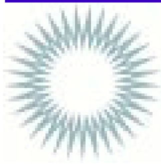

NAPPP NATIONAL ALLIANCE of PROFESSIONAL PSYCHOLOGICAL PROVIDERS

March 2024
Volume 19 No. 2

The Clinical Practitioner

The Psychology of Lying

By Keith Petrosky, Ph.D., ABMP

Lying presents some challenges to the therapist. A patient can announce on their first visit that they are a compulsive liar and invite the therapist to challenge them on a regular basis to ensure that they are not lying. This is not all that helpful since if they say they are not lying that could also be a lie. I was victimized once by such a patient who I falsely believed was seeking help to stop this pattern of behavior. That was what he told me, but of course he was lying. He presented a false insurance card from a job that he had been terminated from. When his office voicemail stopped accepting messages he stopped coming for appointments and vanished. He was from a wealthy family (which I was able to confirm) in one of the toniest, "old money," neighborhoods in Connecticut and he promised that his parents would pay any unpaid balance that he owed. However, that did not happen.

This individual would lie to his wife about receiving promotions at work that he did not receive and then celebrate his "success" by purchasing thousands of dollars' worth of new furnishings for their house. They had two small children whose financial support was being threatened by this behavior but he was able to get his wealthy parents to pay off six figure amounts on credit cards from time to time to keep their family afloat. His real reason for coming into therapy remains unknown. However, it would seem that he wanted to tell someone about his "secret life" of deception without changing anything. It did not appear to have anything to do with any guilt.

Brain Mechanisms Involved in Lying [1,2]

Lying involves not just suppressing the truth but substituting something else which involves having the brain work harder. People take longer to respond when lying, probably because the act of deception involves simultaneous coordination of multiple regions of the brain [3]. The prefrontal cortex, which controls executive function, is important in deception as it involves problem solving and planning. Functional MRI studies have shown increased activity in this area during lying. The amygdala, which is involved in emotional responses, also plays a part in lying and it becomes more active when the person is expressing deception. The anterior cingulate cortex is involved in detecting conflicts and monitoring errors. During lying it also shows increased activity, presumably because the brain is grappling with the conflict between truth and deception. The caudate nucleus plays a role in decision making during lying. The thalamus, which relays sensory information to different brain regions, also shows increased activity presumably because of the cognitive effort to maintain a false narrative.

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There is some evidence from a few functional MRI studies that show that the increased activity in the amygdala seen in persons who are lying tends to decrease as they lie repeatedly in experiments that incentivize lying for financial gain. This would seem to support the idea that people who lie repeatedly become more comfortable with this behavior over time. This may help this type of person hide the behavioral indicators of lying such as looking away, changing the subject, etc.

Ordinary Lying

Admitting to at least some occasional lying is part of the MMPI's validity scales to ensure someone is not "faking good." Everyone tells some white lies to not hurt others' feelings or to get out of having to do something they don't want to do. For example, they may say: "I can't come to your party this weekend because I have a family event," knowing that this lie will not affect anything important. People can lie by adding, omitting, or distorting information in either a positive or negative direction.

Pathological Lying [4]

The cause of pathological lying isn't established and there has been limited research on this subject. Mental health conditions that are associated with pathological lying include personality disorders such as antisocial personality disorder, borderline personality disorder, and narcissistic personality disorder. Lying is also associated with Factitious Disorder and Munchausen Syndrome by Proxy.

Lying to manipulate, as in the case of a sociopath seeking to swindle someone out of some money, makes logical sense in that it is purposeful and geared toward a certain goal or outcome. However, lying without a reason to lie, which can occur in pathological lying (aka pseudologia fantastica), is more unusual and bizarre. Estimates of the percentage of people who may show pathological lying behavior vary from 8-13 percent of the population. Pathological liars will often lie indiscriminately, even about minor events, and may feel a rush about getting away with lying. If they are confronted with the truth they may continue to lie. The fear of being caught does not seem to have much effect on their behavior. For some people persistent lying can be a form of OCD in that there is an urge or compulsion to do this much like the need to check the locks on windows and doors.

Pathological liars that I have had as patients will sometimes admit that they make things up that do not serve any purpose. For example, one of these people may tell their spouse that they stopped at a convenience store on the way home when they

did not do so. They may make up a conversation with someone at the store that didn't occur. These behaviors are not based on having to explain coming home a few minutes late because of having a jealous spouse. They could just as easily tell the truth about leaving work ten minutes later than the typical time for them.

Young adults who have engaged in this type of lying over time will sometimes attribute it to a "habit" that got started when they were a teenager and needed to make up things to elude very strict, parental control. In other words, to have more freedom to do the things that their peers were doing they may have felt the need to make up something like being invited for a sleepover at some friend's house when they actually had secret plans to do something else. If they accidentally stayed out later than their curfew, they might find it necessary to invent an excuse to avoid a parental scolding or being grounded. They might manufacture something believable that could have delayed them like being pulled over at a police checkpoint set up for sobriety testing. Having done this over a long period of time they will sometimes say that they now have developed a habit of continually lying. Such individuals sometimes become so comfortable and confident in their lying that they can look right at you and show no sign of deception- no darting eyes or furtive glances, no nervous changes in body position. One wonders if they would show a GSR response on a biofeedback machine or lie detector.

Major and Minor Sociopaths

It is reasonable to assume that most sociopaths lie more than the average person. Sociopaths vary from monsters who are serial killers, capturing people that they keep in the basement and abuse, to people who fleece people of their life savings like Bernie Madoff. There are corporate executives like one vice president of a hospital corporation (in the news) who added several fictitious academic degrees to his resume. This was quite hypocritical since he was the executive in charge of adding new physicians to the hospital system, which involved carefully vetting their credentials. His explanation that an administrative staff member must have accidentally added these credentials to his resume while re-typing it was not believable. However, his boss announced that he would not be terminated for his duplicity since he was otherwise doing a good job.

There are also corporate workers who will manufacture lies about their competitors to halt their progress in gaining a promotion. At other times these same people may lie in order to take credit for the work of others with which they had no collaboration and did not oversee. People who are alcoholics or drug users typically lie to their partners to hide their substance abuse. The same is true for people who are serial philanderers who make up various reasons to be out of the house in order to pursue their sexual interests or addictions. Politicians regularly lie to those on opposing sides of an issue, essentially acting like "double agents" and will "take down" any rivals by making up lies to keep them from winning an election. They would not be affected by the degree of falseness of the accusation or the degree of harm to the other person's reputation. The fact that the other person is a good and decent person would not even enter the picture in terms of, in some cases, an animalistic drive to gaining and maintaining political power. One might speculate, as in Machiavelli's "The Prince," that they may justify their actions on the basis that they may be able to do something better than their rivals who are more ethical and decent as human beings.

Lying as an Expression of Immaturity

Sometimes people tell lies because of immaturity or some other personality-based issue. I once worked with a recent medical school graduate who would embellish things that had occurred and even tell stories that were completely fabricated. People who knew him did not believe him and secretly made fun of him behind his back. In my own view I thought he was a person who wanted more attention than he would otherwise receive if he stopped manufacturing these dramatic stories. His stories typically involved some situation where he exhibited bravado in response to some confrontation by someone or he would boast about romantic conquests with obliging females that were manufactured rather than real.

I have also known some people who will retell a story about a real person that the listener might or might not actually know but then change the ending to get a bigger and better response from the listener. The fact that there may be people present who know what really happened does not seem to have any effect on stifling their embellishments. A song by the offbeat music duo of Courtney Barnett and Kurt Vile [5] expresses this nicely: "I was friendly with this girl… she told outrageous stories. I believed them 'til the endings were changing from endings before."

An Example of Habitual Lying in a Famous Person

Robert Allen Zimmerman – Clinton Heylin's biography about Bob Dylan, "The Double Life of Bob Dylan" [6], provides a portrait of a man who develops and reinvents an inauthentic version of himself a number of times. Documentaries about Dylan, such as D.A. Pennebaker's "Don't Look Back," give the impression of Dylan as playfully poking fun at members of the "un-hip" media as he gives absurd answers to their various questions. However, Heylin's biography about the early part of Dylan's life (1941-1966) reveals Dylan to be not just a "merry prankster" teasing members of the press but a compulsive prevaricator for reasons that are unknown.

Part of Dylan's initial motive to engage in telling untruthful things about himself may have been a tendency since childhood to not want to share any personal information with others. However, Dylan would also fabricate lies for no apparent reason. One of Dylan's contemporaries in the Folksong Scene, Dave Van Ronk, commented: "You never could pin him down on anything. He had a lot of stories about who he was and where he came from, [but] he never seemed to be able to keep [any of] them straight." Another observer, Ian Bell, noted: "He lies outrageously, lies when there is no need, habitually, even compulsively."

In reading Heylin's biography of Dylan, the reader becomes aware that almost any historical detail of Dylan's life has at least several alternatives involving different people, different dates, and different sequences of events so that there is virtually nothing that can be conclusively said about him. Even his adoption of his performing name (which was changed to his legal name), which is often attributed to being taken from the poet Dylan Thomas, has been disputed by him as if he came up with it by some personal inspiration from within.

