

PSYNAPSE

THE NEWSLETTER OF THE CPA'S PSYCHOPHARMACOLOGY SECTION

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A MESSAGE FROM THE EDITOR

Bryan Butler, M.A.
McGill University

Dear members of the Psychopharmacology Section,

It is my pleasure to present our first newsletter of 2021! In this special issue, our colleagues to the south (APA DIVISION 55) share their perspectives on the history and current state of RxP in the United States. I am excited to present these articles as part of our new *RxP USA News* section of the newsletter. It is my hope that these contributions will help to inform and encourage the growth of our own RxP initiative in Canada.

A CALL FOR NEW SECTION EXECUTIVE MEMBERS

We are currently looking for new members of the section's executive committee! If you are interested in joining the section and helping to further the Canadian RxP movement, please contact our Section Chair Dr. Amir Sepehry (sepehryaa@gmail.com) for more information.

A CALL FOR UNDERGRADUATE SECTION REPRESENTATIVES

Are you an undergraduate student who is interested in becoming involved in the section? We would love to hear from you! Please contact our Section Chair Dr. Amir Sepehry (sepehryaa@gmail.com) for more information.

A CALL FOR CONTRIBUTIONS

We are always looking for contributions to the newsletter and welcome any ideas you may have. Here are some examples of what you might submit:

- ▶ Brief articles on psychopharmacology-related topics
- ▶ Short summaries of recently published research related to psychopharmacology
- ▶ Reviews of recently released books related to psychopharmacology
- ▶ Experiences of psychologists who have completed a post-doctoral M.Sc. in Clinical Psychopharmacology
- ▶ Advertisements for jobs—or anything else that might be of interest to section members!

Submissions will be reviewed by Bryan Butler and can be sent to: bryan.butler@mail.mcgill.ca

Previous newsletters can be accessed here: <https://cpa.ca/sections/psychopharmacology/newsletters/>

I hope that you are all keeping well and staying safe during these challenging times.

Kind regards,

Bryan

A TIMELINE OF PRESCRIPTIVE AUTHORITY (RXP) PROGRESS IN THE UNITED STATES

Robert K. Ax, Ph.D.

The RxP movement in the United States has made slow but steady progress over the years, and I'm happy to share a few of the highlights with you here.

- 1984: In an address to the Hawaii Psychological Association, US Senator Daniel Inouye urges psychologists to pursue RxP.
- 1985: First RxP bill introduced, Hawaii.
- 1991: Department of Defense (DoD) initiates the Psychopharmacology Demonstration Project to train doctoral-level psychologists to prescribe psychotropic medications.
- 1995: Cmdr. John Sexton, Ph.D., a graduate of the DoD Psychopharmacology Demonstration Project, becomes the first American psychologist to write a prescription for psychotropic medication at the Naval Medical Center, Portsmouth, Virginia.
- 1996: The Council of Representatives of the American Psychological Association (APA) supports RxP as official policy.
- 1996: APA publishes first model post-doctoral training curriculum.
- 1999: First RxP legislation passed, US Territory of Guam.
- 2002: Psychopharmacology Examination for Psychologists (PEP) becomes available.
- 2002: First state law passed authorizing doctoral-level psychologists with additional training to prescribe psychotropic medications, New Mexico.
- 2004: Louisiana becomes the second state to pass an RxP law.
- 2010: First post-doctoral RxP training programs, at Fairleigh Dickinson University and New Mexico State University, receive APA designation status (analogous to accreditation).
- 2011: APA publishes first practice guidelines for RxP.
- 2014: Illinois RxP law passed. Pre-doctoral training permitted.
- 2016: Iowa RxP law passed.

2017: Idaho RxP law passed.

2020: APA recognizes Clinical Psychopharmacology as a specialty in professional psychology.

2020 –

2021: Florida, New York State, and Ohio introduce RxP bills.

2021: Revised 2019 APA *Standards for Psychopharmacological Training* are published. RxP training at the pre-doctoral level is permitted in the *Standards*.

