

# ASAP TABLET

*The purpose of this Division shall be to advance the practice of psychopharmacotherapy as it relates to prescriptive authority of psychologists.*

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## President's Message Robert McGrath, Ph.D.

The fact that I started working on my presentations for APA a week before the convention seemed to me to be good evidence that I either have too many irons in the fire or I'm a terrible procrastinator. I quickly decided I would put off considering whether the issue is state or trait for another day (uh-oh, evidence for the latter), and got to work. One of my presentations was to be on the state of the division. Over the next few days, I thought through everything that has occurred this year, and I have to say, I was pretty pleased by our accomplishments. I'd like to list off what we have done this year. Note that contacts for additional information about many of the developments described appear at the end of my column.

**Membership:** We have had about 75 new members join the division this year. It has been a remarkable year of growth for us, at a time when most APA divisions are losing membership. Thanks to Beth Rom-Rymer, our membership chair, for her efforts to attract new members.

**State chapters:** We now have 26 state chapters, including 6 new chapters this year alone. The first year of our state chapters grant program was a great success. We will be providing funding to two states, Minnesota and New Hampshire. The money will be used in Minnesota to bring in a speaker on RxP to begin to raise awareness about the issue. New Hampshire will be using their grant to help support a survey of primary care physicians' attitudes towards prescribing psychologists, the first of its kind in the country. Congratulations to Mike Brunner, Anita Remig, Cheryl Kelly, Sandy Rose, and all the others who worked on the proposals, and thanks for Anton Tolman in particular for spearheading the state chapters program.

The 2006 midwinter conference brought over 75 participants to San Diego to attend sessions on the PEP exam and continuing education in pharmacotherapy. This has produced a successful DVD video series. Thanks to Matt Nasseti, Howard Rubin, and many others for their work on making this event a success.

Recently, we entered into an agreement with the Neuroscience Education Institute (NEI). NEI was founded by Stephen Stahl, M.D., and has become a national leader in training physicians in psychopharmacology. In the past, only physicians were eligible for CE for the NEI programs. Beginning this fall, psychologists will receive CE through Division 55 for attending their programs. One of our big concerns in entering into this agreement was the independence of the information being provided. NEI does currently accept pharmaceutical industry funding, but as they grow they have committed to terminating all such funding in the near future. In addition, individuals who have attended the sessions universally indicated that issues of critical evaluation of drug data are an integral part of the program. For these reasons, we thought that NEI was working to become a rela-

## Editor's Column Stephen Rudin, Ed.D.

Here we are, with a post-APA Convention *Tablet*. Instead of commenting on the activities and sessions which I am certain will appear in this and subsequent issues (as well, no doubt, on the List-Serve), I have chosen to reflect on the substantial number of earlier e-mails regarding our positions on interactions with the pharmaceutical industry. These are my own musings, and of course, I do not purport to speak for anyone other than myself.

My recently closed private clinical practice, which spanned over thirty years, has always been in a multi-discipline medical setting in which relationships with the medical profession have been collegial. Pharmaceutical representatives have been a part of the environment for all these years, and I have come to know a great number of them as individuals, and not just sales personnel.

My last six years have been spent in a psychiatric group setting, and, interestingly enough, when the reps learned that I had completed a program and taken a national examination in psychopharmacology, they were exceedingly supportive, and NOT simply because they viewed me as a potential customer. They spent time talking with me about training and education, and wondered if perhaps I could give some classes to them and their colleagues



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## Post SSRI Sexual Dysfunction

**Audrey S. Bahrack, Ph.D.**

Post-market research has now firmly established that the SSRIs and SNRIs can significantly affect most every aspect of sexual functioning at rates significantly higher than the 5-15% reported in pre-market trials. Depending on definitions of sexual dysfunction and methodology, post-market prevalence studies have found rates between 36% and 98%. The 5 to 15% rates of SSRI and SNRI-induced sexual side-effects listed in the current drug-insert literature are based on information obtained in the initial trials via spontaneous reports of individuals who had been on the medications for a short time. The differences in reported rates between the pre-market trials and post-market prevalence studies are an artifact of methodology; we now know that when individuals are directly asked about their experience of sexual side effects via either a structured clinical interview or a self-report inventory, we obtain vastly different rate information than if we rely on individuals to spontaneously volunteer personally sensitive information about changes in sexual functioning.