Having come to New York City from the industrial, iron ore city of Hibbing, Minnesota, Dylan presented himself as being from New Mexico. At other times he said he had lived in Marysville, Kansas and Sioux Falls, South Dakota, and other places. He told some people he had been previously employed as a miner which may have been fashioned from Hibbing's role in iron mining during World War Two. However, with the soft hands and cherubic face that were noted by many people who met him, he certainly did not have the appearance of a miner.

He also claimed to have been raised by a succession of foster parents. In reality he had been born in Duluth and spent his whole life in Hibbing where his family owned an electrical store where he sometimes worked with his father. He grew up in a not very religious, but culturally Jewish, family and became bar mitzvahed and attended overnight summer camps along with his fellow youth from Jewish families in this same area. He spent a year at the University of Minnesota in Minneapolis where he joined a fraternity before dropping out with the intention of reinventing himself as a music artist.

Dylan's girlfriend during his early days singing at Café Wha' in New York's Greenwich Village, Suze Rotolo, who was forever memorialized alongside him on the cover of his "Freewheeling" Album, became acquainted with Dylan through her family who were involved in the music business. Dylan appeared to be quite smitten with Suze although she began to pull away after she realized Dylan was more interested in himself and in his future fame than in their relationship. Suze's mother, Mary, disliked Dylan because of his constant lying and said she knew even when he first introduced himself that Dylan was not his real name. She encouraged her young daughter to study abroad in Italy for a few months which was intended to help break up the romance. One can sympathize with a parent having some concerns about their daughter dating someone even potentially

on the rise to future fame when they appear to have a character flaw of not telling the truth. After all, trust, as we know, is the basis for all human relationships.

Transition from Folk Singer to Rock and Pop - Initially, Dylan wanted to be a rock and roll star like Buddy Holly and made "demos" of records like Elvis Presley's "That's Alright Mama." As noted by many people before and since, he did not have a great singing voice and was sometimes yelled at by people who knew him to "shut up" when they had heard enough. Dylan made a number of unsuccessful attempts to enter the world of rock or pop music. As one example, he auditioned to be a piano player for the music artist Bobby Vee who had the hit song "Take Good Care of My Baby" but missed out when they decided they did not need a piano player after all. He played harmonica on a recording by Harry Belafonte but did not get other harp playing gigs.

Dylan saw what he thought was an easier pathway into the music business through folk music which was popular at the time. He borrowed records from record collectors (like Suze Rotolo's family) and fellow musicians (like Dave Van Ronk) in order to practice imitating folk singers and their guitar playing styles, in particular Woody Guthrie, Ramblin' Jack Elliot, and Robert Johnson. When called out on his obvious imitation of these singers he denied it. He would not admit that he copied their singing from records but instead told people that he had learned these songs from hoboes he met "on the road," perhaps a romantic allusion to Jack Kerouac's novel. However, all the while when he was performing folk music in Greenwich Village on his acoustic guitar, and occasionally visiting Woody Guthrie in the hospital where he was living with Huntington's Disease, he already owned an electric guitar that his mother had purchased for him from Sears.

Civil Rights Songs - While Dylan put out some protest songs (e.g. The Death of Emmett Hill and the Lonesome Death of Hattie Carroll) he had no real interest in civil rights but was just interested in a topical story for a song. This presented a disingenuous image of himself as a civil rights crusader (like his later girlfriend Joan Baez) when it was a just a practical way to get a song published. The inspiration for for these songs probably grew out of the Old English and Scottish historical ballads that were sometimes performed as part of folk music at that time. Dylan's girlfriend, Suze Rotolo, had been involved in some groups working for social change, such as CORE, and that may have also served as an influence in his writing these songs. Dylan did not continue making news inspired songs because he wanted to produce a music legacy for future generations that would be universal and enduring like a painting by Rembrandt (his example).

Dylan was greatly helped in his career because of the positive attention he received from the lyrics of his songs and this probably saved him from being one of the many that tried and failed to make it in the music industry. In those days music publishing was where the money was and his first hit record ("Blowin' in the Wind") captured the attention of Albert Grossman with the lyric: "How many ears must one man have before he can hear people cry." The music itself was a traditional song that he altered with new words.

Ironically, Dylan's false statements about himself worked greatly to his advantage in regards to his first recording contract with Columbia. They had offered him the standard, two percent of the sale price of a record when he signed it. The music industry in those days took advantage of new artists in exchange for helping them to become famous, after which they might negotiate a better contract. However, Dylan was a minor when he signed this contract without a lawyer present and without a parent's co-signature. Dylan had lied to the record company about his parents being dead and having no living relatives. When his agent renegotiated the contract Dylan then received five percent of the sale price.

Dylan has re-invented himself a number of times during his career which has helped him sustain his popularity. Most musical artists lose their audiences over time as they move on to new interests. Dylan, however, has forever been changing right along with his audience and this has allowed him to attract new followers as old ones drift away. At the early part of his career, he transitioned from the cloth cap wearing version of himself as a folk singing vagabond to a cooler, leather jacket wearing, electric guitar playing artist who wrote original songs such as "Like

a Rolling Stone." At the Newport Jazz Festival he was loudly booed by his faithful followers for his new electric style of performing but he was undeterred by their reactions. He simply replaced them with a new group of fans. Since that time, he has gone on to adopt several musical styles that have allowed him to have a lifelong career as a musician and songwriter. Albert Grossman's decision to take Dylan on as agent based on his songwriting potential was proven true many times over as Dylan would eventually receive a Nobel Prize in literature, more specifically for "having created new poetic expressions within the great American song tradition."

Will Compulsive Lying Be Included in the Next DSM ?

While pathological lying is not a mental health diagnosis in the DSM 5, a 2020 study defined pathological lying as constantly telling five or more lies in a period of 24 hours, every day, for longer than 6 months [7]. This sounds a lot like the criteria that are listed in the DSM for a "mental disorder." If so, one might ask if a person would qualify as meeting the criteria for the condition if they told just four lies during one day or skipped a day between telling lies. The absurdity of defining everything behaviorally is just one of the many things that can be said about the process of developing these diagnoses by majority opinion of selected academics impaneled to make these judgments. If compulsive, pathological lying does qualify for its own diagnosis, naturally the next step in this pharmaceutically oriented manual would be to medicalize this behavior as a "brain disorder" and to identify possible medications to treat it. If so, I would predict that they will recommend a serotonin medication since SSRIs are the panacea used for practically anything except for people suspected of having Bipolar Disorder.

Summary

In summary we have discussed the various forms of lying in this article, including ordinary lying that normal people do (known as "white lies") to more pathological lying the motives for which can be complex and varied. I do not believe that pathological lying by itself will ever rise to be a new DSM diagnosis but rather I believe it will remain a symptom of other diagnosable conditions. However, **the lying patient presents a challenge to the therapist** who cannot even be sure that they are telling the truth even when they confront the patient about their veracity on a regular basis. I invite the reader to offer their own vignettes regarding working with compulsive liars in therapy if anyone wishes to do so. Perhaps we can share these in a future article.

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

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In My Opinion

The Pendulum Swing in US Clinical Practice

By Jerry Morris, Psy.D., ABMP

Recently, Dr Petrosky alluded to the Ketamine move in the seeming torrent of medical and pharmaceutical establishment's now apparent play book of developing new categories of medications to keep the revenue and services flow strong once the science and public education make patients aware of the very meager positive effect, limited duration due to accommodation/pooping out, and inadequate treatment evident by medication (especially medication only) approaches to mental disorders. We have viewed NAPPP's white paper exposing the underwhelming efficacy of antidepressants and psychotropic techniques in treating mental illness.

Drs. Caccavale, Dr. Rubin, and I have published on the limited efficacy research on aesthetics (now they are pushing Ketalar, ketamine/ketoprofen/lidocaine topical, ketamine/midazolam/ondansetron systemic), methylphenidate and similar drugs in the treatment of ADHD and pooping out evidence after 18-24 months, and the STARD, and NICE studies showing limited difference (though) weak overall outcome differences between antidepressants and neuroleptics. Still, the junk science, poor ethics, marketing ploys, and outright falsification of efficacy research has become well known and chronicled.

The American Board of Medical Psychology in consort with NAPPP got the Chief Psychiatrist of the FDA to publish a letter indicating that no well-trained physician believes that a medication only approach is adequate treatment for a mental disorder. Yet, we see scientifically goofy, but monetarily rewarding (for pharmaceutical houses and physicians) recommendations of medication techniques like Ketamine, LSD, amphetamine and related drugs, antidepressants, and neuroleptics as stand-alone treatment approaches, and selling these drugs at budget crippling rates. In 2023, total drug company sales reached over $38 billion, and this was a 5% increase and a 14% growth when adjusted for the Covid epidemic. In 2021 Americans spent over $550 billion on medicine. In 2022 the eight biggest pharmaceutical companies reported $10 billion in profits. Over 3% of the US GDP is from the biopharmaceutical industry.