Now: More than 20 states have introduced RxP authorizing bills. The Department of Defense, Indian Health Service, and Public Health Service permit qualified psychologists to prescribe psychotropic medications. The Chicago School of Professional Psychology is actively training students for RxP, including several at the pre-doctoral level. The Beth Rom-Rymer scholarships are awarded annually to qualified applicants for RxP training at the post- and pre-doctoral levels.

Soon: More state authorizing laws passed; RxP authorized in the Federal Bureau of Prisons and Veterans Administration; more RxP pre- and post-doctoral training programs; a strong RxP movement throughout Canada!

Our progress is your progress if we work together! Let's collaborate on behalf of Canadian and US RxP!

Robert K. Ax, Ph.D. is a Fellow of APA, a member of the Canadian Psychological Association, and the former president of APA's Division 18 (Psychologists in Public Service).

FIFTEEN YEARS OF PRESCRIBING: THOUGHTS FROM AN RxP PIONEER

AN INTERVIEW WITH MARIO MARQUEZ, Ph.D.

By George M. Kapalka, Ph.D.

In 2020, New Mexico celebrated an important RxP anniversary. Fifteen years prior, in February 2005, Dr. Mario Marquez and Dr. Elaine LeVine obtained RxP certificates, becoming the first psychologists outside of the military to obtain prescriptive privileges. In the Summer of 2020, Dr. Mario Marquez [referred to as MM] below was interviewed and shared his thoughts about his experiences and New Mexico's RxP journey.

What was the most unexpected thing that you discovered or came across after you started prescribing?

MM: For me, it was the attacks I encountered from RxP opponents. I knew psychiatrists would not like it, but it was much worse, and much more personal than I expected. Some of the psychiatrists complained about me and claimed incompetence on my part, saying I lacked the appropriate knowledge to make decisions about medications. It got so bad that they filed a complaint against me with the New Mexico Board of Psychologist Examiners, and a special prosecutor was appointed to investigate my case. After 9 months I was cleared of all charges, but this was an extremely stressful time. And to make matters worse, while we had a small but tenacious group of early RxP supporters informally organized to pursue this effort [G.K.: this was before the formation of SPA], some psychologists in New Mexico – including from the New Mexico Psychological Association – were opposed. Much of the opposition effort was led by the psychiatry department at UNM and the psychology department at UNM.

How was your experience as a prescriber unique or different from other early RxP prescribers?

MM: Elaine and I were the first two, but Elaine was in Las Cruces, so I was the only prescribing psychologist in the Albuquerque area for a while. The need in this area was (and is) very significant, especially including the Hispanic population, and so my patient population was likely a little different than some of the other early prescribers. In fact, I received a lot of support from the Hispanic Caucus at the New Mexico legislature, which helped offset some of the bitter opposition I encountered from so many psychologists and psychiatrists. I also work a lot with children, and so this age group presents unique challenges and requires specialized knowledge of psychological as well as developmental and educational issues.

How is your RxP practice now different than it was when you first started prescribing?

MM: When I first started, one of my goals was to approach prescribing to children very conservatively. For many years, as a practicing psychologist, I have seen children on 4 or 5, even more medications at once. I considered that unethical and unprofessional, and at times immoral. I often said that the power to prescribe is also the power to un prescribe, and when I started prescribing, I often discontinued inappropriate and/or excessive prescriptions and dosages. Nowadays I don't see quite as much of it as I used to, perhaps it's because we, prescribing psychologists, tend to be more objective and

conservative, and so cases I see where meds were previously managed by other prescribing psychologists tend to have been handled more competently and professionally. I think some psychiatrists nowadays also recognize that less is more, especially when it comes to children. I still see cases where children are overmedicated, especially in inpatient and residential treatments, but not quite as much as I used to.

From your viewpoint, how is the practice of RxP different in New Mexico than in other states (for example, Louisiana)?

MM: I don't have much knowledge about Louisiana directly, but one thing that bothers me is that in Louisiana the prescribing psychologists don't have to continue being licensed as psychologists, because the prescribing part is under the medical board. To me, that changes the professional identity. I think psychologists are the best prescribers, because we have the most mental health training. When we add prescribing to our tools, but we remain psychologists, we tend to continue to utilize psychological techniques (like psychotherapy) and don't just rely on writing prescriptions. That's the approach that I think is best, and maintaining a license as psychologists helps us keep that identity. I am concerned that when one no longer needs to maintain a psychology license after beginning to prescribe the psychologist identity can start to decline.

