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ACADEMY UPDATE FROM THE PRESIDENT
BY STEPHEN GARY MCCLURE, PHD, ABMP

PRESIDENT'S LETTER

Dear AMP Colleagues,

Multiple AMP members have communicated with me about the increased demands for treatment from patient's impacted by the COVID-19 pandemic. The effects of the pandemic have touched everyone, in some way, and our services are needed now more than ever. Psychologists are working tirelessly to service their patient's needs despite the risks and demands posed by the COVID-19 environment. I am honored to be a part of a group (medical psychologists) that is committed to addressing the needs of patients, during this unprecedented time in our lives.

In addition to treatment demands, some members have raised concerns about the "politization" of the pandemic. There are volumes of misinformation in cyberspace driven by politics, money, power, and greed. Medical psychologists are needed now, more than ever, to distill fact from fiction, in an effort to provide accurate information about the virus to our patients and other interested parties.

Previously I reported the personnel changes to the AMP Board of Directors, with Dr. John Cacavalle and Dr. Jerry Morris retiring and receiving distinguished Emeritus status from AMP.

Those vacancies were filled by Dr. Amie Cooper and Dr. Keith Petrosky who are active contributors to the board and enthused about servicing psychologists as AMP board members.

Recently, Dr. Susana Galle was awarded Emeritus status as an AMP board member for multiple contributions to AMP and service to all psychologists. Dr. Galle's was acknowledged with a plaque from AMP memorializing her service. Dr. Galle made multiple scientific contributions to AMP publications and my hope is that she will continue to participate

Dr. Mohammad Hamza has applied for AMP diplomate status and he is preparing for the Oral exam and Written exam to complete the AMP requirements for board certification

Since his recent Board Certification, Dr. James Underhill has graciously provided significant contributions to AMP.

Dr. Underhill recently completed and filed a Continuing Education (CE) application with the American Psychological Association that would authorize AMP to provide Continuing Education credits for our courses.

Dr. Underhill also created a new AMP website and information from our current website is being transitioned to the new AMP website.

On behalf of AMP, I want to express my deep appreciation and gratitude to Dr.

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EXECUTIVE DIRECTOR'S COLUMN

WARD LAWSON, PHD, ABPP, ABMP

Dr. Gary McClure is leading a flexible and adaptive board this year that appreciates the limits of our size, budget and the importance of our elite specialty, which is becoming one of the highest repute specialties in psychology. We have consistently practiced patience, practicality, and envisioning the idealistic but adapting aspirations to our relatively young status as an organization and resource limits.

During the initial phases of COVID-19, we contacted every governor in the US to offer three suggestions to assist with the mental/physical health of our citizens. First, provide financial support in the form of grants (as was afforded physicians) for full and sustained telehealth implementation. Secondly, immediately grant prescription privileges to psychologists. Thirdly, mandate staffing of psychologists in all health care facilities that takes Medicaid and Medicare, e.g., nursing homes, general medical and behavioral-health hospitals, primary care facilities, residential care and substance abuse treatment facilities, etc. We need psychologists with relationships with key leaders in their states to follow up on this letter and push for change!

We continue to refine our written exam and orals process and the board is pitching in with great commitment and effort. We continue to train and develop an average of two to three board certified Medical Psychology specialists a year (about what the smaller ABPP boards develop). Specialization is a multi-year commitment and only a few psychologists in the US and World will make that huge commitment. That commitment to learning and excellence is one reason they are differentiated from the average practitioner! We have several good and committed candidates in the pipeline that finishing their training in 2020.

Our Archives of Medical Psychology profession journal continues to be a big and important accomplishment. Many board members extend themselves to produce peer reviewed and publishable articles and to do reviewer and editor work. This is a great commitment and effort.

Dr. Morris and Dr. Caccavale, both Emeritus board members, continue to contribute immensely in many ways, including being the primary drivers of the ongoing development of the CE center which will evolve into a post-graduate online master's degree program in Medical Psychology. This takes great vision, financial resources and a national accreditation review- no small task! AMP appreciates Emeritus members who continue to contribute!

Dr. Petrosky has taken the initiative to contact CAQH and advocate for ABMP board certification recognition in their credentialing system. The wheels of changes in these big systems grind slowly! We need this type of frontline work! Thank you, Keith!

I also want to take a moment to applaud Dr. Susana Galle, a very credentialled and long-time advocate of medical psychology, who was recently honored with Emeri

tus Board Member status for her years of service on the board. Thank you, Susana! As members of the Academy may not know, the board has staggered terms with practice representative orientations which are melded together to limit terms and cause new blood rotations on the board. See the web site rules and descriptions of this process. We have several seats that are up in 2020 or will be up in 2021 and, as we say each year, it is the responsibility of each board member, including input from the board, to develop their successor and to make nominations. Remember, board members recruiting potential successors are reminded that these potential board members are oriented and acculturated and evaluated by work on a Committee of Committees and must be recruited for committee work by the board. We are pleased that there are several members and board certification candidates who have expressed an interest in serving! There is so much to be done- we welcome additional volunteers for Committees - Finance and Fund Raising, Marketing, Education, Government Relations, Publications, and Credentials.

In closing, I look forward to what's going to be accomplished in 2021. I want to thank you, the membership, and thank you Board!

Dr. Ward Lawson
Executive Director

Whither Personality Screening for Medical Psychologists in the Distress Tolerance/Coping Skills Era

Jerrold Pollak, Ph.D., ABPP, ABN

Introduction: Historically, mental health care has proceeded, for the most part, without formal personality screening or more comprehensive psychological assessment to facilitate differential diagnosis, case formulation, treatment planning and the monitoring of the course/outcome of psychotherapy. This has been true despite the increased research- based attention paid to the significant impact of personality dynamics, traits and patterns on the development, expression, maintenance and exacerbation of mental health difficulties, notably "high base rate" symptoms of anxiety and depression (Bagby, Gralnick, Al-Dajani, & Uliaszek, 2016; Zinbarg, Uliaszek, & Adler, 2008).