Most patients with mental illness get medication only techniques and most from general physicians with little depth diagnostic or treatment training relative to mental disorders. Still, the powerful marketing, tight merger between pharmaceutical companies and prescribers, and the well-known halo effect relative to these entities have resulted in little government regulation, efficacy evaluation of practice sites relative to mental disorders, and little refinement of regulation of the industries. No one really monitors and evaluates primary care centers and hospitals diagnostic accuracy and efficiency, treatment plan comprehensiveness and reasonability, and outcomes beyond a very cursory and superficial level. No one diligently and effectively evaluates these centers, where the majority of the mentally ill are treated vigorously enforces the adequacy of psychological staffing and availability and privileging at these facilities. These facilities have been exposed in articles and reports by many of us as inadequately staffed, with poor mental illness diagnoses, and inadequate or unethical and inappropriate treatment plans.

NAPPP has issued a policy statement that indicates the importance of getting a doctoral level practitioner with specialty in the diagnoses and treatment of mental disorders to assess and establish treatment orders and a treatment plan for the patient. Clearly, the current pattern of psychopharmacology and inadequate treatment and often goofy medication only approaches thrive upon and perpetuates this flaw in the US healthcare system and system design and enforcement. This situation, and especially after many of we psychologists and psychiatrists have written extensively about these flaws belies either ignorance and poor medical training in our nation's facilities, predatory and unethical patient care and facilities organization and management, or abject greed and

guild like practices. Huge medical and pharmaceutical lobbies and political contributions maintain these abuses of US patients and precious healthcare **resources**.

The clinical practitioner and patients are not only facing these obstacles to quality mental health care, but they are also facing massive cultural challenges in operating a psychology practice. Many Medical Psychologists and psychopharmacologists are well trained to challenge the inappropriate or inadequate treatments noted above and to provide accurate scientific reviews and patient and public education. But the clinical practitioner of the 2020s is also challenged to treat a changing culture. The nation is divided, fractionated, and groups are more hostile, rejecting, feeling persecutory illusions, and is regressive than in previous generations and probably since the Civil War and the Viet Nam War. Strong regressive energies push more and more individuals into childlike logic and totally inaccurate statements, threats, and violence, and undermining past cultural values of honesty, empathy, humanism, and Christianity. The culture is faced with coping with school and mall mass shootings, media propaganda, sect supporting alternate realities, and infantile acting out against others, institutions, and the Government. Personalities that previously would be clearly identified as personality disorders, or even psychotic are now revered as acceptable, understandable, or even leaders, righteous rebels, or even patriots and saviors.

In this national cultural environment, there is strong **pressure of clinical practitioners of mental illness** to avoid diagnoses of individuals and groups and institutions (well within our training and function in this society), to acquiesce to patient requests to leave them with their character defenses, delusions, and regressions and "simply give them a comforting drug." There will be even stronger resistance to careful and professional assessment and interventions to establish a working doctor-patient alliance against their mental illness and to maintain it long enough for enduring neuronal change.

In such an environment there will be a growing schism between actual curative psychotherapy and palliative medication avoidance of self-awareness, insight, and motivation to grow and change. Many, but not all, in the Medical Industrial Complex (that includes physicians, facilities, and pharmaceutical companies) will capitalize on this fractionation and will profit from the fleeing of many of the mentally ill into palliative rather than change oriented diagnoses and treatment. This situation will further separate the opportunists and the clinicians in the US healthcare system. There is not only a cultural divide and battle going on in this country but one that will intensify in the Medical Industrial Complex and the hapless Government regulation that has allowed its evolution. Medical associations, and in fact some psychiatrists will resent us knowing about these issues, and will, in fact, claim we are the unethical or distortive ones (in clear projective-identification defense), and others will join us in engaging the dilemma and national need!

The pendulum has swung to a regressive period in the US healthcare system and our culture. It is fraught with danger for some patients, society, and for clinical practice. However, this is hope and pendulums tend to reach their apical point and then swing back. NAPPP and many of our leaders have been courageous, scientifically informed, and ethical and concerned doctors addressing these issues **in our healthcare system**, **the mental health sector**, our culture, and outpatient care. Still, the clinical practitioner of this era will need exceptional skills, exceptional patience, and humility and acceptance of Jung's writings in the early 1900s (echoed by Dr. Caccavale to me on many occasions) indicating that not all patients have the capacity to be treatable and change! That realization is not a reflection on the doctor, but rather a sadness and feeling of helplessness in some situations that the doctor must master without damaging themselves or the disturbed individual!

Biogen pulls controversial Alzheimer's drug Aduhelm

The US Food and Drug Administration awarded accelerated approval to Aduhelm in June 2021, a decision that was highly contentious at the time because the agency overruled its own independent advisors, who found there was insufficient evidence of benefit.

At least three of the 11-member independent committee that voted unanimously against recommending the drug subsequently resigned, and US congressional investigators slammed the accelerated approval as "rife with irregularities."

Biogen said it was discontinuing Aduhelm to put more resources into Leqembi, a newer Alzheimer's medicine that was fully approved last year under the traditional regulatory pathway.

https://medicalxpress.com/news/2024-01-biogen-controversial-alzheimer-drug-aduhelm.html

Dr. Reinhardt: Not to mention is does not work and causes significant adverse effects.

Antipsychotic Medications and Mortality in Children and Young Adults

In a cohort of 2,067,507 Medicaid patients aged 5 to 24 years, antipsychotic treatment was associated with increased risk of death only for patients with doses greater than 100-mg chlorpromazine equivalents. Risk was not significantly associated with lower doses or with either dose in children aged 5 to 17 years.

This was a US national retrospective cohort study of Medicaid patients with no severe somatic illness or schizophrenia or related psychoses who initiated study medication treatment.

Current use of second-generation antipsychotic agents in daily doses of less than or equal to 100-mg chlorpromazine equivalents or greater than 100-mg chlorpromazine equivalents vs that for control medications (agonists, atomoxetine, antidepressants, and mood stabilizers).

The beginning study medication treatment filled 21,749,825 prescriptions during follow-up with 5,415,054 for antipsychotic doses of 100 mg or less, 2,813,796 for doses greater than 100 mg, and 13,520,975 for control medications. Mortality was not associated with antipsychotic doses of 100 mg or less but was associated with doses greater than 100 mg.

JAMA Psychiatry. Published online November 29, 2023. *doi:10.1001/jamapsychiatry.2023.4573*

Dr. Reinhardt:Subjects had "no severe somatic illness or schizophrenia or related psychoses".

Note: mortality is NOT compared to placebo, but rather to those receiving control medications (agonists, atomoxetine, antidepressants, and mood stabilizers).

WHY were these Medicaid insured children, ages 5-17, with no history of psychosis, poisoned? Should NAPPP, AMP and the APA bring legal action against these prescribers?

Major Drug–Drug Interaction Exposure Among Medicaid-Insured Children in the Outpatient Setting

This study aimed to determine the prevalence of major DDI exposure and factors associated with higher DDI exposure rates among children in an outpatient setting. Of 781,019 children with 2 medication exposures, 21.4% experienced a major DDI exposure. The odds of DDI exposure increased with age and with medical and mental health complexity. Frequently implicated drugs included: Clonidine, psychiatric medications, and asthma medications.

CONCLUSIONS: One in 5 Medicaid-insured children were exposed to major DDIs annually, with higher exposures in those with medical or mental health complexity. DDI exposure places children at risk for negative health outcomes and adverse drug events, especially in the harder-to-monitor outpatient setting.

https://publications.aap.org/pediatrics/article-abstract/doi/10.1542/peds.2023-063506/196380/Major-Drug-Drug-Interaction-Exposure-Among?redirectedFrom=fulltext

Dr. Reinhardt: As with the prior story, what science is being used to determine these chemicals are safe or appropriate for a 5 year old? Show me a study. The chemical salesmen are doing an excellent job, convincing physicians to prescribe poisons to children.

Psychotropic Polypharmacy Among Youths Enrolled in Medicaid

Concomitant use of medications for attention-deficit/hyperactivity disorder (ADHD), antipsychotics, mood-stabilizing anticonvulsants, and antidepressants is referred to as psychotropic polypharmacy. Over the past 2 decades, psychotropic polypharmacy in youths increased, raising safety concerns. Our goal was to examine trends from 2015 to 2020 in psychotropic polypharmacy among youths aged 17 years or younger who were enrolled in Medicaid to identify temporal changes and characteristics associated with psychotropic polypharmacy.

Across all years, 126,972 unique youths met the inclusion criteria. Psychotropic polypharmacy prevalence among youths who used psychotropics increased from 2259 of 53,569 youths (4.2%) in 2015 to 2334 of 50,806 youths (4.6%) in 2020. The 2015 to 2020 increase in psychotropic polypharmacy prevalence was observed for those with Medicaid eligibility from foster care (414 of 3824 [10.8%] and 387 of 3420 [11.3%]), CHP (225 of 10?354 [2.2%] and 222 of 7974 [2.8%]), and being from a low-income household (648 of 30?222 [2.1%] and 883 of 31?172 [2.8%]). The adjusted odds ratios (AORs) of psychotropic polypharmacy for the year was 1.04 (95% CI, 1.02-1.06), a 4% increase in the odds of psychotropic polypharmacy per year. The supplemental analysis revealed a significant increase in 2019 and 2020 relative to 2015. Psychotropic polypharmacy was significantly more likely among youths who were disabled or in foster care relative to youths in the low-income group. Individuals aged 10 to 14 and 15 to 17 years had significantly higher odds of psychotropic polypharmacy than those who were younger than 10 years. Black individuals or individuals who identified as other races (including individuals identifying as American Indian, Asian, Hispanic, or Pacific Islander, or other races) had significantly lower odds of psychotropic polypharmacy than White individuals

JAMA Netw Open. 2024;7(2):e2356404. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2815234

Dr. Reinhardt: Find a path for drug companies to get paid more and expect more sales of ineffective and harmful chemical restraints for kids. Medical Psychologists should take over ALL psychotropic prescribing to save our children.