What's your advice to psychologists who are contemplating or pursuing RxP in New Mexico?

MM: Never give up your psychologist identity. We are the best trained mental health professionals, period. No other mental health profession has the length and depth of our training in psychology, psychotherapy and assessment. We should *add* prescribing to our toolbox, and not *replace* anything we already do with prescribing medications. That's what makes us unique and the best mental health prescribers in my opinion.

ONCE UPON A TIME THERE WAS A TAVERN

Pat DeLeon, Ph.D., MPH, JD (former APA President)

The 2021 APA Practice Leadership Conference (PLC) was entirely virtual, given the nation's pandemic, and yet was extraordinarily exciting and visionary. APA President Jennifer Kelly and CEO Arthur Evans movingly reflected upon psychology's responsibility for addressing today's most pressing social issues surrounding Social Justice and Health Equity. Jared Skillings reminded us to be proud that we decided to become psychologists and of our rich heritage in responding to evolving opportunities. As always, Dan Abrahamson was extraordinarily supportive of involving graduate psychology and nursing students from the Uniformed Services University (USU).

Patricia Carreño (2LT, MSC, USA): "As a graduate psychology student at USU, this was my second time being invited to participate in the 2021 APA PLC, and it was once again a rewarding, rich experience, even though virtual due to the global pandemic. I remain forever indebted to the continued trust and mentorship of my colleagues in my abilities to contribute to the success of this field, as they allow me to fully immerse myself in these rich conferences and associated events, which has continued to shape my personal growth and development as a graduate student.

"One of the panels which resonated with me most during this year's conference was Chair of the Advocacy Coordinating Committee Kate Brown's panel titled *Everyday Advocacy: Make it a Habit*. In this panel, three racial and ethnic minority psychologists spoke candidly about their experiences with social justice and advocacy. Over the course of the discussion, the panelists shared similar messages all centered on the practice of providing psychological services itself as everyday advocacy for our patients. Arlene Noriega and Maysa Akbar's stories in particular were fascinating and resonated with me deeply – as a second-year doctoral student in clinical psychology and an advocate for social justice in medicine, research and academia, I find myself actively resonating with the panelists' values and incorporating some of the steps they discussed in all facets of my learning, including but not limited to my experiences in the classroom, throughout research, and my clinical work as an extern at Walter Reed National Military Medical Center.

"Notably, I found Maysa Akbar's immigrant story to be compelling; hearing her journey provided me with hope and confidence in knowing that I can and will be able to succeed in this discipline, despite the insurmountable number of challenges and barriers that I face as a racial and ethnic minoritized student with multiple intersecting identities. As a native of Venezuela who fled my native land as a child due to political unrest and violence, I also found her story as a graduate student in a predominately White institution to be incredibly validating. They are both respected, venerated psychologists who identify as Latinx/Hispanic – they also spoke on unique experiences in their lives that ultimately shaped their development and understanding of advocacy work during their graduate studies. Arlene Noriega's heartfelt stories on her prior work with transgender and migrant youth were incredibly powerful to hear,

and Maysa Akbar provided sound, rich perspectives for consideration throughout her historic efforts through the Connecticut Psychological Association.

“Participating in the 2021 PLC provided me with much-needed skills and frameworks for me to continue incorporating advocacy into every space I occupy as a graduate student and in the future as a licensed psychologist. I look forward to attending future conventions, I remain hopeful future convention themes can center on the decolonizing of psychology; the systemic impact of racism and discrimination in our society, and how the field of psychology can be used to dismantle some of the central systemic issues affecting our patients and communities.”

Beth Rom-Rymer, who will be on the APA Presidential ballot this year: “During our discussion of Prescriptive Authority (RxP) at this year’s annual PLC, one of the key questions that we were asked was: ‘Is it necessary to bring the psychiatrists and/or medical society into alliance with you before lobbying for RxP legislation?’ Beth Lonning (Iowa) and I agreed that it was important to *offer* to sit down with the psychiatrists, prior to submitting legislation to our legislators. And, it is important to *sustain an ongoing conversation* with our legislative opponents (the Psychiatric Society and the Medical Society), *in some form*, whether it is with the medical societies’ lobbyists, legislator allies of the medical societies, or with the executive committee members of the medical societies. However, it is also important to secure legislative successes with our prescriptive authority legislation, *before* making major concessions. It is a complex dance in which we strive to pass important, life-changing legislation, while offering assurances to legislators and the public, alike, that what we are doing is safe and evidence-based.”

