

ACADEMY OF MEDICAL PSYCHOLOGY

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IN THIS ISSUE

- 1** PRESIDENT'S MESSAGE
- 4** EXECUTIVE DIRECTOR'S COLUMN
- 5** RELATIONSHIP, STRESS AND BIOLOGY
- 8** TRENDS IN PSYCHOPHARMACOLOGY
- 11** LIFE ON THE INSIDE: PRISON PSYCHOLOGY
- 14** A WEIGHTED WAIT: HOSPICE LIFE

President's Message

By Keith Petrosky, PhD, ABMP

As president of AMP my goal is to help to further actualize John Caccavale's vision for professional psychology when he established AMP as well as the National Alliance of Professional Psychology Providers. As many of you know, his motive for doing this was to compensate for what the American Psychological Association had largely failed to do in not properly representing and supporting the doctoral provider.

When psychologists first began to prescribe in New Mexico, on March fifth in 2002, APA never got "on board." I was there in Sante Fe at that time to celebrate this historical event and it is hard for me to believe that this was more than 24 years ago. A psychiatrist who worked with the Native American Health Service was one of the speakers that day. He was a graduate of Princeton University, and he expressed his complete confidence that doctoral psychologists could safely prescribe. I thought that would be the beginning of

a rapid transition to national prescription privileges for psychologists. I was wrong. Even now, APA is only giving lukewarm support for the RXP initiative.

By contrast the national nurses' association was able to gain nationwide prescribing privileges in about a year's time for their members by fully backing this effort for an expansion of nurses' scope of practice. Since the inception of nurse practitioner prescribing the supervision requirements have lessened. They are now doing this largely independently. We know that nurses are not trained to diagnose mental health conditions to the same proficiency level as a doctoral psychologist (nor are most physicians) and that they also do not have sufficient time with the patient to adequately choose the best medication. Some of the prescriptions that I have seen (for example psychostimulants like Adderall for depression in middle-aged adults) are

unusual if not erroneous.

I am still amazed that John Caccavale was able to do more to help the practicing psychologist than all of presidents and board members of APA over several decades (along with organizations like the National Register that have also largely failed us). Jerry Morris also deserves substantial credit for providing significant assistance in helping to reify John's vision for AMP.

The Academy has also been well served by past presidents and executive directors as well as our many distinguished and accomplished board members both past and present. In taking the reins of this organization I am attempting to stand on the shoulders of these distinguished practitioners to add something significant to what has already been accomplished.

Board Member News - Our current board consists of Ward Lawson, Jeff Cole, Robert DeFrancisco, Cherie Rubin, Elizabeth Moham, and myself. Jeff has taken over the AMP Newsletter and Robert DeFrancisco is chairing the Oral Exams. Bob has also contributed several ideas to expand our membership. Elizabeth Moham is a recent ABMP diplomate who is dually credentialed as a medical psychologist and board-certified psychiatric pharmacist. She was kind enough to volunteer to help our National Plan by researching the names of the legislators who serve on committees for health or mental health for each state. She is currently assisting Jeff Cole in putting together this newsletter.

I am appreciative of Ward Lawson's solid support in his role as Executive

Director for the strategy I have proposed for expanding AMP's visibility to professionals and to the public as well as the plan to use consumerism to help launch national psychologist prescribing. Having everyone on the same page is so important to our goals and objectives and future success!

The National Plan - I am happy to report that the National Plan is now operational on Facebook and we can track how many people are presented with the ad, the pages that people click on, and whether someone takes the final step of sending a letter to their state legislator. When they send these letters, we also capture their names and email addresses.

The formula that Facebook uses is an internal algorithm that they have for sending our advertisement to people they think will respond to it as they scroll on Facebook. Their algorithm is different from Google which operates by sending advertisements to people based on the words that they enter their search bars.

I am still learning about this modern advertising technology along with everyone else and I sometimes make assumptions that turn out to be erroneous. For example, I thought that if I searched on Facebook for things like mental health medication, anxiety, depression, etc., that I would begin to see our ad popping up as I scroll. It does not happen exactly like that. However, I have lately been pleased to see our ad beginning to pop up randomly as I scroll.

Judging from my own experience as a consumer, I recognize that most people are not going to respond to an ad the first time they see it. I sometimes do

not have the time to look at something interesting that I see or I may be waiting for the ad to repeat when I am in the proper “head space” to take a closer look.