Additionally, personality factors have been shown to influence a range of key treatment parameters: Choice of therapeutic approach, strategies and focus; setting realistic treatment goals and objectives; alliance building; motivation for initiating and persisting in treatment and treatment adherence/compliance (Bagby, Gralnick, Al-Dajani, & Uliaszek, 2016; Bucher, Suzuki, & Samuel, 2019).

Patient personality characteristics may also play an important role when it comes to preferences for type, frequency and duration of treatment, satisfaction with process and outcome and therapist-patient matching (Bagby, Gralnick, Al-Dajani & Uliaszek, 2016).

In effect, there is growing empirical support that for "better or worse" individual differences in personality trait profile likely have a significant impact on the course/ outcome of psychotherapy (Buchher, Suzuki, & Samuel, 2019).

The rather limited use of personality assessment to inform and guide treatment has continued into the present era. Current clinical practice reflects a marked uptick in the utilization of mental health services nationwide and, specifically, involvement in psychotherapy which emphasizes the systematic teaching of distress tolerance, emotional regulation and other coping skills like mindfulness/meditation to address disruptive symptoms and, in some instances, broader mental health concerns/difficulties.

As for medical psychologists this includes working with patients to cope with the behavioral and psychological concomitants of chronic and life threatening medical conditions as well as evaluation and treatment of pre-existing mental health disorders which have been exacerbated by medical illness.

The distress tolerance/coping skills model has its genesis in the evolution of Cognitive Therapy to Cognitive Behavioral Therapy/ CBT beginning in the 1980's and the rise of Dialectical Behavioral Therapy/DBT and kindred psychotherapies in the 1990's. In addition to CBT and DBT this model figures prominently in a number of other contemporary psychotherapies including Mindfulness/Meditation and Acceptance/ Commitment therapy.

Evidence-Based Practice: There is a well-established evidence-base for the efficacy of CBT for a fairly wide range of mental health conditions and good evidence for the effectiveness of DBT especially for reduction in the frequency and severity of self-harm behavior (Hoffman, Asnaani, Vonk, Sawyer & Fange, 2012; Panos, Jackson, Hasan & Panos, 2014) Empirical support is less robust but continues to accrue for the clinical utility of other psychotherapies cited above which, to varying degrees, incorporate a distress tolerance/coping skills model (Ost, 2008). All of these psychotherapies represent a significant advance in tailoring mental health care to the "real world" needs and life circumstances of many patients, in part, because of

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Integrated Healthcare & an Infrastructure Unprepared: the Challenge of the COVID-19 Pandemic

Rory Fleming Richardson, Ph.D., ABMP, TEP

During the first weeks of the COVID virus outbreak in the USA, we started to hear of other countries which were being impacted. First was China, then Italy and Iran and so many others, including the Untied States. Slowly the reality of what was upon us sank in, as an increasing numbers of people infected. California and New York started to get hit. Washington's Kirkland first responders elected to self-quarantine. The run on online stores and major department stores started with people hoarding food and toilet paper. Alternative news varied from strong recommendations of preparation to frantic panic responses. At the same time, we would hear President Trump state that they had things covered, with the best people working on stopping the threat. On March 13, 2020, President Trump declared a National Emergency. One of unfortunate thing is that when one designs a complex infrastructure, with volumes of rules on what can be billed, you end up with an "institutionalized healthcare workforce."

Cruise ships became plague ships slowly returning the potentially infected and infected to passengers to their respective countries. At the same time, physicians in Kenowick, Washington were starting to tell an older counselor to stay home for up to two months. Many individuals believed that the virus would behave like other influenza viruses as far as length of viability on surfaces, but it was later discovered that the virus remained at least 17 days after the passengers disembarked (Moriarty LF, Plucinski MM, Marston BJ, et al. 2020).

I remember hearing a few weeks before about one person who was planning to go to Comic-Con, another having a spouse flying out to Ireland, another who had just returned from the Denver Airport, and several others who had just returned from Illinois, Texas and other states where the virus had spread. At what point does a psychologist or healthcare provider decide to stop seeing patients face-to-face. For me, this was not an easy decision. After 45 years of working in the field, I value the face-to-face magic and chemistry which happens between a patient and the therapist. I have periodically entertained the thought of doing telepsychology, and had taken the courses to do telehealth. I was hesitant to start providing treatment in this modality. With the oncoming epidemic and people facing isolation, I had to face the fact that face-to-face treatment may have to be limited, and during specific periods, absent. The question as to when a psychologist or other healthcare provider has to end the face-to-face standard and go to telemedicine haunts, I believe, every therapist who is living through this period of time. The other issue was that some of the most experienced, expert practitioners were among those who were most likely to die if infected. They, like myself, were older and not in prime health. I was more than aware of the potential impact of the infection and pandemic having designed a model based on sociometry to determine the most likely spread of the disease. When the first cases of COVID started to show up in Missouri, I realized that the clock was ticking. On March 26, 2020, I heard that someone in the small town of Mansfield, Missouri, where I work, tested positive for CoV-19.

On March 26, 2020, there were 85,594 positive cases of COVID-19 in the USA. Dr. Colleen Smith, an emergency room doctor in Elmhurst, Queens, shared that there is a profound lack of support and supplies to meet the need. She shared that patients who came into the emergency room who had no fever or abdominal pain (coming in for injuries and accidents) showed on CT scans a scan suggesting they had coronavirus. Due to this and the lack of protective equipment, doctors and nurses were getting COVD-19. In addition, she was seeing those coming in appear sicker, and younger patients with no comorbidity getting ill.

At the same time, the President was talking about having won over COVID-19 and projected lifting recommendations for isolation despite the recommendations of the medical professionals.