The relationship of prenatal acetaminophen exposure and attention-related behavior in early childhood

Acetaminophen is currently the only analgesic considered safe for use throughout pregnancy, but recent studies indicate that prenatal exposure to acetaminophen may be related to poorer neurodevelopmental outcomes. Multiple studies have suggested that it may be associated with attention problems, but few have examined this association by trimester of exposure. The Illinois Kids Development Study is a prospective birth cohort located in east-central Illinois. Exposure data were collected between December 2013 and March 2020, and 535 newborns were enrolled during that period. Mothers reported the number of times they took acetaminophen at six time points across pregnancy. When children were 2, 3, and 4 years of age, caregivers completed the Child Behavior Checklist for ages 1.5–5 years (CBCL). Associations of acetaminophen use during pregnancy with scores on the Attention Problems and ADHD Problems syndrome scales, the Internalizing and Externalizing Behavior composite scales, and the Total Problems score were evaluated.

Higher acetaminophen exposure during the second trimester of fetal development was associated with higher Attention Problems, ADHD Problems, Exter-

nalizing Behavior, and Total Problems scores at ages 2 and 3. Higher second trimester exposure was only associated with higher Externalizing Behavior and Total Problems scores at 4 years. Higher cumulative exposure across pregnancy was associated with higher Attention Problems and ADHD Problems scores at ages 2 and 3.

Conclusions: Findings suggest that prenatal acetaminophen exposure, especially during the second trimester, may be related to problems with attention in early childhood.

Recent evidence indicates the analgesic effect of acetaminophen occurs via the endocannabinoid system. The endocannabinoid system has been shown to play an important role in brain development, playing roles in cell differentiation, migration, and synaptogenesis, in addition to immune regulation via microglia. Cannabinoid receptor 1 (CB1R) has been implicated in both inattention and hyperactivity in animal models. CB1Rs are expressed early in neurodevelopment with evidence indicating that they may be present in neural tissue as early as approximately gestational week 5 in human fetal development.

https://pubmed.ncbi.nlm.nih.gov/38199313/

Dr. Reinhardt "Acetaminophen is currently the only analgesic considered safe." Ever wonder who is doing the considering? Federal law even expressly limits acetaminophen use in the elderly to 4 gm per day due to it's hepatotoxicity.

Non-overweight depressed patients who respond to antidepressant treatment have a higher risk of later metabolic syndrome: findings from the METADAP cohort

The primary objective of our study was to assess prospectively the impact of response to antidepressant treatment on developing MetS in a sample of MDD patients with a current major depressive episode (MDE) and who are newly initiating their treatment.

In the 6-month prospective METADAP cohort, non-overweight patients, body mass index <25 kg/m2, with MDD and a current MDE were assessed for treatment response after 3 months of treatment, and incidence of MetS after 3 and 6 months of treatment. Outcome variables were MetS, number of MetS criteria, and each MetS criterion (high waist circumference, high blood pressure, high triglyceridemia, low high-density lipoprotein-cholesterolemia, and high fasting plasma glucose).

In total, 98/169 patients (58%) responded to treatment after 3 months. A total of 2.7% (1/38) developed MetS out of which 12.7% (10/79) (p value < 0.001) had responded to treatment after 3 months. The fixed-effect regression models showed that those who responded to treatment after 3 months of follow-up had an 8.6 times higher odds of developing MetS (odds ratio = 8.58, 95% confidence interval 3.89-18.93, p value < 0.001).

Conclusions: Compared to non-responders, non-overweight patients who responded to treatment after 3 months of antidepressant treatment had a significantly higher risk of developing MetS during the 6 months of treatment. Psychiatrists and nurses should closely monitor the metabolic profile of their patients, especially those who respond to treatment.

Psychol Med. 2023 Jan 11;53(14):1-10. *https://pubmed.ncbi.nlm.nih.gov/36628576/*

Dr. Reinhardt: "Anti"depressant advocates can add yet another life-changing event to their cost-benefit analysis: metabolic syndrome and diabetes, hard science demonstrated with a p<0.001. Very depressing (especially for the victims).

The response rate to the chemical approach was 58%, about the same as the do-nothing (watchful waiting) approach, perhaps a bit lower than expected...

Depression rates continue to soar, in lockstep with new "anti"depressant dosing. Correlation or causation?

Bidirectional association between autoimmune disease and perinatal depression: a nationwide study with sibling comparison

The objective of this study was to investigate the bidirectional association between PND and AD. Using nationwide Swedish population and health registers, we conducted a nested case-control study and a matched cohort study. From 1,347,901 pregnancies during 2001–2013, we included 55,299 incident PND, their unaffected full sisters, and 10 unaffected matched women per PND case.

We identified 41 subtypes of AD diagnoses recorded in the registers and compared PND with unaffected population-matched women and full sisters, using multivariable regressions. Women with an AD had a 30% higher risk of subsequent PND (95% CI 1.2–1.5) and women exposed to PND had a 30% higher risk of a subsequent AD (95% CI 1.3–1.4). Comparable associations were found when comparing exposed women with their unaffected sisters (nested case-control OR: 1.3, 95% CI 1.2–1.5, matched cohort HR: 1.3, 95% CI 1.1–1.6), and when studying antepartum and postpartum depression. The bidirectional association was more pronounced among women without psychiatric comorbidities (nested case-control OR: 1.5, 95% CI 1.4–1.6, matched cohort HR: 1.4, 95% CI 1.4–1.5) and strongest for multiple sclerosis (nested case-control OR: 2.0, 95% CI 1.6–2.3, matched cohort HR: 1.8, 95% CI 1.0–3.1). These findings demonstrate a bidirectional association between AD and PND independent of psychiatric comorbidities, suggesting possibly shared biological mechanisms.

If future translational science confirms the underlying mechanisms, healthcare providers need to be aware of the increased risk of PND among women with ADs and vice versa.

Mol Psychiatry (2024). *https://doi.org/10.1038/s41380-023-02351-1*

Dr. Reinhardt: Researchers identified those with depression using the National Prescribed Drug Register. “We might have missed PND diagnosed in primary care during 2001–2005, and afterwards for women without antidepressant prescription.”

Subjects identified as depressed as a result of their taking of “anti”depressants were found to have significantly more autoimmune diseases later in life. “Anti”depressant advocates can add yet another life-changing event to their cost-benefit analysis: autoimmune disease.

Autoimmune disease rates continue to soar, in lockstep with new “anti”depressant dosing. Correlation or causation?

Perinatal depression and risk of mortality: nationwide, register based study in Sweden

To determine whether women with perinatal depression are at an increased risk of death compared with women who did not develop the disorder, and compared with full sisters, 86,551 women with a first ever diagnosis of perinatal depression were ascertained through specialised care and use of antidepressants, and 865,510 women who did not have perinatal depression were identified and matched based on age and calendar year at delivery. Primary outcome was death due to any cause. Secondary outcome was cause specific deaths (ie, unnatural and natural causes).

522 deaths (0.82 per 1000 person years) were reported among women with perinatal depression diagnosed at a median age of 31.0 years over up to 18 years of follow-up. Compared with women who did not have perinatal depression, women with perinatal depression were associated with an increased risk of death (adjusted hazard ratio 2.11 (95% confidence interval 1.86 to 2.40)); similar associations were reported among women who had and did not have pre-existing psychiatric disorder. Risk of death seemed to be increased for postpartum than for antepartum depression (hazard ratio 2.71 (95% confidence interval 2.26 to 3.26) v 1.62 (1.34 to 1.94)). A similar association was noted for perinatal depression in the sibling comparison (2.12 (1.16 to 3.88)). The association was most pronounced within the first year after perinatal depression but remained up to 18 years after start of follow up. An increased risk was associated with both unnatural and natural causes of death among women with perinatal de-

pression (4.28 (3.44 to 5.32) v (1.38 (1.16 to 1.64)), with the strongest association noted for suicide (6.34 (4.62 to 8.71)), although suicide was rare (0.23 per 1000 person years).

Conclusions: Even when accounting for familial factors, women with clinically diagnosed perinatal depression were associated with an increased risk of death, particularly during the first year after diagnosis and because of suicide. Women who are affected, their families, and health professionals should be aware of these severe health hazards after perinatal depression.

Cite this as: *BMJ 2024;384:e075462*

Dr. Reinhardt: Many researchers continue to come to unsupported conclusions. They labeled these women as depressed based on their prescription of “anti”depressants. This study seems to prove that “anti”depressants “were associated with an increased risk of death, particularly during the first year after diagnosis and because of suicide.”