Our ad has reached 23,160 people and 4 percent of them have responded to our ad by clicking on it for more information. That is considered excellent. This preliminary data shows that the front page of the ad is effective at getting people’s attention. In terms of actual numbers, in the first ten days of our campaign our advertisement reached 2,175 people and 90 of them clicked on our ad to find out more about it. We are quickly finding that we need to get people to the final (letter writing) page sooner since most are not progressing past page three or four. Our web designer is making this modification to see if it helps. Of course, if I were a member of the public I might need to see the ad more than once to have the time to send a letter. So, judging by that this possible need for a “second look” may not be anything out of the ordinary.

Our advertising campaign will also probably take time to build as people tell their friends and relatives about our campaign and hopefully get them to “spread the word” to help us to accomplish our objectives. After a little more experimenting with modifications of our Facebook advertisement our web designer will begin putting it on Google.

Re-Starting Grand Rounds - We are also in the process of re-starting our popular Grand Rounds program which had lapsed due to some administrative issues. Re-starting this program, which provides APA CE credit, was one of my first initiatives as the new president. As

soon as we get the go-ahead from APA (hopefully any day now) we will begin resuming providing CE credit programs that focus on psychopharmacology as well as psychotherapy and other issues. In the past psychopharmacology was not a particular emphasis of our Grand Rounds programming but considering that every ABMP diplomate is expected to maintain their psychopharmacology knowledge for recertification each year we have decided to provide a lot more instruction in this area.

Our members are also encouraged to take advantage of the psychopharmacology programs of Decera Clinical (formerly Clinical Care Options). They offer free, “live” (virtual) continuing education. You can register with them, and you will begin receiving notices of educational events that cover the entire gamut of physical and mental healthcare. These programs provide APA CE credit with one CE for each hour of training. In our Grand Rounds programs, we will attempt to summarize some of the more important elements of these seminars for our own group of participants who may not have the time to attend these programs when they are offered. Sometimes they can take up an entire weekend of one’s time and that is something that may not always be possible for someone to do.

While the application for an ABMP sets a minimum standard for supervised medication recommendations, some members of our group have considerable experience doing this. We will be taking advantage of this clinical experience in our Grand Rounds programs. For example, two of our board members (Robert DeFrancisco and Elizabeth Moham) make

medication recommendation decisions virtually every day in their clinical practices. I also have extensive experience in recommending medications (over five thousand prescriptions) during the 13 years that I worked in a general hospital.

I will be calling on Bob and Elizabeth (and myself) to digest the essence of some of the Decera lectures on psychopharmacology and to present a more condensed version to members of our Grand Rounds group. However, any member of AMP who has extensive prescribing experience is welcome to take a turn at presenting on these topics.

For example, someone may work with a particular population, and they may provide some helpful tips regarding issues to watch for. Someone else may have knowledge of a class of psychotropics that interacts with medications that are frequently prescribed for a particular condition. That knowledge is valuable to those of us who may only see those cases on an occasional basis and thus not have this “insider” knowledge.

As always, any AMP member or diplomate is welcome to present at our Grand Rounds if they follow the APA requirements for CE credit. (We will provide those details to any interested parties.)

That’s enough news for now, so look for more updates about AMP’s activities in our next publication. Send any comments or questions to drkeith1@verizon.net.

Executive Director’s Column

by Ward Lawson, PhD, ABMP, ABPP



I am proud to represent the members of the AMP, some of the most well trained psychologists in the world. Our membership is holding steady with some retiring balanced with new members, including graduate students and late career psychologists. Accrediting bodies and stakeholders continue to ask for confirmation of board certification status for fellows indicating the diplomate credential is viewed as highly valuable and indicative of excellence in training. Additionally, we’ve had ongoing updates to our website with a streamlined membership renewal process, along with the addition of several CE courses inherited from the National Alliance of Practicing Professional Psychologists.

Our own trademarked professional journal, *The Archives of Medical Psychology*, which is our repository of professional literature supporting the value and relevance of the specialty, slowed in publication frequency due to the retirement or deaths of some of the great leaders of our field who contributed regularly. We need you highly trained individuals to step up and contribute to the specialty and its body of knowledge by submitting articles for

consideration for publication.