In the early days of the COVID-19 National Emergency, the declaration by President Trump that obstacles to treatment would be waived had a mixed effect. It resulted in a tsunami of questions as to if various rules were in fact changed, and how to bill for the service provided. In addition, many healthcare providers were not prepared for the set-up of telehealth operation for their clinics. How would they do telehealth? What would it mean to HIPAA standards and Medicare standards? Would Medicaid also be able to be billed since each State has different medicaid systems? Would private insurances cover treatment? How long would this change be covered? The list of questions go on and on. The Listservers were alive with these unending questions. As healthcare management systems strained at change, providers and patients were left to face the unknown without knowing if either would financially survive this pandemic.

The reality is that healthcare in the USA has become so institutionalized and complex that being able to respond quickly was almost impossible. To complicate this picture, several groups of providers

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Underhill for his efforts on these two major undertakings.

The board is communicating with the Council for Affordable Quality Healthcare, Inc. (CAQH), a credentialing database used by various stakeholders to verify medical provider status. CAQH is defined as a non-profit alliance of health plans and related associations working together to achieve the shared goal of streamlining the business of healthcare.

The objective of AMP is for CAQH to acknowledge AMP diplomates as board certified medical psychologists and to include the Board Certification acknowledgment as part of the CAQH quarterly recertification requirement for medical providers. A second letter, penned by Dr. Lawson was recently submitted to CAQH requesting the acknowledgment of AMP Diplomates by CAQH.

Here is CAQH Assistant Manager of Operations, Ngozi Young's response:

"Good afternoon Dr. Lawson and Dr. Keith,

I hope this email finds you well and safe.

We received your follow-up letter in the mail regarding adding 'American Board of Medical Psychology' to the Specialty Board drop-down menu in ProView. As a result of a missed oversight on our end, we failed to complete your original request that we received in February and we are truly sorry.

I am working with my team to ensure that this change is made in September 8th and in a few days, let you know once the date is confirmed.

Our sincerest apologies for the delay in processing your request. If you have any questions or concerns, please feel free to reach out to me.

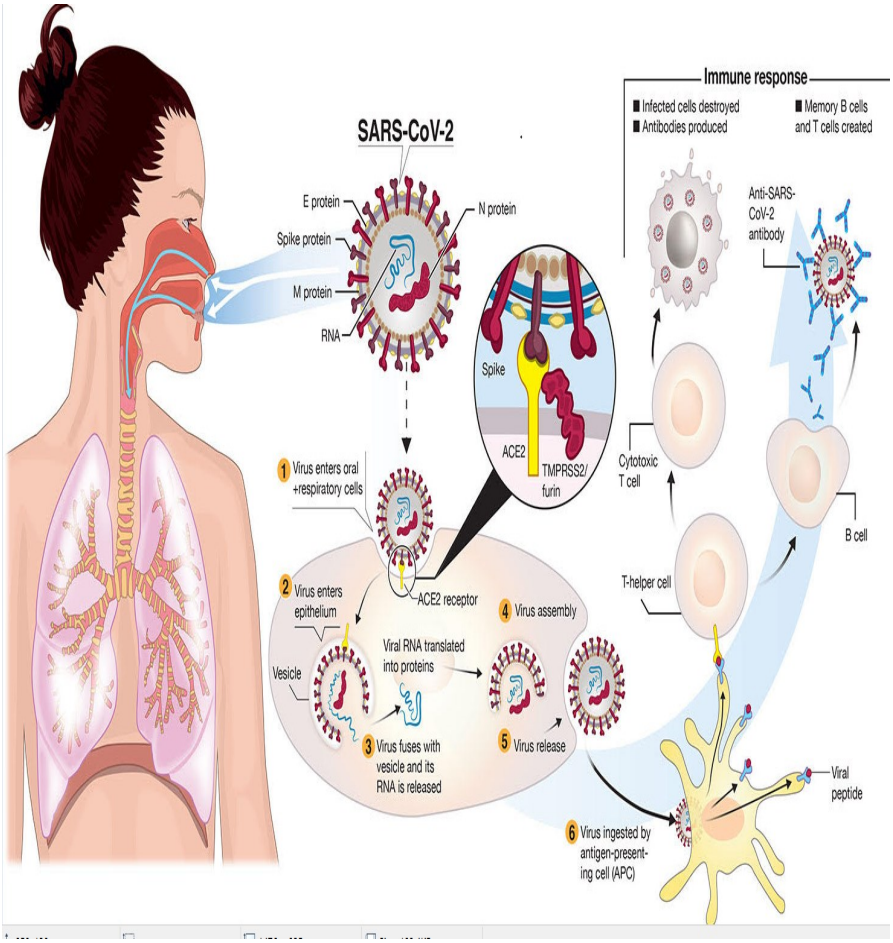
Thank you,

Ngozi Young
Assistant Manager, Operations
CAQH – Streamlining the Business of Healthcare
2020 K Street, NW |Suite 900 |Washington, DC 20006
Phone 202.664.5610 | nyoung@caqh.org | www.caqh.org"

The AMP board of directors is considering candidates for a board of directors' vacancy and we hope to be fully staffed in the next two months.

Finally, I want to thank my friends and colleagues on the AMP board for their time, tireless efforts, and commitment to enhancing the specialty of Medical Psychology for the benefit of our patients and communities. There are many "moving parts" at AMP and the AMP board welcomes interested AMP members to contribute to the advancement of medical psychology by becoming involved in some capacity, in the AMP effort.

Please stay safe and healthy



(Whither Screening, Pollak cont.'d from p. 3)

their embrace of this model.

However, data is clearly needed as to whether personality screening, employed during the intake process and, as deemed appropriate, periodically through the course of treatment, is helpful in identifying patients who are most likely to benefit from a distress tolerance/coping skills care model in contrast to patients who may be better served by alternative interventions. Also, specifics would be welcome as to whether such screening would help to decrease iatrogenic effects (the unintended negative consequences of seemingly helpful health care interventions) by alerting medical psychologists to personality factors that may prove inimical to a distress tolerance/coping skills approach and result in less than favorable and even deleterious outcomes for some patients.