Tim Kimball (ENS, MSC, USN): “PLC provided an excellent glimpse into psychology’s ever-expanding styles of leadership. For all of the philosophies and research into the field, it seems to me that leadership as a quality is dependent upon a growth mindset. I have found that before one could truly understand and embody those multitudinous qualities that describe a ‘good leader,’ they must be willing to incorporate a sense of impermanence and fluidity into its conceptualization. One action in one context could be seen as the actions of a leader, but an overreliance on that same strategy may lead to failure in a different context. And this is an important distinction to make; there is never one single answer to the myriad of problems a leader will face. To this end, it is essential to continually seek self-improvement in authentic and personal ways – in ways that can be understood on an individual level and with a degree of honest self-reflection” (USU psychology graduate student).

A Virtual Hill Visit: Robin Miyamoto (former Hawai’i Psychological Association (HPA) President) – “HPA was well represented this year as we conducted our annual Congressional Hill visits through the virtual platform, Soapbox. Our team included current HPA President Noza Yusufbekova, Past APA Presidential Candidate Kathleen McNamara, HPA Clinical Representative Richelle Concepcion who is also the current President of the Asian American Psychological Association, and myself. We were joined by HPA Executive Director Ray Folen and two outstanding student members, Katherina Bui and Monet Meyer. The Hawai’i Congressional Delegation has always been a friend to psychology but this year’s issues will require strong advocacy on their part. Our HPA team requested support for the permanent expansion of audio-only tele-behavioral health services as well as the removal of the in-person service requirement under Medicare. We also requested sponsorship of the Tele-Mental Health Improvement Act (S660) which would create parity for telehealth services. While Hawai’i is lucky to be one of only 15 states with parity for telehealth, federal legislation is necessary to support mental health needs across the country.

“Coverage of audio-only tele-behavioral health is truly a social justice issue. Prevention of these services disproportionately affects elderly, rural, and low SES patients because they have lower rates of broadband

services or limited or no data plans that allow for cell phone video use. It also penalizes the elderly who may lack the knowledge and confidence to access online services. Rural communities including those on Oahu, for example Waimanalo, have very poor broadband coverage which has limited their ability to participate in healthcare, work from home, and distance learning during COVID. We shared stories of our patients who had to cancel their telehealth appointments as they approached the end of their cell phone plan cycle because they had run out of data. While the Congressional delegation was familiar with some of the issues, they were surprised to learn the extent of the problems and the effect on their constituents. We look forward to witnessing the work of Senators Schatz and Hirono, and Representatives Kahele and Case in the coming year.”

A National Tragedy: The horrendous shootings in Atlanta, Georgia once again vividly brought home to the nation the crucial PLC theme of Social Justice for all, regardless of race, sexual orientation, religion, and/or socio-economic status. On March 18, the Asian American Psychological Association (AAPA) presented testimony to the Judiciary Committee of the U.S. House of Representatives. Excerpts from AAPA statement: “As an organization whose mission is to advance the mental health and well-being of Asian American communities through research, professional practice, education, and policy, we urge policymakers to advance policy and enhance funding for (a) public messaging campaigns against anti-Asian racism; (b) the development of additional channels to track, assess, and provide referrals for victims of hate incidents, including in-language hate reporting hotlines; (c) bystander intervention trainings; (d) comprehensive, culturally and linguistically appropriate mental health, health, and other social services to address the multitude of stressors Asian Americans are experiencing, and (e) additional funding for research efforts to track and understand the short and long term impact of anti-Asian racism and violence. These resources are needed to better document and address the harms of racism and violence, stop the surge in discrimination and violence, and promote recovery in Asian American communities.