Relationship, Stress and Biology



By Jeffrey D. Cole, PhD, ABMP

As research has improved over the years and there has been more attention paid to qualitative and narrative studies to better inform our interpretation of population studies we are getting a clearer view of the role of relational-affective processes in mental health, illness and healing and of the interactive and reciprocal relationship that constitutes interacting psychological-biological variables versus “biological OR psychological” variables in these states and processes. This brief article reflects on some of the state-of-the-art findings in interpersonal-neurobiological events from practice evidence as well as populations studies affecting mental health, disorder and treatment and their implications for psychotherapy and mental health treatment in general.

Evidence suggests that psychotherapeutic and biological intervention both contribute to healing and providing these together might comprise the most effective approach to treatment. At the same time there is preliminary data showing that those psychological approaches that result in the most measurable biological change are the most enduring (Sened, Zilcha-Mano & Shamay-Tsoory, 2022). For experienced psychotherapists results showing the

potency of psychotherapy is not surprising given observations from our practices of patients fully recovering and growing beyond premorbid levels of functioning with psychotherapy alone, or with medications as an adjunct even if in another setting the same symptom presentation might have been addressed with primary biological intervention, e.g., medication.

As early as the 1900’s Ramon y Cajal demonstrated neuronal changes associated with stimulation. Since then a whole body of research has grown up showing that our nervous system is not static or “locked in” early in life (Fuchs & Flügge, 2014). Instead, encounters with our environment - i.e., life experiences - and our associated behavioral responses result not only in changes in the communication between our neurons but in the structure of our nervous system itself. Changes in our nervous structure and operation are usually Hebbian changes often summarized as “neurons that fire together, wire together” (Choi & Kaang, 2022). That is repeated, simultaneous activation of neurons strengthens synaptic connections. These strengthened connections form the biological basis for learning and memory. Thus, some of the earliest studies in neuroplasticity - changes in neural connection and innervation due to experience - were in the domain of memory (Liggan & Kay, 1999). This experience and response driven plasticity increases efficiency between cells. It can involve structural growth, establishing stable networks known as cell assemblies.

Much of the impact on our nervous system associated with our mental health is at the level of our emotions and how we handle - or don’t handle, i.e., defend against - our emotions. How we handle or defend against our emotions depends largely on our interpersonal experiences. Unmanaged emotional experience results in stress.

Protracted stress, in turn changes our neurobiology over time through the effect of neuroendocrine processes that change availability of key neurochemicals, e.g., norepinephrine, dopamine and serotonin involved in our psychological processes, response to challenges and well-being.

Key learning experiences associated with handling our emotions are those that involve our interpersonal, in particular our attachment experiences. Our interpersonal-affective history determines our response to emotional stimuli and challenges and our expectations of subsequent relationships. Learning that relationships are potentially supportive and facilitative of managing environmental challenges and the accompanying emotional events provides a vastly superior resource for navigating reality versus expectations that no one can be relied on or trusted and that life is, in many ways unpredictable and beyond our abilities to manage and control.

What are the relational processes of psychotherapy that “change the brain” of someone who has experienced emotionally unsupportive or invalidating interpersonal relationships? These can be summarized as those interpersonal events that result in the patient experiencing their emotion themselves differently, i.e., manageable as opposed to overwhelming stimuli to be avoided or defended against. Looked at in terms of nuanced interpersonal behavior these events include the psychotherapist attuning with the patient emotionally, i.e., interpersonally perceiving and intrapsychically accessing the emotional quality of the patient’s experience and conveying this awareness to the patient. This process results in the individual experiencing their emotion as both interpersonally acceptable and physically survivable (Stern, 1985).

What is the meaning of “both

interpersonally acceptable and physically survivable”? Psychogenic stress results when the person experiences protracted affective conflict. This can occur when simultaneously present emotions or needs obstruct processing of each other. Fundamentally, this includes the conflict between the patient’s emotional needs and expression and attachment with the attachment figure when the attachment figure fails to attune with and validate the individual’s emotional needs and experience, i.e., “misattunement.” In an infant or young child this conflict takes the form of the child having to “choose” between their emotional needs and experiences on the one hand and the survival instinct to preserve the relationship with the attachment figure -- on who the child depends for their life -- on the other. In order to cope with this “life vs death” dilemma the

child defends against their emotions and “chooses life,” i.e., renounces their emotional needs to preserve the relationship with the misattuned or invalidating attachment figure.