That said, the issue of medical psychologists routinely referring their patients for formal personality assessment to assist in clinical decision- making is often problematic especially for the many patients who are primarily seeking relief from troublesome symptoms. Reasons include problems accessing psychologists who specialize in personality evaluation given the "hit and miss" and often low insurance reimbursement for this service; frequent lack of patient compliance/follow through and timely completion of these evaluations.

What is sorely needed in mental health care generally and, specifically, for the many patients for whom a distress tolerance/coping skills approach is being considered, are brief evidence-based personality screening tests which have been shown to be meaningfully related to key treatment parameters and that can be quickly and easily incorporated into intake evaluations and, as needed, reintroduced during the course of treatment including in the termination phase.

Such screening instruments would, hopefully, serve to compliment and augment the use of symptom checklists which are increasingly being employed with good success during the intake process to clarify diagnosis and plan treatment. These "personality screeners" might also be productively combined with motivational interviewing techniques in specific cases.

Five-Factor Personality Dimension Model: Research highlights the sensitivity and strong associations of the "Five Factor" personality dimension model to the treatment parameters cited above.

Extraversion versus Introversion

Agreeableness versus Antagonism

Conscientiousness versus Undependability

Openness versus being Closed to Experience

Neuroticism versus Emotional Stability.

Based on this model examples abound that may hinder achieving favorable outcomes utilizing a distress tolerance/coping skills approach: Motivation to persist in treatment may be compromised among patients who are low on Conscientiousness and Openness and high on Neuroticism. It may be difficult to productively engage patients with this approach, which typically involves a substantial "homework completion" component, when they are low on Agreeableness, Conscientiousness and Openness. Alliance building may be thwarted by patients who are low on Openness and Agreeableness.

Moreover, following a sustained improvement in presenting symptoms medical psychologists may encounter considerable resistance

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being able to respond quickly was almost impossible. To complicate this picture, several groups of providers had been told in the past that some services would be covered only to find that payment was denied. This has significantly undermined any trust of directive or promises made by the government and/or other entities to healthcare providers.

For many decades, the health of the American population has been undermined. Over the last four decades, the average American's food consumption has steadily increased. In 2017, the average American consumes a whopping 3,600 calories per day, a 24 percent increase from 1961 (Bird, J. et al, 2017). During this same period, the nutritional (vitamins and minerals) deficiencies in the USA have increased contributing to physical and mental/emotional problems. The reality is that the foods ate in 1953 had more nutritional value than they do today. Thirty-two percent of Americans are deficient in vitamin B6 intake, ninety-five percent of adults (ninety-eight percent of teens) are deficient in vitamin D, and sixty-one percent of adults (ninety percent of teens) are deficient in magnesium. These deficiencies, and the intake of foods that promote free-radicals, contribute to difficulty in recovering from both physical and psychiatric maladies. Research has suggested that a zinc deficiency can contribute to the damage done by the coronavirus (te Velthuis AJW, van den Worm SHE, Sims AC, Baric RS, Snijder EJ, et al, 2010) . Zinc deficiency, which is commonly with elderly, may contribute to the damage done by COVID-19. It has been found that Zinc (Zn2) can inhibit activity of coronavirus and arteriivirus. It has been shown that N-acetyl-L-cysteine can inhibit virus replication and expression. It has also been suggested that N-acetylcysteine (NAC) can inhibit virus replication and expression (Geiler J1, et al, 2020). N-Acetylcysteine is a supplement form of cysteine, an amino acid, which is found in most high-protein foods (i.e., chicken, turkey, yogurt, cheese, eggs, sunflower seeds and legumes). It has been used in reducing the damaging effects of acetaminophen overdoses.

Thanks to the work of key scientists in China and other countries, it is suggesting that nutrient deficiencies are key factors in the treatment of SARS CoV-19. This is very concerning. Over the last decades we have seen an increased number of nutrient deficiencies in the general population, especially in older adults. These nutrient deficiencies, the increasing pollution of the environment by chemicals and electromagnetic frequencies, (EMF) which increase oxidative stress and inflammation, and deterioration of our immune systems set the stage for increased impact of a pandemic. Both free radicals and EMF have been shown to increase oxidative stress, undermining overall health (Kıvrak, E. G., Yurt, K. K., Kaplan, A. A., Alkan, I., & Altun, G., 2017). Inflammation caused by oxidative stress is a problem in several psychiatric and medical conditions. The impact of oxidative stress and mitochondrial dysfunction has been shown to be present in bipolarity (Salim, 2017). The specific role of oxidative stress is unclear, but there is evidence that it is a contributing factor. This would justify attention to possible factors which increase oxidative stress and ways to reduce it (Salim, 2014). One of the sources of oxidative stress is EMF (electromagnetic frequencies) which include wifi, cellular phones and other devices (Kıvrak et al., 2017). Another source of oxidative stress is the ongoing exposure to neurotoxins (including glyphosate) in the environment and in our foods. Supplements such as Vitamin C and E do help (Bhardwaj, Mittel, Saraf P, 2019). Neurotoxins such as glyphosate, pesticides, herbicides, and heavy metals have all been associated with neuroinflammation. In contrast, various nutrients have been shown to help support the immune system. Zinc is well known for antiviral action, and has been shown to be of value in both reduction of infections and the healing of wounds. Vitamin A has been shown to help reduce various infections (measles virus, HIV, avian coronavirus), and deficits in Vitamin A could impair the effectiveness of some vaccines. Vitamin D acts as both a nutrient and a hormone. Deficiency in this nutrient can easily impact the maturation of immune cells. Vitamin D is responsible for not only bone density, but also is involved in optimizing the immune system and reducing inflammation (Gunville, C., Mourani, P., & Ginde, A., 2013). Almost everyone knows that you should take Vitamin D3 in combination of eating calcium rich, fatty foods, but the balancing act does not stop there. The relationship between Vitamins D3 and K2 is like a marriage. Vitamin D3 may do a great deal of work, but K2 helps guide it on where to go (van Ballegooijen, A. J., Pilz, S., Tomaschitz, A., Grübler, M. R., & Verheyen, N., 2017). Selenium deficiency can cause oxidative stress and undermines body's ability to fight off viruses. The bottom line is that our bodies function on a biochemical/biophysiological balance which, if impaired, can make us more susceptible to viral infections and greater viral virulence (Zhang, L. & Liu, Y., 2020). The need for integrated healthcare is obvious.