“The Pew Research Center found that 31% of Asian Americans report that they have been the subject of racial slurs or jokes. Emerging research shows that the surge in anti-Asian racism tracks with rhetoric used by politicians and other public figures, who have referred to COVID-19 as the ‘China virus,’ ‘Wuhan virus,’ and ‘kung flu.’ Anti-Asian bias had been steadily decreasing between 2007 and early 2020, but began to increase after political officials and conservative news outlets began using this stigmatizing language. Race-based hate incidents towards Asian Americans have profound implications for their health and mental health. Racism is a chronic and acute stressor that harms health. The effects of racism on Asian Americans likely compound with other pandemic-related stressors to negatively impact mental health. We urge members of this subcommittee to bear in mind that racism and discrimination against Asian Americans did not begin with the start of the pandemic and without decisive, structural change, will persist long after the pandemic’s end.”

Public Service – A Gift that Keeps on Giving. A long-time friend and U.S. Senate colleague, the late Leon Billings: “Working for Senator Edmund S. Muskie, I helped craft the Clean Air Act and the Clean Water Act and we opened the Highway Trust Fund for investments in mass transit. As executive assistant to the Secretary of State, I was engaged on a daily basis with the efforts to free the hostages taken in our Embassy in Teheran. I was constantly reminded of what the people who serve our government do on a daily basis. I left the Federal service after 15 years because Jimmy Carter was not reelected. I left the Maryland General Assembly after 12 years, because I was not reelected. In each case, I ended my service to my country regretting only that I could not have been a public servant longer. My reward was that I knew I made a difference and that was enough for me.” “Those were the days my friend” (Mary Hopkin). Aloha.

DO SIDE EFFECTS OF ANTIDEPRESSANTS CREATE PROBLEMS IN ROMANTIC RELATIONSHIPS?

Esha Chakraborti, MCP, RCC, CCC., Veronica Li, MCP, RCC., and
Amir A. Sepehry, M.Sc., Ph.D., Section Chair
Adler University

Have clients mentioned that they are not interested in being intimate with their romantic partner while taking antidepressants? Or perhaps they reported feeling a general sense of disconnect with their partner, especially after starting antidepressants. If this situation sounds familiar, your clients are not alone!

As a clinical counsellor and doctoral psychology student working with individuals and families struggling with mental health issues, I hear clients commonly talk about how mental health struggles affect their romantic relationships. Such as when a client mentions that their partner's depression is impacting their desire for sexual intimacy or when a client's spouse discloses that the client is apathetic and has a limited range of emotional response.

Clinical depression affects not only the individual but also those people who are close to the individual (Sharabi, Delaney, & Knobloch, 2016; Whisman, 2004). For instance, a study in have shown that clinical depression impacts a romantic relationship in various ways, but in particular induces a lack of romantic and sexual intimacy, isolation, and lack of motivation within relationships (Sharabi et al., 2016). These impacts often leave partners with unmet needs, a disconnection with their partner, feelings of abandonment, and thoughts of having to face the world alone. Thus, for the clinician or clinician in training, it is imperative to recognize the experience of both partners when treating clinical depression of an individual. When working with clients who bring up relationship struggles it is important to get a holistic and thorough background of their concerns.

In order to understand the impact of clinical depression on relationships, clinicians need to conduct a thorough assessment and have an understanding of treatment methods that may assist the client. This knowledge can help with further treatment planning within a framework of the biopsychosocial model. A biopsychosocial approach involves a review of the biological, psychological, and social environment of a client to provide support in the management of clinical depression. One of the treatment approaches for clinical treatment can include the use of prescribed medication such as antidepressants.

Antidepressants can be helpful and necessary for the treatment of clinical depression. They can help reduce symptoms of depression and enhance motivation for daily activities. Antidepressants may provide positive enhancements to a client's life; however, like many medications there can be potential side effects. Some common antidepressant side effects can include dry mouth, lower sex drive, tiredness, weight gain, and for some people temporary emotional blunting (Centre for Addiction and Mental Health, 2009; Kelly, Posternak, & Alpert, 2008; Rosen, Lane, & Menza, 1999). These side effects may in turn create further communication struggles for the relationship, and if the treatment process does not address relationship changes it may negatively impact the management of depression.