As the child proceeds through life this pattern of “emotional access limited by defense response” governs the individual’s relationship with their emotions to the extent that processing - i.e., accessing, experiencing and working through - their emotions becomes blocked and -- given circumstances evoking the emotion/defense dynamic -- they stay in a state of sustained conflict which is registered by the brain as threat and by the neuroendocrine system as “stress.” Over time this stress affects the operating of the biological system resulting in what we think of as “mental disorder,” the form and type depending on interaction with the individual’s existing biological composition (e.g., genetics and epigenetics) and the form, type, strength, duration and

pattern of stressors including internalized interpersonal experiences of emotion. A “mouse stress atlas” was recently proposed by researchers looking at results of an analogue study showing the different stress patterns and associated nuances in changes to the Hypothalamic Pituitary Adrenal (HPA) Axis differentiated by different stress profiles in mice (Flati, Gioiosa & Chillemi, 2020) with potential to investigate different stress profiles related to interpersonal-emotional conflict in humans.

When the psychotherapist attunes with their patient emotionally the patient has the experience of an attachment figure staying present with them even with their defended-against emotions. This “staying with” results in the patient gradually attaining fuller access to and awareness of their emotions - and the concomitant relinquishing of associated defenses - processing and working-through of the emotions and resolution of emotional conflict. This processing and resolution of emotions and emotional conflict results in abatement of threat as interpreted in the brain and a return from an allostatic to homeostatic systemic state, changes in neurochemical availability and abatement of symptoms of mental disorder.

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Introducing Dr. Elizabeth Moham, Pharmacology Editor



It's a tremendous honor to introduce myself as the co-editor for the ABMP newsletter. A little bit about me: I've been a registered pharmacist since 2005, and then 20 years later, I became a licensed psychologist! A very unexpected career change for sure, but one that I'm so proud of. It's never too late to do what you love, and I'm living proof of that! Although I have a ton of clinical experience on the medical side, it's exciting to embark on this new journey in psychology! I'm hoping I could add a different perspective to Medical Psychology and maybe even to our newsletter. In this issue, we've added new columns such as experiences from other healthcare workers as well as a psychopharmacology update. I hope you find the information useful, and please contact us if there's anything you'd like us to add!



Trends in Psychopharmacology

by Elizabeth Moham, PharmD, PsyD, BCPP, ABMP

Every year, the Food and Drug Administration (FDA) is tasked with reviewing hundreds of thousands of new drug applications from the pharmaceutical industry, and yet only about 50 of those submissions are approved. Only a fraction of these submissions is related to mental health. The fact that we are still medically treating schizophrenia with a mechanism of action that was developed at the same time that poodle skirts and saddle shoes were the rage - or that the drugs of choice we use for bipolar disorder were discovered when Led Zeppelin was - should tell us something about how little progress science has made thus far in psychopharmacology. We still have a very long way to go. Regardless, medical psychologists are committed to remaining at the forefront of any pharmaceutical breakthroughs - no matter how infrequent they may be - while also incorporating psychological therapy to treat the patient both wholly.

In case you missed it, here are the most noteworthy updates over the past 2 years in psychopharmacology:

2024

New Medications:

Cobenfy (xanomeline-trospium) for schizophrenia via M1/M4 receptor agonism

Pros	Cons
Works differently from traditional antipsychotics	Studies are small (only 1,000 people)
Oral medication	No head-to-head comparisons with traditional antipsychotics
Mild ADRs (nausea/constipation)	Only been studied in patients with prior exposure to antipsychotics
An available option to avoid metabolic effects and TD	Unknown if using in combination with another antipsychotic is superior to either agent alone
¼ more adults had at least a 30% reduction in schizophrenia symptoms than placebo	Must take twice daily
	Requires titration that may be confusing to patients
	Must watch with patients on CYP2D6 inhibitors (i.e., paroxetine, fluoxetine, bupropion)
	Anticholinergic: may cause urinary retention or lower GI motility
	EXPENSIVE: nearly \$2,000 per month
	Prior authorization is likely going to be required
	Cannot take with severe hepatic impairment
	Must take 1 hr before or 2 hrs after meals to decrease GI sxs

FINAL VERDICT: Traditional antipsychotics should be recommended first. Transition to LAIs if needed, especially if compliance is a problem. Xanomeline-trospium may be tried if intolerance of traditional antipsychotics or if adjunctive therapy is needed.