Suicide rates in lockstep with new “anti”depressant dosing. Correlation or causation?

The lived experience of withdrawal from Selective Serotonin Reuptake Inhibitor (SSRI) antidepressants: A qualitative interview study

To explore antidepressant users’ experiences and views on the withdrawal process and how it affected their quality of life across multiple life domains we conducted in-depth qualitative interviews with 20 individuals from the community who had attempted to withdraw from Serotonin Reuptake Inhibitor antidepressants in the past year.

Five themes were generated. The first highlighted the challenges of managing the release from emotional blunting and cognitive suppression following antidepressant discontinuation. The second related to the negative impact of withdrawal on close relationships and social interactions. The third showed that concurrent with negative physical symptoms, there was a positive impact on health (exercise was reported by some as a coping mechanism). The fourth theme focused on support from GPs and families, emphasizing the importance of mental health literacy in others. The final theme underscored the importance of gradual and flexible tapering in enabling a manageable withdrawal experience, and the consideration of timing.

Conclusions: The lived experience of withdrawal significantly impacts individuals’ well-being. Participants emphasized that withdrawal is not just about physical side effects but also affects their emotional, cognitive, and social functioning.

09 January 2024 *https://doi.org/10.1111/hex.13966*

Valproate: Men planning a family should seek advice in light of neurodevelopmental disorders risk in children, says regulator

Male patients taking valproate who are planning a family should talk to their doctor, the UK’s drug regulator has said following revised study results which show an increased risk of neurodevelopmental disorders in children born to fathers who took the anti-seizure drug.1

Health professionals treating this group of patients should consider alternatives to valproate (sodium valproate, valproic acid, and valproate semisodium), which is used to treat epilepsy and bipolar disorder, said the Medicines and Healthcare Products Regulatory Agency (MHRA). It said that patients must not stop taking valproate without advice from their medical specialist.

MHRA said it couldn’t yet pass on any more details of the study, but that it was a population based retrospective cohort study which used secondary data from national registries in Denmark, Norway, and Sweden to evaluate paternal exposure to valproate and the risk of neurodevelopmental ...

BMJ 2024;384:q122

Dr. Reinhardt: Note, they correctly called valproate an anti-seizure drug, not a “mood stabilizer”.

Psychotherapy vs Pharmacotherapy for Depression in Heart Failure

Data from a 1-year randomized trial showed that behavioral activation (BA) psychotherapy was comparable to antidepressant medication in relieving symptoms of depression in patients with heart failure. The psychotherapy group, however, demonstrated slightly more improvement in physical health-related quality of life (HRQOL), and had fewer emergency department (ED) visits and days of hospitalization.

Noting concerns about the effectiveness of psychotherapy and the adverse effect burden of antidepressant medications, IsHak et al observed, "clinicians and patients lack evidence on which intervention to use for depression in heart failure."

https://www.psychiatrictimes.com/view/psycotherapy-vs-pharmacotherapy-for-depression-in-heart-failure?ekey=RUtJRDozODE5ODg0OC03NUU3LTRGQ0EtODJDMS03MkI0OEQxOTYzRTM%3D&_hsmi=294490940&_hsenc=p2ANqtz-9DqlpLN3LDa8v6W-WZIgBpljRiGm7fmq-ZYXnaQ3TGCOr_gzR5D7Lrg8zrcGZPqxpZVLG1oYuRwkST7yJLkko8VDpaFIfyAFTEGuEnqIYWrmdJG7Q

Dr. Reinhardt: Surprising to be published in the drug magazine Psychiatric Times. Since The drug group had, of necessity, received significant patient interaction (psychotherapy) they did improve. The better health explanation does not mention the significant adverse effects of the chemicals.

Efficacy, Safety, and Tolerability of Centanafadine Sustained-Release Tablets in Adults With Attention-Deficit/Hyperactivity Disorder

Centanafadine is an inhibitor of norepinephrine, dopamine, and serotonin reuptake transporters under investigation for the treatment of attention-deficit/hyperactivity disorder (ADHD).

Two phase 3 randomized, double-blind, placebo-controlled, parallel-group studies of 200 mg/d or 400 mg/d centanafadine sustained-release tablets versus placebo included adults (18–55 years of age) with a diagnosis of ADHD. The primary and key secondary efficacy endpoints were the change from baseline at day 42 in the Adult ADHD Investigator Symptom Rating Scale (AISRS) total score and the Clinical Global Impression–Severity of Illness Scale, respectively.

At day 42, statistically significant least-squares mean differences in AISRS total score were observed in favor of centanafadine versus placebo in study 1 (200 mg/d: P = 0.019; 400 mg/d: P = 0.039) and study 2 (200 mg/d: P = 0.002; 400 mg/d: P = 0.001). Effect sizes versus placebo were 0.28 for 200 mg/d and 0.24 for 400 mg/d in study 1 and 0.37 for 200 mg/d and 0.40 for 400 mg/d in study 2. The overall rate of treatment-emergent adverse events (TEAEs) was low, but there was a small increase in TEAE occurrence with increasing dose. Incidences of serious TEAEs and abuse potential–related AEs were low.

J Clin Psychopharmacol. 2022 Sep-Oct 01;42(5):429-439. *https://journals.lww.com/psychopharmacology/Fulltext/2022/09000/Efficacy,_Safety,_and_Tolerability_of.2.aspx*

Dr. Reinhardt: The Adult ADHD Investigator Symptom Rating Scale used for this study is a 5 minute screen, and uses a semi-structured interview methodology with suggested prompts for each item to improve inter-rater reliability. The scale's 18 items directly correspond to the 18 DSM-IV symptoms of ADHD where 9 inattentive items alternate with 9 hyperactive-impulsive items. Items include questions such as "Do you make careless mistakes when working on a boring or difficult project?", "Do you fidget or squirm with your hands or feet when you have to sit down for a long time?", and "Do you have difficulty waiting your turn in situations when turn taking is required?" Each item includes a series of additional questions that the interviewer can use to further prompt the participant (for example, for the item on waiting your turn, prompts include, "Are you frequently frustrated with delays? Do you put a great deal of effort into planning to not be in situations where you might have to wait").

High levels of norepinephrine can lead to various health conditions, including high blood pressure; rapid or irregular heartbeat; excessive sweating; cold or pale skin; severe headaches; nervousness or jitters; an adrenal gland tumor called pheochromocy-

toma; and increased risk of heart, blood vessel, and kidney damage.

High dopamine symptoms include anxiety, excessive energy, insomnia, and hallucinations.

The symptoms of high serotonin can include: Agitation or restlessness, Confusion, Rapid heart rate and high blood pressure, Dilated pupils, Loss of muscle coordination or twitching muscles, High blood pressure, Muscle rigidity, Heavy sweating, Diarrhea, Headache, Shivering and Goose bumps. Adverse events caused discontinuation in 8/32 (25%!) of the subjects.

The CGI-Severity (CGI-S) asks the clinician one question: "Considering your total clinical experience with this particular population, how mentally ill is the patient at this time?" which is rated on the following seven-point scale: 1=normal, not at all ill; 2=borderline mentally ill; 3=mildly ill; 4=moderately ill; 5=markedly ill; 6=severely ill; 7=among the most extremely ill patients.

They are trying to demonstrate a benefit to the chemical, but are struggling.

Undisclosed financial conflicts of interest in DSM-5-TR: cross sectional analysis

To assess the extent and types of financial ties to industry of panel and task force members of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, fifth edition, text revision (DSM-5-TR), published in 2022 were assessed. 168 individuals were identified who served as either panel or task force members of the DSM-5-TR. 92 met the inclusion criteria of being a physician who was based in the US and therefore could be included in Open Payments. Of these 92 individuals, 55 (60%) received payments from industry. Collectively, these panel members received a total of $14.2m (£11.2m; €13m). One third (33.3%) of the task force members had payments reported in Open Payments.

Conclusions: Conflicts of interest among panel members of DSM-5-TR were prevalent. Because of the enormous influence of diagnostic and treatment guidelines, the standards for participation on a guideline development panel should be high. A rebuttable presumption should exist for the Diagnostic and Statistical Manual of Mental Disorders to prohibit conflicts of interest among its panel and task force members. When no independent individuals with the requisite expertise are available, individuals with associations to industry could consult to the panels, but they should not have decision making authority on revisions or the inclusion of new disorders.

https://www.bmj.com/content/384/bmj-2023-076902

Dr. Reinhardt: Now who would have suspected such a thing?

RNA Interference With Zilebesiran for Mild to Moderate Hypertension

Angiotensinogen is the most upstream precursor of the renin–angiotensin–aldosterone system, a key pathway in blood pressure (BP) regulation. Zilebesiran, an investigational RNA interference therapeutic, targets hepatic angiotensinogen synthesis.

This phase 2, randomized, double-blind, dose-ranging study of zilebesiran vs placebo was performed at 78 sites across 4 countries. Screening initiation occurred in July 2021 and the last patient visit of the 6-month study occurred in June 2023. Adults with mild to moderate hypertension, defined as daytime mean ambulatory systolic BP (SBP) of 135 to 160 mm Hg following antihypertensive washout, were randomized.