Typically, for first time antidepressant users, treatments start at a low dose to minimize side effects and are slowly titrated until a suitable dose is found for the client. Common types of antidepressants include Selective Serotonin Reuptake Inhibitors (SSRI), Monoamine Oxidase Inhibitors (MAOI) Tricyclic Antidepressants (TCA), Serotonin And Norepinephrine Reuptake Inhibitors (SNRI) and Norepinephrine and Dopamine Reuptake Inhibitor (NDRI) (Centre for Addiction and Mental Health, 2009). SSRI's are usually the first choice for treatment of depression disorders (Centre for Addiction and Mental Health, 2009). They are known to have milder side effects compared to other treatment options; however, their side effects can include sexual dysfunction.

Sexual side effects do not occur for everyone but are common with the use of SSRIs and can include symptoms such as changes in sexual desire (e.g., decline in desire), decrease in arousal response, difficulty with sexual stimulation, erectile dysfunction, delayed or absent orgasm and ejaculation (Goodwin, Price, De Bodinat, & Laredo, 2017; Rosen et al., 1999). Though both women and men may experience sexual side effects with SSRIs, women are more likely to report sexual arousal dysfunction, whereas men report higher rates of adverse effects in sexual desire and orgasm (Lorenz, Rullo, & Faubion, 2016). There are many factors that can influence sexual desire including biological, psychological, and context-related factors such as the quality of the relationship. Although sexual desire may be improved with the use of antidepressants through the treatment of depression, other sexual side effects may actually work to continue hindering desire.

In a study measuring sexual functioning in patients with recurrent Major Depressive Disorder, researchers found that the typical onset of sexual side effects for an SSRI and SNRI occurred within 1-3 weeks of starting the new antidepressant, while the benefits of the treatment for depression did not consistently appear until 2-4 weeks (Gelenberg et al., 2013). This suggests that many individuals would experience the sexual dysfunction before seeing any mood benefits. If the sexual concern is not addressed, it may worsen or prolong the client's depression and ultimately impact quality of life and may lead to non-compliance or discontinuation with treatment (Kennedy & Rizvi, 2009). Another component to treatment-emergent sexual concerns is that it can be an additional factor contributing to distress for the client. For many individuals, sexual dysfunction can be a source of guilt and shame which may worsen their depressive symptoms. Different sexual side effects may also coexist and exacerbate one another. For example, difficulties achieving orgasm may lead to even lower sexual desire. Depression is a major risk factor for sexual dysfunction and sexual dysfunction is also a risk factor for depression (Lorenz, Rullo, & Faubion, 2016). Therefore, it is important to accurately assess for sexual functioning before the use of antidepressants and screening for sexual functioning should occur at the onset.

Apart from sexual functioning and arousal problems, a side effect that occurs with SSRIs include emotional blunting. Emotional blunting can influence a client's interest in relationships and partner interest (Goodwin et al., 2017). Emotional blunting is when one's feelings and emotions are dulled to the point of not feeling any positive or negative emotion. Emotional blunting includes feeling indifferent or apathetic to situations where previously emotions were stronger. For instance, a study found that more than 40% of patients on SSRIs antidepressants have experienced emotional blunting (Goodwin et al., 2017). People in romantic relationships taking antidepressants may experience both a loss of sexual desire and decrease in ability to feel strong emotions; hence they may perceive their partner differently than prior to taking antidepressants.

Another theory about antidepressants and how they might influence strong emotions include the impact of neurotransmitters as they relate to the feelings of romantic love. SSRIs increase the levels of serotonin in

the brain, but also suppress the dopamine circuit (Meyer, 2007). Dopamine is hypothesized as one of the neurotransmitters involved in feelings of romantic love and deep attachment, therefore when suppressing dopamine, it is also suppressing the feelings of romantic love (Meyer, 2007). Both SSRI direct and indirect adverse effects may have an additive consequence upon an individual's romantic life.

Antidepressants have side effects that may impact romantic relationships. These side effects may not occur in all individuals; however more empirical support is required to learn about the exchange between relationship satisfaction and mental health drug treatment (Meyer, 2007). Additionally, romantic love and relationship struggles can also be impacted by a variety of confounding variables such as, family, trauma, addiction, abuse, or illness that are unresolved and still adversely affecting mood. However, antidepressants may bring positive changes to the treatment of depression, such as with improvement of depressive symptoms clients are able to better focus on their partner.