Kisunla (donanemab-azbt) for mild Alzheimer’s reduce amyloid beta plaques in brain

Pros	Cons
Removes beta amyloid plaques	Intravenous - may cause infusion reactions
Medicare Part B covers this drug for patients enrolled in the CMS National Patient registry	Mild cognitive impairment or mild dementia stages of AD
	Plaques must be confirmed on imaging
	May not provide any noticeable benefit
	No evidence that patient functioning is improved
	No evidence that there will be a delay in placing patient in nursing home
	Regular PET scans are required
	May cause brain edema or micro-hemorrhages
	Patients on anticoagulants must avoid
	Costs up to \$30,000 per year in addition to PET scan costs
FINAL VERDICT: Traditional treatments should be recommended first.	



Expanded Indications:

- Fanapt (iloperidone) is now approved for manic or mixed episodes in bipolar I disorder

New formulations:

- Ingrezza Sprinkle (valbenazine) for patients with tardive dyskinesia and dysphagia.
- Onyda XR (clonidine) is now a liquid suspension for pediatric ADHD
- Erzofri (paliperidone palmitate) now has a simplified single first-month injection.

New prodrug:

- Zunveyl (benzgalantamine), designed to reduce GI side effects in Alzheimer's disease

2025

Delirium: Antipsychotics are no longer recommended for prevention or routine treatment; only for extreme distress or dangerous behavior after nonpharmacologic strategies have been exhausted

Benzodiazepines: Tapering should never be abrupt, but gradual and personalized with doses reduced in progressively smaller amounts as the dosage lowers (hyperbolic taper)

Treatment-Resistant Depression (TRD): Esketamine (Spravato) is approved as monotherapy for TRD

Major Depressive Disorder: Lumateperone (Caplyta) is now FDA-approved as adjunctive therapy for MDD

Bipolar Disorder: Uzedy (risperidone ER subcutaneous injectable suspension) is approved in adults as monotherapy or as adjunctive therapy to lithium or valproate for *monthly* maintenance treatment of bipolar I disorder

Schizophrenia: Clozapine: REMS enrollment is no longer required; however, ANC regarding the boxed warning for neutropenia must still be monitored

Substance Use Disorder: Buprenorphine ER (Sublocade) rapid initiation label update! Allows for transition to injection after a brief exposure to the sublingual film, as opposed to an extended lead-in tolerance regimen

Fibromyalgia: Transmucosal cyclobenzaprine (Tonmya) was approved for sleep and pain; this hasn't been proven to be more effective or have less ADRs compared to cyclobenzaprine tablets; continue to stress on improving QOL as opposed to total pain relief; dosages should always be low and slow for fibromyalgia, especially in the elderly

Alzheimer's Disease:

- Donanemab (Kisunla) is modified with a slower titration; new regimen was created to reduce the risk of Amyloid-Related Imaging Abnormalities (ARIA), especially brain swelling (ARIA-E)
- Lumipulse is the first FDA-approved blood test to help diagnose Alzheimer's Disease in adults

ADHD: FDA adds limit of ER stimulants in kids < 6 to prevent excessive weight loss

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Life on the Inside: Working in a Correctional Environment

By Elizabeth Moham, PharmD, PsyD, BCPP, ABMP

"I want to work in a prison when I grow up!" said no child ever.

Corrections is a field that is typically stumbled upon. Maybe after graduating with that criminal justice degree, it was the only agency that was hiring. Or perhaps the stringent physical requirements weren't quite achieved for the military. It could be that the state police written examination was met with an unsuccessful score. For me, I first entered corrections as a pharmacist. I was burnt out from toiling away for 12 hours at a time in retail pharmacy. I finally wanted to work a chill M-F 0730-1600 schedule.

Boy, was I wrong.

Mundane and routine? Absolutely. Most of the time, I see my patients and perform my clinical duties. However, because maintaining the safety and security of the prison is number one, non-custody staff (i.e., anyone who's not a correction officer) such as myself receive correctional training to meet this goal. For example, I may have to pat search transgender female inmates or female visitors. If staffing is short, I could be asked to make rounds of a housing unit, help conduct cell counts, shake down cells, or serve meals during lockdown. In addition, we must be familiar with camera surveillance during any use of force, including force-feeding during hunger strikes, as well as de-escalating a tense situation with an agitated inmate (although as licensed psychologists,

we are already trained on this). We also need to know how to use our emergency tools, such as our body alarm button on our radios and pepper spray in situations where we may be in distress.

