, on left.

Page 34 Pictured:

- 1) President Elect and Chair of Research Council Lynette Pujol awarding a Research Travel Grant to graduate student Kira Charles at the 2024 APA convention
- 2) Steve Curtis, Division 55 president, presenting the Outstanding Work in Expanding Prescriptive Authority for Psychologists Award to Nancy Klein at the 2024 APA conference
- 3) Brian Humphrey presenting at NJPA convention in October 2024 on Integration of Psychopharmacology in Private Practice
- 4) Jamie Wilson and two ASL interpreters at APA 2024

Page 35 Pictured:

- 1 & 6) Beth Rom Rymer presenting at NJPA convention 2024 Keynote speaker
- 2) Judi Steinman presenting at APA 2024 with interpreter in the foreground.
- 3) David Shearer Presenting on New and Novel Drugs at NJPA convention Oct 2024
- 4) President Elect and Chair of Research Council Lynette Pujol awarding a Research Travel Grant to Jenna Martinez at the 2024 APA convention
- 5) President Elect and Chair of Research Council Lynette Pujol awarding a Research Travel Grant to graduate student Kelsy Yeats-Fleegel at the 2024 APA convention

Answer Key (Bipolar Disorder):

1) Answer: C: Completion of a clinical interview is appropriate in this scenario. Asking the young man to complete a personality inventory would be reasonably appropriate, as his symptoms are atypical of bipolar depression. Asking the young man to complete a drug screen would be reasonably appropriate, as his behaviors may indicate he is trying to hide substance use. Discussing a trial of CBT-based family therapy is not appropriate at this time, but is at least not physically dangerous or life threatening. Discussing a trial of lamotrigine is not appropriate at this time and is the least appropriate option as lamotrigine can potentially cause Stevens-Johnson syndrome, which can be life threatening. In addition, CBT-based therapy is appropriate for numerous problems, while lamotrigine's usefulness is limited to only a few specific situations/conditions.

2) Answer: B: Though the girl is exhibiting behaviors often associated with a manic episode, there is no evidence to suggest she is in immediate danger or immediately dangerous to herself or others. Offering to hold the child down to administer an injection is as inappropriate as it is uncalled for and dangerous. The possibility of long-term placement may be appropriate in the future depending upon response to treatment and numerous other factors, but is neither appropriate nor necessary at this time. Discussing the use of another agent with the doctor is the most appropriate option thus far, but it does not account for the child or family input. Discussing treatment with the girl and her family is the most appropriate option. This option is most desirable in that it allows for a less invasive treatment than an injection. If the patient is willing to try an oral medication in place of an injection in this situation, that invalidates the need for a forced injection, may help further establish a working relationship, and may help with treatment compliance in the future.

3) Answer: D: Lamotrigine is often associated with the risk of Stevens-Johnson syndrome. Olanzapine is often associated with weight gain and metabolic problems. Lithium is often associated with acne as well as a myriad of other problems. Lurasidone is one of the least sedating SGAs and would not be commonly associated with sedation.

Answer Key (Anxiety)

1) Answer: D: Without adequate rapport and a proper therapeutic alliance, treatment compliance falls apart. Explaining to the mother that safer options than imipramine exist is not a bad start, but there is a better answer.

Fluoxetine is an appropriate first-line agent, but adopting the stance that one is an all-knowing expert will typically not help establish rapport nor promote treatment compliance. Discussion of treatment options, potential risks, potential benefits, etc. is a part of the informed consent process and the best approach of the available answers.

2) Answer: C: The young man in the vignette may suffer from anxiety, but may also be experiencing a myocardial infarction, which is bad and requires immediate medical attention. The other three options could be appropriate if it were not for the potentially life threatening cardiac emergency.

3) Answer: B: Clonazepam is a benzodiazepine and enhances the functioning of GABA. The other responses are correct.

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**HAPPY HOLIDAYS FROM
THE SOCIETY FOR
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