The adverse side effects of antidepressants can be mitigated. One way to manage sexual side effects is to let partners know about possible side effects and finding alternative ways to enhance intimacy (Yasgur, 2020). For example, some people may have low desire and are less interested in sex, but once sexual activity begins the desire increases and the activity becomes satisfying (Yasgur, 2020). This can refer to an individual's responsive desire, which is important to account for when having discussions about sexual desire and intimacy. Talking about realistic expectations about sexual responses need to be explored and communicated amongst partners. For example, sexual effects of antidepressants will be greater in older people compared to younger people due to younger people having stronger somatic capacities for sexual behaviour (Yasgur, 2020). Antidepressant induced side effects resolve over time or become tolerable (Yasgur, 2020). If the antidepressant side effects are difficult, clients should speak to their prescriber about stopping or taking a break from the treatment. Stopping treatment without prescriber recommendation would not be helpful and could have harmful effects. The prescriber may provide options for changing the medication, changing the dose, adding other medications or reviewing alternatives (Yasgur, 2020).

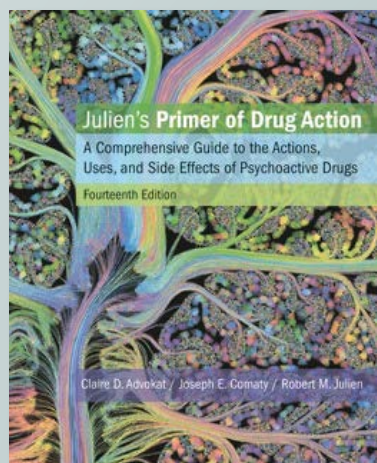
Overall, antidepressant side effects, in particular SSRIs, may be causing or exacerbating problems in romantic relationships. It is necessary for mental health professionals treating clients with relationship struggles, who are on antidepressants, to have a background in understanding antidepressants and its impacts on brain chemistry. Psychoeducation regarding antidepressant side effects and resources would be helpful to review with clients. By providing this information to clients, it allows them to choose options for treatment that fit best for them.

Mental health clinicians can recommend therapies such as cognitive behavioral therapy (CBT) and Mindfulness-based approaches to be incorporated into a biopsychosocial approach to understanding relationship and mental health struggles. Mental health clinicians may also recommend the client to seek services from a sex therapist or clinician that provides sex therapy. Psychoeducation about sex and desire may help normalize the clients' experiences and challenge any misunderstandings clients may have about sexual functioning. Psychotherapy may help both partners change how they think in order to increase positive coping within relationships. Therefore, it is important to bring up concerns about sexual functioning, emotional blunting, challenges with mood and any side effects of medication with the prescriber and/or mental health professional.

BOOK REVIEW:

JULIEN'S PRIMER OF DRUG ACTION: A COMPREHENSIVE GUIDE TO THE ACTIONS, USES, AND SIDE EFFECTS OF PSYCHOACTIVE DRUGS

Amir A. Sepehry, M.Sc., Ph.D., Section Chair
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Julien's primer of Drug Action: A Comprehensive Guide to the Actions, Uses, and Side Effects of Psychoactive Drugs

14th edition, 2019

By: Claire D. Advokat; Joseph E. Comaty; Robert M. Julien

ISBN: 9781319138073, 738 pages

Worth publishers: Macmillan learning (New York)

A highly underestimated textbook of psychopharmacology in comparison to other similar seminal works, as it is often not talked about as much, this concise textbook in its 14th edition provides an amalgam of knowledge for both novices as much as to the expert eye. Consisting of four segments, initially it provides an introduction to

psychopharmacology for those with limited or entry-level perspective. This introduces the fundamentals of clinical psychopharmacology, pharmacokinetics and pharmacodynamics, with an overview to neuroanatomical correlates predominantly at the cellular level (neuron, synapse, and neurotransmitters).