Randomization to 1 of 4 subcutaneous zilebesiran regimens (150, 300, or 600 mg once every 6 months or 300 mg once every 3 months) or placebo (once every 3 months) for 6 months was conducted.

Of 394 randomized patients, 377 (302 receiving zilebesiran and 75 receiving placebo) comprised the full analysis set (93 Black patients [24.7%]; 167 [44.3%] women; mean [SD] age, 57 [11] years). At 3 months, 24-hour mean ambulatory SBP changes

from baseline were 7.3 mm Hg with zilebesiran, 150 mg, once every 6 months; 10.0 mm Hg with zilebesiran, 300 mg, once every 3 months or every 6 months; 8.9 mm Hg with zilebesiran, 600 mg, once every 6 months; and 6.8 mm Hg with placebo.

Over 6 months, 60.9% of patients receiving zilebesiran had adverse events vs 50.7% patients receiving placebo and 3.6% had serious adverse events vs 6.7% receiving placebo. Nonserious drug-related adverse events occurred in 16.9% of zilebesiran-treated patients (principally injection site reactions and mild hyperkalemia) and 8.0% of placebo-treated patients.

Conclusions and Relevance In adults with mild to moderate hypertension, treatment with zilebesiran across a range of doses at 3-month or 6-month intervals significantly reduced 24-hour mean ambulatory SBP at month 3.

JAMA. Published online February 16, 2024. *https://jamanetwork.com/journals/jama/fullarticle/2815379*

Dr. Reinhardt: This is a great example of how using an "active" placebo (without revealing it) can manipulate results! Can you believe twice as many "placebo" recipients had serious adverse reactions compared to those taking the chemical? Yet 51% of chemical recipients had adverse reactions, meaning 102% of placebo recipients did, very difficult math. Even with the all too obvious manipulation, SPB decreased by 7.3 mm Hg in the chemical group compared to 6.8 mm Hg with the placebo, hardly a clinically insignificant result. I suspect they will go ahead with marketing research.

Drug for Agitation in Alzheimer Disease Dementia Fails in Phase 3 Trial

Otsuka announce topline results of the phase 3 clinical trial of AVP-786, a combination of dextromethorphan hydrobromide and quinidine sulfate, in the treatment of agitation associated with Alzheimer disease dementia. A statistically significant difference was not achieved on the primary efficacy endpoint, which was mean change from baseline to week 12 in the Cohen-Mansfield Agitation Inventory (CMAI) total score compared with placebo.

During the trial, there was 1 treatment-emergent adverse event that appeared with an incidence rate of more than 5% in patients treated with AVP-786 and greater than placebo: falling. In the AVP-786 high dose group, there were 16 participants who had a fall (8.6%), and 18 (9.1%) in the AVP-786 low dose group. In the placebo group, there were only 6 (2.8%). There were also 4 deaths reported in the trial; 1 (0.5%) in the AVP-786 low dose group and 3 (1.4%) in the placebo group.

https://www.psychiatrictimes.com/view/drug-for-agitation-in-alzheimer-disease-dementia-fails-in-phase-3-trial?ekey=RUtJRDozODE5ODg0OC03NUU3LTRGQ0EtODJDMS03MkI0OEQxOTYzRTM%3D&_hsmi=294490940&_hsenc=p2ANqtz-8-47VTVhbL_LkUb-CfpgZMyCkL8X-eRNWOpCmF8m8WiUJKSzL9oxxy9kqo63BL_Hn-vfBp-dZQI_yW5qI7scv9SJGwbLbI3v-byStb3UvFMnrFKW6hc

Dr. Reinhardt: Several years ago I attended a drug presentation to nurses at a SNF for Nuedexta, a drug to treat pseudobulbar affect. the drug salesman gave his pitch but was reluctant to discuss the diagnostic protocol with this group of middle-aged women.

His trainee, to his surprise, popped the protocol up on his laptop and the entire group burst out laughing. Seems Neudexta indications mirrored menopausal symptoms!

Neudexta is an approved combination of dextromethorphan hydrobromide and quinidine sulfate also. Dextromethorphan hydrobromide is an OTC cough supressant, and quinidine sulfate is an old HTN med. Nuedexta contains very low concentrations of these chemicals, well below OTC cough meds and well below effective BP control use. Neudexta is available by prescription for over $31 per dose. The cost of the separate ingredients (involving much pill splitting to match dose) is about $0.31.

Adverse effects for Nuedexta abound: Serious reactions of QT prolongation, thrombocytopenia, lupus-like syndrome, hypersensitivity rxn, hemolytic anemia, hepatitis and respiratory failure. Common reactions (>10%) include diarrhea, dizziness, asthenia, cough, vomiting, peripheral edema, UTI, influenza, GGT elevated, flatulence, muscle spasticity, abdominal pain, and muscle spasms.

Pity the dementia patient with an overzealous psychiatrist!

Can Semaglutide Help in Psychiatry Too? Research Shows Promise for AD and PD

There has been an increased interest in using antidiabetic agents in the treatment of Alzheimer disease (AD) and Parkinson disease (PD) due to the identification of possible links between DM and the development of AD and PD.

https://www.psychiatrictimes.com/view/can-semaglutide-help-in-psychiatry-too-research-shows-promise-for-ad-and-pd?ekey=RUtJRDozODE5ODg0OC03NUU3LTRGQ0EtODJDMS03MkI0OEQxOTYzRTM%3D&_hsmi=293996907&_hsenc=p2ANqtz--aFhK7DziDxtrJ-8j46x-x982Z6f0MmBj1V2Y4orx85acIXSFKtHVRa55SIrzsnQIFS-rzYOqdm-VSFq2Pvv8OgzdXdyXW6onwfhRcZ1lJ3nZSBODs

Dr. Reinhardt: Masterful marketing. The chemical companies must hurry before GLP-1 chemicals are pulled from the market due to adverse effects (like every other diet drug presented in the last 150 years of “medicine”).

Are body temperature and depression linked? New study says, yes

People with depression have higher body temperatures, suggesting there could be a mental health benefit to lowering the temperatures of those with the disorder, a new UC San Francisco-led study found.

The study, published today in Scientific Reports, doesn’t indicate whether depression raises body temperature or a higher temperature causes depression. It’s also unknown whether the higher body temperature observed in people with depression reflects decreased ability to self-cool, increased generation of heat from metabolic processes or a combination of both.

Researchers analyzed data from more than 20,000 international participants who wore a device that measures body temperature, and also self-reported their body temperatures and depression symptoms daily. The seven-month study began in early 2020 and included data from 106 countries.

The results showed that with each increasing level of depression symptom severity, participants had higher body temperatures. The body temperature data also showed a trend toward higher depression scores in people whose temperatures had less fluctuation throughout a 24-hour period, but this finding didn’t reach significance.

https://dx.doi.org/10.1038/s41598-024-51567-w

Dr. Reinhardt: An interesting study on sad mood. The study did not control for “anti”depressant use but on self reports. Could use of those chemicals cause inflammation, increasing body temperature? This was not discussed in the study. Language often betrays hidden symptoms. “Just chill out” takes on new importance!

Alternate Approaches

Multivitamins and Cognition: New Data From COSMOS

The meta-analysis of three separate cognition studies provides “strong and consistent evidence that taking a daily multivitamin, containing more than 20 essential micronutrients, can help prevent memory loss and slow down cognitive aging,” study investigator Chirag Vyas, MBBS, MPH, with Massachusetts General Hospital and Harvard Medical School, Boston, told Medscape Medical News.

In a statement, JoAnn Manson, MD, DrPH, chief of the Division of Preventive Medicine at Brigham and Women’s Hospital, who led the overall COSMOS trial, said that “the finding that a daily multivitamin improved memory and slowed cognitive aging in three separate placebo-controlled studies in COSMOS is exciting and further supports the promise of multivitamins as a safe, accessible, and affordable approach to protecting cognitive health in older adults.”

“We are not now recommending multivitamin use, but the evidence is compelling that supports the promise of multivitamins to help prevent cognitive decline,” Vyas said.

https://www.sciencedirect.com/science/article/pii/S0002916523663427?via%3Dihub

Dr. Reinhardt: The most serious flaw in all of these studies was that they did not enroll and study subjects based on their having any nutritional deficiencies, which are very common according to the USDA. That is like doing an antidepressant trial on a random sample including those who are not depressed. In spite of these errors, benefits of supplements reached significance.

"We are not now recommending multivitamin use": This recommendation should be based on a cost-benefit analysis. Cost: $0.09 per day, no adverse effects/Benefits: "improved memory and slowed cognitive aging". This might cause one to doubt anything coming out of Massachusetts General Hospital and Harvard Medical School.

A standardized Ashwagandha root extract alleviates stress, anxiety, and improves quality of life in healthy adults by modulating stress hormones: Results from a randomized, double-blind, placebo-controlled study

Ashwagandha, an ayurvedic adaptogen has been traditionally used to manage stress, anxiety, and general well-being. We assessed the effect of Ashwagandha root extract standardized for 2.5% withanolides as per USP protocol with piperine (5 mg of 95% piperine) once daily for 60 days (12.5 mg withanolides/day) to alleviate stress and anxiety in healthy individuals with mild to moderate symptoms.