Our knowledge of the impact of inflammation and oxidative stress is extensive thanks to Agent Orange and the Gulf War Syndrome. Research groups such as Golomb Group at UCSD have been exploring various aspect of oxidative stress and mitochondrial dysfunction for years. One physician, Alex Vasquez, DO, ND, DC, who is in Barcelona, Spain, has attempted to provide the medical

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Introducing New Board Member, Dr. Keith Petrosky:

Keith Petrosky, PHD, ABMP, is a graduate of the University of Pennsylvania. He did his doctoral studies at Temple University. He has been a regular contributor to The Clinical Practitioner for the last several years.

Dr. Petrosky is in full time private practice in the Main Line Philadelphia suburb of Exton. He evaluates and treats adults and children using cognitive behavioral therapy and biofeedback. He performs disability evaluations for veterans as well as employees of a number of private and public corporations. He also evaluates couples who are hoping to adopt children or to become foster parents. He does presurgical evaluations for bariatric and spinal implant surgery. He provides pain management services to several pain practices and physical rehabilitation services.

In addition to his private practice work with adults, children, and families, he is a consultant to a regional cardiology program where he has directed a lifestyle change group for heart attack and post-surgical heart patients for more than 15 years. He developed a number of hospital-based programs, including an integrative health and healing program for cancer patients and an anxiety management program for patients anticipating surgery. He has provided stress management programs for large business corporations and hospital employees.

JOIN OUR GROUP OF PROFESSIONALS

Members are licensed psychologists who have an interest in medical psychology and will have full voting privileges in elections of officers and board members. Members are not Diplomates/Specialists in Medical Psychology, but are licensed psychologists who have an interest in medical psychology… http://amphome.org/wordpress/why-join-amp/

BOARD CERTIFICATION INFORMATION

Board certification in Medical Psychology indicates specialty expertise, which distinguishes you from other psychologists who do not have post-doctoral specialty training in medical psychology, basic science, and psychopharmacology and work with patients in or in affiliation with healthcare facilities in the nation's core healthcare system… http://amphome.org/wordpress/abmp-requirements/

GET THE TRAINING YOU NEED

The national practitioner's association (National Alliance of Professional Providers in Psychology) in psychology (www.nappp.org), one of our affiliated organizations has kindly offered the below CE courses relevant to our discipline. There are several continuing education courses available to members… http://amphome.org/wordpress/continuing-education/

ALLCARE MEDICAL CENTERS (ACMC)

IS OFFERING:
PRE-DOCTORAL INTERNSHIP AND POST-DOCTORAL RESIDENCY TRAINIING OPPORTUNITIES FOR PSYCHOLOGY STUDENTS AND GRADUATES IN:

CLINICAL PSYCHOLOGY, MEDICAL PSYCHOLOGY AND NEUROPSYCHOLOGY

Dr. Matthew Nessetti, one of AMP's pioneering founders and specialists in medical-psychology is also a physician specializing in family medicine. He and his wife, who is also a physician, operate AllCare Medical Centers (ACMC) comprehensive clinics in Florida providing medical, psychological and integrative healthcare services. AllCare is offering a psychological internship as described in the advertisement below.

AllCare is a family owned organization providing primary healthcare to patients of all ages, from newborn to aging adults. A psychological component is integrated throughout the primary healthcare practice, concentrating on the necessity to concurrently treat both the mind, as well as the body. Interns will provide psychological services, including individual and family therapy, to an outpatient population to children, adolescents, adults, and geriatrics that present with acute mental health issues. Interns will have the opportunity to provide neuropsychological assessments to patients presenting with psychological, neuropsychological, and medical conditions. Interns will also provide comprehensive psychological assessments to children, adolescents, and adults for diagnostic clarity and treatment planning.

ACMC offers a one-position two-year Residency in Medical Psychology. Throughout the program, each resident will benefit from a planned, programmed sequence of supervised training experiences. The first year serves as the post-doctoral year required by most states for licensure. Each resident is evaluated based on their experience, training and level of competency in clinical services, with training activities then tailored to meet each resident's needs. The second year serves to meet the licensure requirements in some states and build toward the board certification process. Selection is based upon the quality of the application and the compatibility between the applicant's interests and their ACMC goals and objectives.