Though most of the time our jobs are uneventful, there are also bursts of intense violence. Correctional staff are often blamed for the tense atmosphere inside the prison due to restrictive policies and invasive procedures that we haven't created yet must enforce. Sometimes we are the recipients of aggression, either verbally or physically. But most of the time the violence is inmate-on-inmate. I'll never forget when I responded to a medical emergency where the inmate suffered third-degree burns after rival gang leader threw a microwaved concoction of water and baby oil on him while he slept. The rainbow mixture of his liquified skin on that gray, concrete floor next to his metal bedframe were melted tattoos - and it's an image that's scarified on my brain. Another time, an inmate was stabbed repeatedly in the neck with a golf pencil by a jilted lover and later succumbed to his injuries in the hospital. I'll always remember helping mount his limp, lifeless blood-soaked body onto a gurney. This combination of routine, dull tasks and unexpected, life-threatening brutality and violence has caused me to always be on guard. It's like I can't ever turn off my brain, even when I'm off the clock. For example, I have worked with many offenders who have sexually terrorized innocent beings ranging from household pets to even their own young biological children. Knowledge of the details of these crimes has made me extremely wary of all men in general. When my sons were little, I was so afraid of the one college guy who worked in their daycare during the summer and so I had the boys removed and transferred to an all-female staff facility. I unfairly labeled him a creep based on the sex offender profiles I've read at work. I also never allowed my sons to go to sleepover parties because of this fear of child predation. The fears extend beyond keeping my kids safe. Even when I go out to a restaurant, I am hypervigilant of my surroundings. I always face the entrance/exit when seated. This is because as correctional workers, we don't ever intentionally have our backs towards the inmates - we never know what they're up to.

Speaking of, inmates play manipulative games to get what they want out of staff. In the institution I used to work for, there were a lot of stray cats on the yard. An inmate stated that he was concerned about the felines because other inmates give them medicine when they're sick. He wanted to know what medicines to avoid. I explained to him that they are unable to metabolize Tylenol and even one tablet can be fatal. The following day, several cats were found dead. I was a vehicle for the inmate to discover how he could murder those poor kitties.

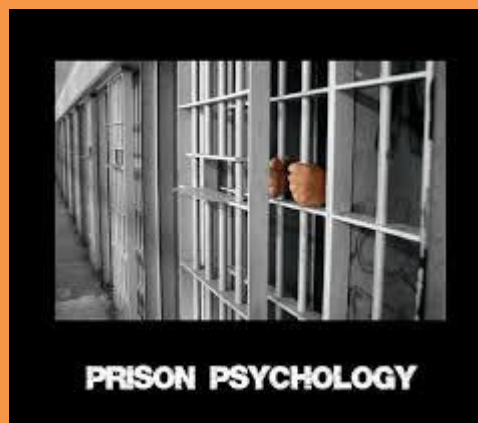
Within the buildings themselves, manipulation continues. In health services, staff must remain vigilant while administering medications, such as ensuring that inmates are not 'cheeking' or 'palming' their pills to sell on the compound to other inmates. Contraband is a serious problem in every prison. Oftentimes, these guys are incredibly wealthy due to their criminal history and try to bribe staff into smuggling in illegal goods, such as drugs, needles, tattoo paraphernalia, cell phones, cigarettes, vapes, etc. Others may try to spark a romantic relationship with staff, which is itself a crime that can lead to a lengthy prison sentence and sex offender registration for the staff member who chooses to engage. We learn how to avoid becoming compromised by inmates by immediately shutting down flattery, praise, and personal questions. Inmates use these tools to gain

trust, ask for favors, and then later threaten to turn staff in if the staff decide to stop complying. We once had a staff member who fell in love with an inmate (or so she thought). Once she crossed the line and became intimate with him, he threatened to report her if she did not sleep with his friends. She had been with over 100 inmates before she was eventually caught.

Because of manipulation, hypervigilance, violence, and unpredictability of the job, many of us experience what's known as corrections fatigue - physical and mental exhaustion caused by long-term exposure to prison life. Anyone who's ever worked inside the walls knows the profile - the chronically negative, emotionally numb, angry prison worker. Nearly a quarter of us have depression or PTSD, as well as other chronic health problems such as heart disease and gastrointestinal illnesses. And suicide risk is 40% higher than the general population - even more elevated than what the police and military experience. It's no wonder that the average lifespan of a correctional worker is only 59 years old.