A randomized, double-blind, placebo-controlled study was conducted for 60 days using ARE (n = 27) and placebo (n = 27) once daily at night. The objectives of this study were to assess an improvement in perceived stress scale (PSS), generalized anxiety disorder (GAD-7), quality of life (QOL), cognitive scores in the Cambridge Neuropsychological Test Automated Battery (CANTAB), changes in salivary cortisol, urinary serotonin, dopamine, serum levels of nitric oxide (NO), glutathione (GSH) and malondialdehyde (MDA) from baseline to end of the study. Safety was evaluated by laboratory parameters, and by monitoring any incidence of adverse events.

54 individuals were randomized and 50 of them completed the study. The PSS, GAD-7, and QOL scores improved significantly in all the participants taking ARE compared to the placebo. The CANTAB analysis revealed a significant improvement in multitasking, concentration, and decision taking time in ARE compared to placebo. ARE was also associated with a greater reduction in the morning salivary cortisol and an increase in urinary serotonin compared to placebo. Serum levels of NO, GSH, and MDA were not significantly different. Biochemical and hematological parameters remained in the normal range in all participants and ARE was well tolerated during the study.

Conclusions: The results of the study suggest that ARE with 2.5% withanolides can effectively improve stress and anxiety by reducing cortisol and increasing serotonin in healthy individuals with mild to moderate symptoms.

https://todayspractitioner.com/wp-content/uploads/2024/01/AshwagandhaStress_Medicine-1.pdf

Dr. Reinhardt: No study to date has identified any addiction issue!

Eight-month intensive meditation-based intervention improves refractory hallucinations and delusions and quality of life in male inpatients with schizophrenia: a randomized controlled trial

A randomized controlled trial assigned 64 male inpatients with schizophrenia and TRHD equally to an 8-month iMI plus general rehabilitation program (GRP) or GRP alone. Assessments were conducted at baseline and the third and eighth months using the Positive and Negative Syndrome Scale (PANSS), 36-Item Short Form-36 (SF-36), and Five Facet Mindfulness Questionnaire (FFMQ). Primary outcomes measured PANSS reduction rates for total score, positive symptoms, and hallucinations/delusions items. Secondary outcomes assessed PANSS, SF-36, and FFMQ scores for psychotic symptoms, health-related QoL, and mindfulness skills, respectively.

In the primary outcome, iMI significantly improved the reduction rates of PANSS total score, positive symptoms, and hallucination/delusion items compared with GRP at both the third and eighth months. Treatment response rates (=25% reduction) for these measures significantly increased in the iMI group at

the eighth month. Concerning secondary outcomes, iMI significantly reduced PANSS total score and hallucination/delusion items, while increasing scores in physical activity and mindfulness skills at both the third and eighth months compared with GRP. These effects were more pronounced with an 8-month intervention compared with a 3-month intervention.

Conclusions: An iMI benefits patients with TRHDs by reducing persistent hallucinations/delusions and enhancing health-related QoL. Longer iMI duration yields superior treatment outcomes.

https://onlinelibrary.wiley.com/doi/10.1111/pcn.13641

ADHD and Vision Problems

There is evidence for shared environmental biological risk factors—such as pre-term birth and systemic infections—for both vision problems and ADHD.1 Given that the brain and eye develop from the same embryologic tissue, this raises the possibility that altered neurodevelopment may contribute to the risk of both vision problems and ADHD. Bellato and colleagues5 performed a systematic review and meta-analysis of ADHD and vision problems, following PRISMA guidelines.

The authors screened 65 potential full texts, of which 37 studies met inclusion criteria. They identified another 6 studies from the references of retrieved articles. Altogether, they included 43 studies in a narrative synthesis and 35 studies (392,423 with and 2,858,482 without ADHD) in the meta-analysis. There was no evidence that ADHD is more prevalent in patients with versus without vision problems (logOR=1.07, 95% CI -0.11-2.25).

By contrast, there was significantly increased risk of astigmatism (logOR=0.58), hyperopia and hypermetropia (logOR=0.58, 95% CI 0.51-0.66), reduced near point of convergence (logOR=1.61), strabismus (logOR=0.66), and unspecified vision problems (logOR=0.66). Between-study heterogeneity was not significant, and there was no evidence of publication bias.

There were no significant differences in anatomic ocular measures in individuals with and without ADHD, including axial length, ganglion cell layer thickness, intraocular pressure, macular thickness, macular volume, and retinal nerve fiber layer thickness. Between-study heterogeneity was significant, but there was no evidence of publication bias.

In terms of functional measures of vision, ADHD was associated with increased difficulties and errors in color discrimination (Hedge's g = 0.52) and reduced contrast sensitivity (Hedge's g = -2.81), but with evidence of both significant between-study heterogeneity and publication bias. Regarding visual acuity, ADHD was associated with increased lag (Hedge's g = 0.63) and variability (Hedge's g = 0.40). By contrast, there was no difference in refractive error or visual acuity. There was also increased self-reported vision problems in those with ADHD (Hedge's g = 0.63)

Conclusions: The authors concluded that there was evidence for an association between ADHD and reduced color discrimination and contrast sensitivity, atypical accommodative response and convergence, astigmatism, hyperopia, hypermetropia, and strabismus.

There was no association between ADHD and visual acuity, refractive error, and anatomic ocular measures. There was not an increased prevalence of ADHD in patients with vision problems. Thus, evidence points to a complex relationship between ADHD and visual problems.

https://www.psychiatrictimes.com/view/adhd-and-vision-problems?ekey=RUtJRDozODE5ODg0OC03NUU3LTRGQ0EtODJDMS03MkI0OEQxOTYzRTM%3D&_hsmi=294779765&_hsenc=p2ANqtz-8eEOkf25osPdhM0O6nzMafQMv0ReYsr6D8hG_ePpLQapHO-C5JHk_BqE7WuaoU-Imeo8IfZABusZ6hfzvysLX7kpazuIlspVW200-x_abXI-j24L2U

Dr. Reinhardt: ADHD co-occuring with vision problems, or vision problems driving sufferers to distraction? In my ADHD specialty practice I have seen many kids and adults who were inappropriately "diagnosed" as ADHD, who, when other issues were corrected turned out to be well within the "normal" range. Food allergies have been by far the biggest culprits; eating something that causes an immune reaction affects mood and behavior. There does not need to be a runny nose as well! Most common, a

cow's milk allergy (specifically to the casein protein) is not easily distinguished from ADHD-like symptoms. I also have found that vision problems like those discussed in this article also can shape a person's outlook, behavior and level of distractibility.

Psychological Pain and Suicidality in Patients With Depression

MDD is associated with an increased risk of suicide, so, identifying risk factors for and predictors of suicide in this patient population is crucial. Psychological pain (psychache) is an important factor in understanding suicide. Psychological pain is characterized by intense feelings of shame, humiliation, anguish, despair, loneliness, and dread, as well as feelings of failure, abandonment, and belief that the pain is irreversible. Suicide may be viewed as the only means of escaping psychological pain that exceeds an individual's threshold of tolerance.

Wang and colleagues performed a meta-analysis of the relationship between psychological pain and suicidality in MDD. The investigators concluded that psychological pain was associated with increased odds of suicidality in MDD. This association was moderated by older age, but not gender. Between-study heterogeneity was significant, and there was evidence of potential publication bias, but the association remained significant in post-hoc analyses.

https://www.psychiatrictimes.com/view/psychological-pain-and-suicidality-in-patients-with-depression?ekey=RUtJRDozODE5ODg0OC03NUU3LTRGQ0EtODJDMS03MkI0OEQxOTYzRTM%3D&_hsmi=293363582&_hsenc=p2ANqtz-_j2KjBoEQwPWs0DuTJupjJmel56oLhikyaYOcMfFSo38_4l4YvPjdh3CLORg232BmrHFdjVDDSU5gqCH4Zp8A306Cqbgd_1_0XquMunM35hRaTdKI

Dr. Reinhardt: Yes, psychological pain can be another name for depression. Wang and colleagues might have presented something valuable if they would have searched for a link between suicidality and absence of "psychological pain".

They actually got published, and funded. We are in the wrong business!

A pilot study of chlormequat in food and urine from adults in the United States from 2017 to 2023

Chlormequat chloride is a plant growth regulator whose use on grain crops is on the rise in North America. Toxicological studies suggest that exposure to chlormequat can reduce fertility and harm the developing fetus at doses lower than those used by regulatory agencies to set allowable daily intake levels.

Here we report, the presence of chlormequat in urine samples collected from people in the U.S., with detection frequencies of 69%, 74%, and 90% for samples collected in 2017, 2018-2022, and 2023, respectively. Chlormequat was detected at low concentrations in samples from 2017 through 2022, with a significant increase in concentrations for samples from 2023. We also observed high detection frequencies of chlormequat in oat-based foods.

These findings and chlormequat toxicity data raise concerns about current exposure levels, and warrant more expansive toxicity testing, food monitoring, and epidemiological studies to assess health effects of chlormequat exposures in humans. IMPACT: This study reports the detection of chlormequat, an agricultural chemical with developmental and reproductive toxicity, in the U.S. population and U.S. food supplies for the first time. While similar levels of the chemical were found in urine sampled from 2017 to 2022, markedly increased levels were found in samples from 2023.