Please contact Kelly L. Nessetti Prather at AllCare (contact information below) for additional information on the program and for information on applying:

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It has been proven repeatedly that the medical colleges of the Western world are deficient in training in nutritional sciences, and its ongoing interplay with psychiatry and general health. Funding for integrative medical care, functional medicine, nutrient laboratory testing, and other areas of medicine have been reduced to almost nothing. Natural approaches have been essentially ignored by the "medical community" all the while the prescribed medications have increasingly depleted the bodies of patients. When the patients use of supplements is noted, the potential help or harm is not truly understood by some practitioners due to their lack of knowledge. Psychologists depend on medical staff to rule out medical conditions in order to determine psychiatric diagnoses. Yet, a thorough assessment including the levels of nutrients, is rarely provided. This is concerning since many of these nutrients can mimic or lend to psychiatric disorders. A patient with memory difficulties who is also having muscle cramps, and problems with reducing bone density may be suffering from hypocalcemia. A patient who reports seizure events, anxiety issues, hypertension, muscle twitching, increased pain perception, and hyperactivity may be suffering from hypomagnesemia. It is estimated that fifty percent of the American population is magnesium deficient. This impacts the ability of Vitamin D to be properly utilized[2]. A patient with vision distortion, arrhythmia, irritability, nervousness, paresthesias, weakness, lethargy, apathy, fatigue, and depressed mood may be suffering from hypokalemia. The fact that we do not test for these, or take into account the amount of supplements a patient has taken in the past and currently, constitutes a failure of the medical community to provide adequate medical assessment and treatment options. The amount spent on over-the-counter antacids and prescription GERD medications is extensive. Given this, it is concerning that repeated use of antacids can result in B12 deficiencies. With this pattern, it is becoming even more essential that all psychologists and physicians (and supplemental professions of nurse practitioners and others) become aware of the potential problems which can be caused by not providing the essential nutrient and health practices for health. We are sometimes too quick to prescribe medications for symptoms rather than do the work to identify causes.

As a medical psychologist, I have found myself in a complicated position. By professional and ethical obligation, I have continued to extend my expertise to include extensive psychological sciences, theories, psychotherapeutic arts, psychodiagnostics, testing, biomedical sciences, clinical biochemistry, psychopharmacology, and the complex interplay of Western medical approaches and psychological approaches. Because of that, I have been drawn into the areas where Western approaches have lost their way in ignoring the very basics of physiology. It has been proven repeatedly that the medical colleges of the Western world are deficient in training in nutritional sciences and its ongoing interplay with psychiatry and health. Funding for integrative medical care, functional medicine, nutrient laboratory testing, and other areas of medicine have been reduced to almost nothing, natural approaches have been abdicated by the "medical community."

This lack of interaction between healthcare providers has been used as one of the reasons why clinical nutritionists and medical students are lacking awareness of clinical nutrition. There has been a failure of medical schools to provide adequate training in clinical nutrition. Another factor which tends to reduce the full implementation of integrated care is that medical practices, which do not focus on prescription medications, tend to be minimized or negated in funding of healthcare. These include laboratory tests, functional medicine, and complementary/alternative services. For example, recent concerns about having too much Omega-3/6 in an individual patient's system was raised by some medical publications, yet the laboratory testing for essential fatty acids is not covered by most insurances including Medicare. This leaves patients and practitioners to "guess at" the levels in a patient taking supplements. The benefits of essential fatty acids has been well established, especially in countries on Western diets with limited, if any, inclusion of oily fish in their diet[1]. There are essential fatty acids in fish oil which are not available in flaxseed oil or chia seeds.

The self-isolating and self-quarantining are the best methods we have of reducing harm. To make this work, all the details of ongoing treatment needs and new treatment needs must be addressed. I have always found that minimizing and deceiving the public is likely to amplify panic and negative reactions once the true is known. To "lose little" in this situation, we need to take the more restrictive "stay at home" options. I know that this is not appealing, but it is necessary to reduce the number of individuals harmed and minimize the impact on economy.

Even after opening reimbursement up for telepsychology, there have been missing elements which continue to be missed. For example, individuals who are not existing patients of a psychologist, or other behavioral health specialist, do not have any access to telepsychological evaluation or services. This means that if you have a psychiatric issue that you have been able to marginally manage under normal conditions, the

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trying to help patients who are low on Openness and High on Neuroticism to successfully transition to a broader set of treatment goals. These might include addressing longstanding problematic patterns of behavior and thinking as well as enhancement of subjective well-being and self-understanding (Bagby, Gralnick, Al-Dajani, & Uliasek; Zinbarg, Uliaszek & Adler, 2008).

Research indicates that clinicians utilizing a Distress Tolerance/ Coping Skills model should be especially mindful regarding treatment goals and objectives with patients with high Neuroticism as this Five Factor domain has been persuasively linked to less favorable outcomes likely due, at least in part, to problems making effective use of coping skills (Bucher, Suzuki, & Samuel, 2019) Some patients with significant elevations on this Five Factor personality dimension may respond better to psychopharmacologic treatment or a combination of a distress tolerance/coping skills approach and medication management especially in the treatment of depression (Bagby, Gralnick, Al-Dajani, & Uliaszek, 2016).

In general, patients with Low Neuroticism but with Intermediate to high scores on the other Five Factor dimensions may have the best outcomes in psychotherapy including those that include a distress tolerance/coping skills component. (Bucher, Suzuki & Samuel, 2019).

Selection of Screening Measures: There are several abbreviated measures for personality screening, predicated on the Five Factor Model, which are relevant to a distress tolercoping skills approach especially for medical psychologists working in time sensitive- busy clinical settings: Big Five Inventory/ BFI, Five Factor Model Rating Form/FFMRF, Ten Item Personality Inventory/TIPI and the NEO -FFI-3 (Conte, 2017; Gosling, Rentfrow, & Swan, 2003; McRae & Costa, 2010; Rammstedt & John, 2007; Samuel, South, & Griffin, 2015).

The NEO- FFI-3, a sixty item instrument based on the considerably longer two hundred and forty item NEO-PI-3, is strongly preferred as the screening measure of choice (McCrae & Costa, 2010). Although it involves somewhat more time to administer and score than these other briefer measures its many strengths far outweigh the additional time expenditure. These include good support for reliability and validity as well as separate norms for male and female adolescents and adults. Included are T score conversions and clinically useful classifications for each of the five personality domains: Very Low, Low, Average, High and Very High.

This test also includes a three item- yes/no respondent validity check component to gauge the accuracy of patient report and the manual includes discussion of response sets which can highlight possible inaccurate and misleading reporting.