Within the second part, this book covers psychopharmacology of drugs of abuse from the epidemiology to the neurobiology of addiction. Specifically, various psychoactive substances are discussed, including alcohol, inhalants, caffeine and nicotine, cocaine, amphetamine, and other psychostimulants, psychedelics, cannabis and opioid analgesics. It further discusses policy and implications of the drugs on society.

In the third section, the book covers major classes of psychotherapeutic drugs including antipsychotics, antidepressants, anxiolytics, sedative hypnotics, anesthetics, anticonvulsants, followed by specific drugs used for the management of bipolar disorder.

Lastly, this book covers special populations and integration, including developmental perspective starting with children to geriatric psychopharmacology. Interestingly, the authors cover the various challenges practitioners of psychopharmacology and society experience for mental health condition management (e.g., limited resources).

It is noteworthy that the book includes two appendices providing a quick reference to psychotropic medications for specific conditions (e.g., OCD, BPD, and insomnia) and an introduction to epigenetics.

In more detail, and with high quality illustrations, each chapter covers epidemiology, clinical implications, historical background, dependence, site and mechanisms of action at the brain level, treatment issues, and informs on the most recent and highly cited clinical trials (e.g., CATIE, CUtLASS, STAR*D). In addition, each

chapter, as appropriate, provides clinical example, and includes a section listing study questions for further self- or group study.

This 14th new edition includes several updates, covering emerging topics such as the opioids of abuse, and drugs used to treat of opioid dependence and opioid overdose, novel therapeutic approaches for management of conditions such as Alzheimer's disease, Epilepsy, and PTSD, and specifically covers pharmacological, physiological, and psychoactive effects of synthetic marijuana including its toxicity. Cannabidiol (CBD) and its therapeutic uses, and research of the efficacy of antipsychotics to treat dementia, Parkinson's, bipolar, Obsessive Compulsive Disorder (OCD), and PTSD were also covered. Other research highlight included are the showcase of research on hallucinogenic compounds for the treatment of various disorders including 3,4-Methylenedioxymethamphetamine (MDMA) for the treatment of PTSD, Psilocybin for treatment of depression and end-of-life anxiety, and Ayahuasca to treat psychiatric disorders. In addition, novel assessment approach for the appraisal of treatment efficacy of antidepressant treatment via genetic testing has been highlighted. Latest literature updates on the use of ketamine for the treatment of depression are also provided.

The updated 14th edition of Julien's Primer of Drug Action and its 15th edition on the way has evolved side by side with the field. It delivers a thoroughly up to date look at psychotherapeutic and recreational drugs, including the latest research and the newest formulations. It comes with useful instructor resources as well, such as a test bank, lecture slides, and a resource manual for use in a graduate level course.

What I would have liked to see more would have been a section on the management of neuropsychiatric syndromes related to cardiovascular/cerebrovascular conditions, and traumatic brain injury (TBI). In line with TBI research and the relationship with substance use, providing a guideline on when to use recreational drugs (e.g., wine) post-TBI/ concussion would have added value to the already established book. The effect of exercise on drug metabolism and pharmacokinetic generally would have enriched the various sections of the book.

By the same token, a section on the interrelationship between microbiome, medications and drugs of abuse generally would have been a useful addition. Further supplement would have been the development and changes to drug trial response assessment approaches, such as what was observed in Alzheimer's trials, using Amyloid-related imaging abnormalities (ARIA) as a marker of adverse events.

When I had first used the earlier edition of the book (e.g., 13th), it surpassed my high expectations and was nothing at all like I expected. It was small and within reasonable price tag, and that is written for nearly all audiences. It was hard to find a concise textbook for a graduate level psychology course in a PsyD program, where students had limited preparation for this type of material. Especially since I was teaching this course for the first time! Yet, after several rounds of teaching the course with this textbook, supplemented with content from various other sources, I managed to complement and enrich the course content for my PsyD level students. Of course, this is not to say that the book is not enough for the level I am teaching, rather, more information was needed regarding clinical guidelines and case examples to make illustrations or to provide background information for a given course lecture topic. I would commend this seminal work done by the authors, Drs. Advokat, Comaty, and Julien, highly impressive.

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DO SIDE EFFECTS OF ANTIDEPRESSANTS CREATE PROBLEMS IN ROMANTIC RELATIONSHIPS?

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