I think the worst part of our jobs is how the public perceives us. The military are often revered and thanked for their service. Police are also held in much higher regard. When people see a correctional worker, they imagine a ruthless, uniformed brute palm-tapping a rib-splitting metal baton, looking forward to the next opportunity to bludgeon an inmate. People may also picture corrupt staff smuggling iPhones or Suboxone sublingual films inside. This is all thanks to what the media portrays. The reality is that although these unfortunate situations may occur, they are not common. Most correctional staff give inmates what they have coming - no more, no less. What instead should be emphasized is how we keep our neighborhoods safe while risking our own lives. I personally have had several threats of sexual assault and threats on my life by combative inmates. I once barely dodged a punch to the face. Many of my colleagues haven't been so lucky and were forced to retire due to traumatic nerve damage, brain injuries or even the loss of an eye. Some have even lost their lives. Yet the media reports none of this on the national news.

It's not a job that most consider, but corrections is a field that is critical to maintaining a safe society. The perception that we are corrupt and vicious toward helpless prisoners needs to change. While recognition of our work won't alter the perception overnight, it would be a good start.



STUDENT CORNER

A Weighted Wait: My Experience as a Hospice Nurse



By Jordan Moham, a 2nd-year Nursing Student at Rowan College of Burlington County

“Jordan, since you’re planning on pursuing nursing, why don’t you call Virtua hospital to see if you could volunteer to see what it’s about?”

“I already did, mom. Just to shadow as a high school student, they need pretty much everything from the middle name of dad’s childhood pediatrician to my American Airlines frequent flyer number.”

“Try calling the local hospice then. I saw signs that they’re desperately looking for patient visitors.”

Huh? Hospice? What’s that? Is that short for hospital? Like the mini-mart convenience store version of a level I trauma center? A grab ‘n go, drive-thru type of medical care similar to a CVS minute clinic – where the overworked, baggy-eyed, 5-o’clock-shadowed, caffeine-crashed, nicotine-deprived, too-young-for-jowls-at-his-age physician assistant’s pen-tapping the 25-minute remainder of his 12-hour shift, praying that no more patients last-minute him so he could soon collapse onto his chocolate leather La-Z-Boy and binge-watch the first season of Family Karma with leftover general Tso’s and a cold one?

Well, my imagination of hospice was dead wrong (pun intended). My trusty Google search resulted in something I wasn’t expecting – key words such as “palliative,” “comfort care,” and “life-limiting disease” pulled up.

So hospice is where the terminally ill go to live out their final days. Yikes, I don’t know if I want to do this. I’ve never seen anyone die before, let alone even know people who’d passed away! What would I do if I witness an elderly patient flatline? Or worse, how about

watching someone's beloved cystic fibrotic son take his final gasp of air through his fatigued, scarred lungs? And then tending to that grieving family – what would I even say? Would I be able to emotionally weight-lift this heaviness?

While psychologically hyperventilating, I realized that I first needed to see what hospice was about. On my first day, I was tasked with assisting Mr. L, a retired wealthy business executive suffering from stage 4 prostate cancer. Mr. L had no one who'd visit, so the volunteer coordinator made sure that I spent my entire allotted time with him. I was hoping he wasn't some smug, arrogant, colostomy bag of a human.

He couldn't be more opposite.

Within a month, I had grown to adore Mr. L and knew more about him than anyone else in the institution. We both looked forward to our time together and the 2 hours of banter we exchanged at each visit. I can tell you his favorites: a medium-rare prime rib with A-1 sauce, the Philadelphia Eagles, a "sexy" 1968 Camaro", 75% off Walmart clearance racks with the yellow and black stickers, and The Monkees ("even though they didn't write their own music!") His peeves: Brazilian butt lifts, the Vlasic pickle stork's voice, Clay Aiken, the entire state of California, and any dude hanging a pair of testicles off the back of his pickup truck.

Can you see why I love this guy?