In addition, this version of the NEO includes self-report and informant/observer forms. The latter can be especially useful when there is concern about the accuracy of patient report based on history, clinical presentation and findings from the patient's protocol. In some instances, the informant/observer form could also be completed by medical psychologists as they gain greater familiarity with the patient over the course of treatment.

As well, the test manual includes examples of treatment implications for psychotherapy, broadly defined, which dovetail with the examples cited above.

A computer generated report is available for more detailed personality profiling including information which can facilitate feedback to patients regarding find-

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Ings and recommendations.

Unfortunately, unlike the NEO-PI -3, the NEO-FFI-3 does not include the six "lower order facet scales-" six items comprising each of the five "higher order" factor scales. This set of thirty items helps to provide a more nuanced and, arguably, a more clinically useful personality profile.

Also, although the NEO-FFI-3 is marketed as requiring a maximal time expenditure of twenty minutes for manual administration and hand scoring additional time may be needed for some patients and medical psychologists to make productive use of this test, in particular, patients who are highly anxious and/or are circumspect and deliberate in their approach.

Of course the NEO-FFI-3 can be bypassed in favor of administration of the NEO-PI-3 (which includes the "facet scales") with selected patients who seem motivated to complete a lengthier and more time intensive test and also appear to have a complicated clinical status which may warrant a more in-depth assessment.

Treatment Impasse: For patients in a seemingly intractable treatment impasse but who appear invested in continuing in treatment, a referral for psychological testing should be considered with a rule out of one or more personality disorders and/or other mental health conditions as contributory to the stalemate. This would typically include use of instruments like the Minnesota Multiphasic Personality Inventory/ MMPI (the third edition is preferred which is expected to be available later in 2020) or the Millon Clinical Multiaxial Inventory- IV/MCMI-IV together with other tests deemed appropriate by the consulting psychologist.

Of course, medical psychologists are free to complete such assessment on their own. Still, a "third party" with a "fresh set of eyes" is often a more prudent course to follow when treatment appears to have stalled.

Future Research Directions: It remains an open question whether integrating personality screeners into the treatment process and, in particular, to a distress tolerance/ coping skills model of care, will prove to significantly enhance differential diagnosis, intervention planning and outcome as well as have a salutary impact on other important treatment parameters. More research is clearly needed to better clarify this issue. This would include studies which would, hopefully, provide more robust support for the kinds of clinical examples cited above which are theoretically compelling but need stronger empirical validation. Ideally, research will emerge which identifies Five Factor personality profiles which are reliably associated with key treatment parameters and significantly impact clinical decision-making for the better.

Data is also needed regarding the attitudes/opinions of medical psychologists and other clinicians, who may utilize a distress tolerance/coping skills model, as to the clinical utility of personality screening, which instruments, if any, they employ and the extent and context of their use.

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(Dr. Richardson cont'd from p.)

correctional system, before treatment could be addressed.

In attempting to control cost through complicated rules and hoops which may have been sold on the basis of quality control are in fact, simply adding to the obstacles to providers believing that they will be reimbursed for their efforts, and being assured that they will not become the target of litigation or Board actions.

Another complication which was not foreseen, is that not all Americans have access to using the internet or have adequate access to wifi or cellular signals. Much of our nation is rural with limited signals.

What is of great concern is that in the face of the extended nature of the COVID-19 SARS pandemic there is a balancing act between survival of the economy versus the survival of the populous. Medical experts consistently assert the need for total "shelter in place" until the pandemic is control against the desire to rush to a resolution to return commerce to normal function. This is where the COVID-19 pandemic creates a new landscape. The virus is highly contagious, long living, with an extended incubation period. These conditions are the perfect storm in impacting civilization. The normal flu had a relatively short period of life on surfaces and a rapid incubation period. Thanks to information from various sources, it is obvious that this virus can live very long on surfaces, be spread by air droplets, and have an incubation period longer than 27 days. This significantly extends the length of time that it will take to control the pandemic.

If we had created a healthcare reimbursement structure which was flexible, and depended on the autonomous decision making of the licensed healthcare providers, rather than a "one size fits all" system, the professional judgement and ethics of those professionals could have resulted in a more responsive infrastructure. The more the autonomy of the professionals are undermined by excessive "cost saving rules," the more resistence to change is present. In the UK and Canada, where universal healthcare is available, the structures bypass the excessive cost of fighting with insurance companies and entities for answers.

If we wish to be able to respond to this and future pandemics, it is essential that we simplify the reimbursement system, start to promote nutritional education in both medical schools and other healthcare professions, and set the stage for professionals to do their work with more autonomy and flexibility to respond to immediate needs of patients. The healthcare professions have seen a drop in enrollments, and an exodus of highly skilled professionals, due to the complications and harassment that professionals face today. The strength of any nation is the skills, talent, and health of each citizen. Mobilizing both professional and manufacturing personnel will not be possible if we do not invest in the education of it's populous. We have outsourced to the point of crippling our workforce and our country, now becoming very apparent as we try to deal with this deadly pandemic. It is time to make changes.

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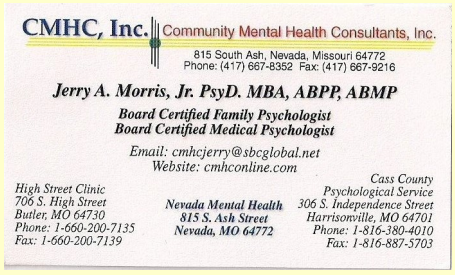