This work highlights the need for more expansive monitoring of chlormequat in U.S. foods and in human specimens, as well as toxicological and epidemiological study on chlormequat, as this chemical is an emerging contaminant with documented evidence of low-dose adverse health effects in animal studies.

Journal of Exposure Science & Environmental Epidemiology (2024). DOI: 10.1038/s41370-024-00643-4

Dr. Reinhardt: chlormequat has been found in Cheerios and other oat products, "In May of 2023, the Public Interest Research Group (PIRG) – sent 10,000 signatures calling on the EPA to reject chlormequat. They stated, "Research shows that chlorme

quat chloride disrupts fetal growth and harms the reproductive system. We shouldn't allow its use on food crops unless and until it's proven completely safe.

Only your politicians know how determine the value of signatures versus dollar payments. Pay to Play EPA!

Continuing Education Credit

By Gary Traub, Ph.D.

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

1. Functional MRI studies have not been able to show increased activity in the prefrontal cortex during lying. True/False

2. Pathological lying is estimated to occur in approximately what percentage of the population?

3. A famous person who was cited by the author as an example of sociopaths "who fleece people of their life savings" is _________________.

4. The famous musician who was described as inauthentic and eventually won the Nobel Prize in literature is ______________.

5. Dr. Morris expressed relief about recent evidence to support the efficacy of psychotropics. True/False

6. The chief psychiatrist of the FDA stated that no well-trained physician believes that a medication only approach is adequate treatment for a mental disorder. True/False

7. Dr. Morris states that in this national cultural environment, people who would be clearly identified as personality disorders or even psychotic, are now revered as acceptable, understandable, righteous rebels, or even patriots and saviors. True/False

8. The controversial Alzheimer's drug that was recently pulled off the market by Biogen is ____________.

9. Anti-psychotic medications were associated with increased risk of death in patients aged 5 to 24 years, "only for patients with doses greater than _____ mg chlorpromazine equivalents".

10. Drug-drug interactions were found to be surprisingly low in children. True/False

11. Over the past 2 decades, psychotropic polypharmacy in youths has increased. True/False

12. Prenatal acetaminophen exposure ,especially during the second trimester, was associated with problems in attention in early childhood, considered safe. True/False

13. Antidepressant use was associated with increased metabolic syndrome and diabetes, but mostly only in obese patients. True/False

14. High levels of norepinephrine can lead to high blood pressure and irregular heartbeat. True/False

15. Ninety two of the 168 individuals who served either as panel or task force members for the DSM-5-TR received a total of how much money?

16. In a study, it was reported that there was a trend toward higher depression scores in people who had less fluctuations in body temperature. True/False

17. A meta-analysis of 3 cognition studies was said to provide strong evidence that daily multivitamin use can help prevent _____________, and slow down ______________.

18. Ashwaghanda has been traditionally used to manage _________, _________, and _______________.

19. Eight months of intensive meditation helped reduce hallucinations and delusions. True/False

20. The little known pesticide, that was found in four out of five people tested, is ______________.

Continuing Education Opportunities Through NAPPP and AMP

By Keith Petrosky PHD, ABMP

Napppsubscribers Postings

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

NAPPP Home Study Programs

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

NAPPP Educational Conventions

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

Covid's Continuing Effect on Live Training

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

Video-Based 'Live' Training

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

The Crisis in Psychopharmacology: The Case for Medical Psychology

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

New AMP Video-Based 'Live' Training

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

(associated, but independent) organizations.

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

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

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

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

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

National Alliance of Professional Psychology Providers

Failure To Serve

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

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

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

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

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

Current Listing of Free CE Courses

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

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

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

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

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

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New Book for Medical Psychology

The Crisis In Psychopharmacology: The Case For Medical Psychology

John Caccavale, Ph.D., ABMP
Editor

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

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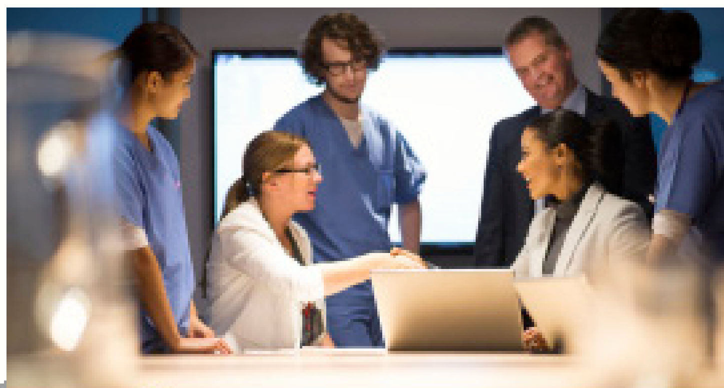

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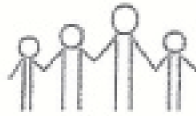

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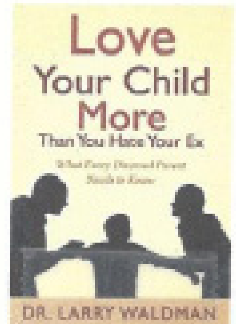

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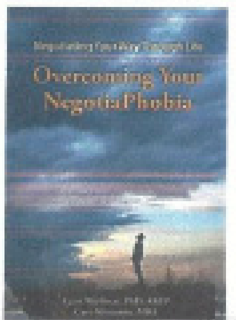

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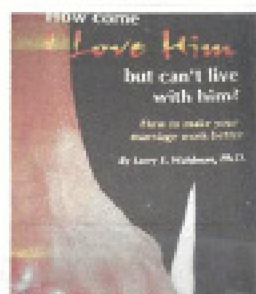

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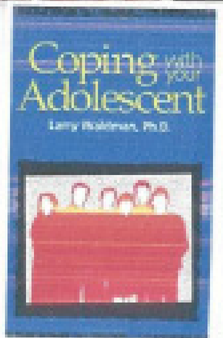

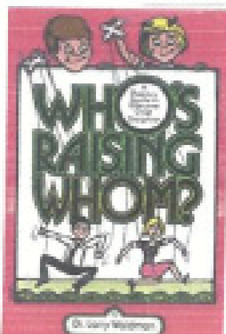

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A Board Certification for Clinical Psychologists

The ABBHP is a board certification in Behavioral Health Practice. This rigorous diplomate is designed for clinical psychologists to distinguish themselves from other practitioners and who desire to place a focus on their healthcare training and experience. This board certification is only available to doctoral level, licensed psychologists to highlight the value added of being a doctoral level practitioner.

Requirements

The ABBHP board certification is not a vanity board. It was designed by an experienced and influential board to be rigorous and to ensure the public, healthcare providers and the healthcare industry that those who possess this diplomate have achieved a high level of training and experience in providing behavioral healthcare services. Those possessing ABBHP certification are making a statement that they are behavioral healthcare practitioners who work and belong in the healthcare industry. ABBHP diplomates are doctors who provide much more than psychotherapy services and can provide a wide range of interventions that only a doctoral level healthcare professional can. For information on qualifying for board certification, please go to http://www.abbhp.org/

Summary of Requirements

- Current and valid license to practice psychology.
- Successfully pass an examination.
- Complete specific coursework.
- Provide a product sample.
- Provide letters of recommendation.

Board of Directors

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Center for Health Science

Natural Alternatives for Health

Featured Products...For Sleep

Chinese Medicine defines pain as an imbalance between Qi (energy) and Blood
TCM does not differentiate between physical and emotional pain.

Evergreen Calm (ES)®

Calm (ES)® is an updated Traditional Chinese Formula to regulate Liver qi, calm the Shen (spirit) and tranquilize the Heart. It is designed to relieve insomnia with disturbed sleep and night awakenings and to help with stress reflected in poor appetite, headache, tension and insomnia. It is used as an adjunctive formula for depression.

Evergreen Calm ZZZ®

Calm ZZZ is designed to treat those who are under constant stress but also have a deficient constitution. This is one of the best formulas to treat Shen disturbance both during the day and at night. Shen disturbance during the day can manifest as stress, anxiety and emotional instability. Shen (spirit) disturbance at night manifests as insomnia with difficulty falling asleep and/or staying asleep.

Evergreen Schisandra ZZZ®

Schisandra ZZZ® is used with excessive worries and dreams, fatigue, pensiveness, and poor appetite. Applications include insomnia, difficulty falling asleep and staying asleep, poor memory, dizziness, weakness, constant fatigue, and postpartum depression due to anemia. It is formulated to nourish the Spleen and the Heart, tranquilize the Shen and tonify qi and blood.

Why Evergreen? Evergreen Herbs use the best of modern technology to bring the essence of traditional Chinese herbology to mainstream America. Evergreen pharmaceutical-grade, full-spectrum extracts are your assurance of correct species and maximum potency. Evergreen's herbs are tested with HPLC for qualitative and quantitative analysis.

Statements contained herein have not been evaluated by the Food and Drug Administration. These products are not intended to diagnose, treat and cure or prevent disease. Information provided by CHS is not intended to replace a one-on-one relationship with a qualified health care professional and is not intended as medical advice.