Although Mr. L taught me not to take myself so seriously, the wisdom I gained from Mr. L and from the hospice experience is how too many people make the mistake of placing value on materials over memories:

"When you're gone, son, nobody will think about your Rembrandt art collection, the luxury Moorestown, NJ digs for which you plunked down a cool \$2.5 mil, or your 1961 Ferrari 250 GT California (OK, they'll probably remember *that*). My point is, my kids didn't care about replaceable 'stuff.' I was so wrapped up with dining clients at Michelin star-rated restaurants and traveling internationally several times a month for decades that I neglected to be a present father to my own children. I thought I was being a solid provider and figured the boys would understand when they were older. But all they wanted was for me to play Parcheesi with them occasionally, attend their basketball practices, and teach them how to ride a bike, let alone drive a car. I've done none of that. I was always 'too busy,' and I barely even know them. And now my life is a physical version of Harry Chapin's best hit."

Bro, who's Harry Chapin?

After looking up the heartbreaking lyrics to Cat's in the Cradle, I may as well have had a consultation with a cardiovascular surgeon to suture up the shredded aorta and ventricular tissue within my chest. Talk about second-hand devastation. Generosity doesn't simply refer to large cash transactions for your loved ones – it's about making magic in the limited times you share together. I guess that's why our meetings brought Mr. L (and of course me) such joy – they were deep, meaningful hippocampus souvenirs that could never be simply charged on a Visa.

"People assume that hospice means you can't walk, you can't talk, you can't eat, you can't clean yourself. I've been put out to pasture ever since my diagnosis. Retired, done, and deceased to all who knew me. Death had wait-listed me, and it was only a matter of months before my number was called. But now I feel more alive than ever! I'm vivacious,

and I have such a sunny disposition. I've embraced my diagnosis, and you keep me moving forward whenever you stop by. You have given me faith that even at this age, my greatest memory is yet to come! You've been like a grandson to - OK, enough of this sap. Grab me a fruit punch, will ya?"

Wow, I really have made a difference.

Mr. L and I have changed each other's outlooks on life. I think I've shown him that you don't need to be related to be family – loved ones aren't always connected by that polynucleotide double-helix. And because of him, I'm reminded of my own mortality, the importance of savoring each earthly millisecond, and having the courage to prioritize family over a job. I now understand that human connections can never be purchased. Although I'm still a student, becoming a mental health provider is my calling and will be my career. I'm looking forward to creating many more exciting moments with my patients, even if they're their last.

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Editor's Corner

by Dr. Jeffrey D. Cole, PHD, ABMP

Newsletter Revival and Editorial Updates

I am happy to be back as Editor of your organization newsletter, The AMP, this time working together with Co-Editor Dr. Elizabeth Moham who did much of the physical formatting and organizing of this issue as well as contributing her own articles and recruiting contributors to the pharmacology section. The newsletter has been on hiatus for awhile. Commencing my recent presidential tenure meant relinquishing my role as editor of the newsletter at a time when our Board was also reduced due to unforeseen events and all these changes interfered with maintaining regular updates. Now that my term as president has ended, I am pleased to return to the editorial role with The AMP.

Our new Co-Editor, Dr. Moham recently completed her credentialing as a Board-Certified Medical Psychologist with AMP. She brings a wealth of expertise to her editing and writing responsibilities drawing on her extensive background in pharmacy and her credentials as a licensed pharmacist with a PharmD.

Leadership and Specialty Advancements

Our new president, Dr. Keith Pretosky, addressed our current organizational focus in his column, his intent to continue the work of the late Dr. John Caccavale in championing psychological practitioners and our current emphasis on the National Plan toward expanding prescribing privileges nationwide for professionals with appropriate medical psychological training. Dr. Pretosky also talked about how we are utilizing social media to recruit the public's support for prescription privileges for appropriately trained Medical Psychologists. Dr. Lawson - a long-time leader with AMP and in Medical Psychology - reported on our strong and continuing membership from across the span of professional tenure and the increasing recognition and value of our board certification. Dr. Lawson also reported in his Executive Director's column that, like the newsletter, publication of our flagship journal the Archives of Medical Psychology has also been temporarily slowed due to the aforementioned staffing shortages. In spite of challenges coming from without temporarily affecting our organizational publications our Board has held strong and is weathering these changes and we will resume regular publication of all our periodicals in the near future.

It is good to be back in communication with you -- our esteemed membership -- in this venue and we look forward to your continued participation through your submitted articles, biographies and write-ups of your current work in our unique healthcare specialty and premier specialty in mental health treatment: Medical Psychology. - JDC