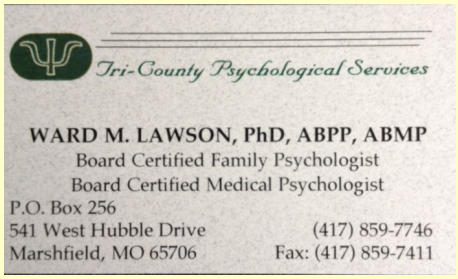

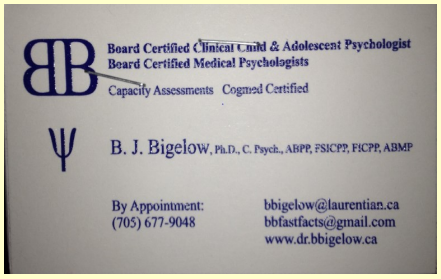

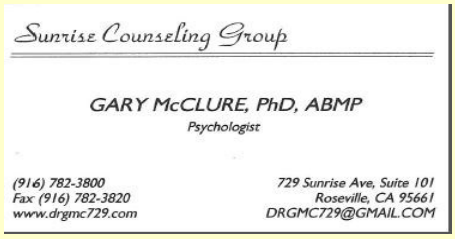

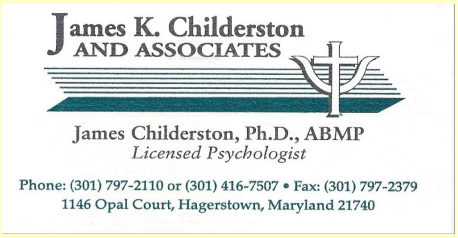

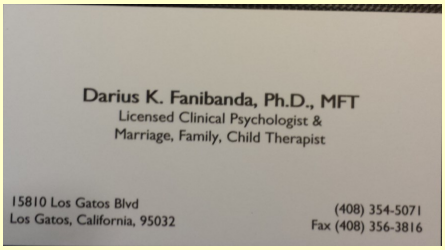

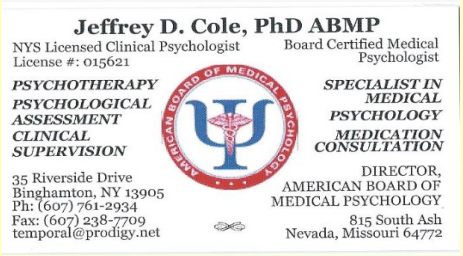

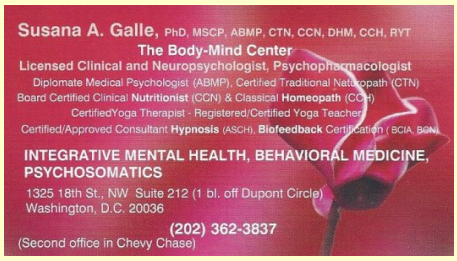

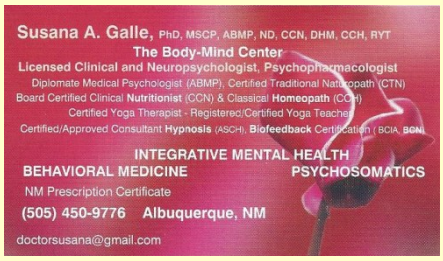

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Specific topics that past articles have addressed, or that would be welcomed, include but are not limited to the following:

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Invitation to Join the Archives of Medical Psychology Team

Ward M. Lawson, PhD, ABPP, ABMP
Managing Editor, Archives of Medical Psychology

The Academy of Medical Psychology received final approval of its trademark and logo of the Archives of Medical Psychology in November 2009. The Board of AMP and ABMP seeks your assistance in the editing and publishing of the Archives of Medical Psychology.

The Academy of Medical Psychology was founded as an organization of practitioners for practitioner interests through volunteerism. Service on the Board is an unpaid duty of psychologists dedicated to the advancement of Medical Psychology. Medical Psychology's goal is to enhance access to specialty behavioral health care that is in such short supply that it has been declared an emergency in some states and recognized by military and veterans' services as a critical shortage. State prisons have been designated as mental health shortage areas by HRSA and prisons in some states are in the hands of federal receivership. Thus, the Academy has a crucial role as practitioner organization in advocating for the health and safety of the public at large and the military and other governmental agencies designed to serve public needs. The advocacy role for public health service must be a primary mission of the Academy.

The Archives of Medical Psychology, on the other hand, is a repository of information that can serve this advocacy function of the organization and collect valuable new data for continuing education of members of the Academy. Editing of the Archives must be by people that have the necessary experience in medical psychology and the skills to carry out these functions. Editing also requires electronic communication skills for the actual publication of the Archives. The variety of the skills necessary for publication in the journal are unlikely to be found even in a complete Editor. Members of the Board of the Academy are already assigned specific tasks and duties within the organization and cannot be expected to contribute routinely in the editing and publishing of the Archives. Therefore, the Board has begun a search for members of the Academy to volunteer in the editing and publishing of the Archives and ask your personal support. The Board of AMP invites you to contribute your services to the Archives. We welcome AMP members with prior publishing experience and those with computer expertise who are willing to learn the rudiments of editing and electronic publishing. For further information contact Ward Lawson at ozarkscare@yahoo.com .

Dr. Ward M. Lawson: Editor

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The year 2020 was a complicated and challenging one for AMP as it was for psychology and healthcare in general. While much of the population faced unemployment Clinical and Medical Psychologists — like other doctors in healthcare — were often facing overwhelming patient caseloads, epidemic stressors and new modes of healthcare delivery, e.g. Telehealth, at levels never before encountered. The learning curve was as steep as caseload — both due to stressors associated with the pandemic and the greater geographic reach afforded by Telehealth — were exponentially expanded. AMP President Dr. Gary McClure and Executive Director Dr. Ward Lawson describe AMP's managing of personnel changes and maintaining a cohesive organization and governing body during these turbulent, high-pressure times. Long-term officials in AMP, Dr. Morris and Dr. Caccavale — revered for their years of fighting for the organization and for practicing Clinical and Medical Psychologists — departed the Board and made way for new leadership as described in Dr. McClure's and Dr. Laswon's articles. AMP positions itself and readies itself for making inroads (via CE's, CAQH recognition and others) toward establishing itself as a far-reaching force in healthcare in 2021.