Because the sexual dysfunction prevalence data were initially so underestimated, I became motivated to look carefully at other findings and assumptions of the SSRI and SNRI sexual side-effects literature, with attention to the specific questions asked and the methods used to answer them. While sexual side effects are probably the most-researched of the SSRI side effects, the focus, motivated by competing drug companies' efforts to get a market share, has been heavily on determining prevalence rates. Significant gaps remain. These include, but by no means are limited to, such basic-seeming information as which sexual side effects are most characteristic of the SSRIs/SNRIs, and when and whether individuals who develop sexual dysfunction secondary to the medications return fully to their pre-medication sexual functioning baseline. My immersion in our formal literature, in my practice as a clinician, and in consumer-provided internet-based information has led me to conclude that our knowledge base is unintegrated, inadequate, and even inaccurate. I believe that we have barely begun to appreciate the pervasiveness and complexity of the impact on sexuality of these medications.

There are indications that some SSRI/SNRI sexual side effects thought to be rare are probably common. The most frequently documented sexual side effects are diminished libido, unspecified "problems with arousal", and delayed orgasm or anorgasmia. Sexual side effects reported in these broad categories, without specifics or severity information, have not appeared to sound an alarm with consumers or health care providers as they seem to fall within a range of common experience. However a number of distinctive treatment-emergent sexual side effects are frequently reported among internet communities and in the occasional case report. These seem to be qualitatively different symptoms; counter-intuitive and even paradoxical symptoms that are not easily classifiable as belonging to any one category of the sexual response cycle, eluding capture in most prevalence studies. These include: erections that may be easily achieved and maintained yet are numb or nearly numb; orgasms that are preceded by little sense of building arousal and are experienced as pleasureless or nearly so; and genitals that respond to touch by erection or lubrication but without attendant subjective feelings of arousal. Aspects of normal sexual functioning seem to be mimicked without the attendant capacity to experience pleasure. While SSRI/SNRI-related decreased genital sensation or genital anesthe-

*continued on page 3*

## Post SSRI Sexual Dysfunction

### continued

sia, and decreased orgasmic intensity or ejaculatory anhedonia are reported to be uncommon, it is more accurate to say that they are uncommonly assessed. Our literature appears to be building upon the assumption that the symptoms are rare by failing to systematically include such symptoms in our instruments, and by failing to transparently report them when they are included.

One study did assess the presence but not the severity of two of these symptoms: Zajecka et al (1997) found that among 42 depressed patients on SSRIs, 28% of women reported treatment emergent decreased genital sensitivity and 25% of men reported decreased intensity of orgasm. While data were collected for both symptoms for both genders, results were only reported for one gender. Clayton and colleagues, whose large, multi-site prevalence studies have provided ground-breaking evidence of the pervasiveness of sexual side effects for most all the new antidepressants, rely on a 14-item validated instrument. The instrument leaves out genital anesthesia, measuring arousal in men for example, by ease and frequency of achieving and maintaining an erection. Thus a man who can easily achieve and maintain an erection, but whose erection is numb, would appear normal in the arousal phase and remain undetected by the instrument. The instrument does include an item related to reduced pleasure of orgasm and its severity. However the item is not separately scored, but rather folded in with two other items related to frequency and timing of orgasm. Thus while Clayton's work undoubtedly provides the best available information about the prevalence of many sexual side effects, it cannot tell us about the occurrence of genital anesthesia and ejaculatory anhedonia because of the limitations of her instrument and its scoring.

Genital anesthesia and ejaculatory anhedonia ought to be of special interest to both researchers and clinicians because they are not known to be correlates of any psychiatric condition, and regardless of their prevalence, seem to be distinctive markers of SSRI/SNRI side effects. Unless a good assessment of sexual functioning baseline and history have been conducted, there is sometimes confusion in the research literature or in the process of treatment about whether newly emergent sexual symptoms are attributable to a "worsening" of the condition being treated or to the treatment itself, in spite of the fact that among sexual dysfunctions, only decreased libido is known to sometimes accompany depressive disorders. When treatment-emergent sexual side effects persist after discontinuing the medica-

tions, as is increasingly being reported among internet communities, individuals' experience may be discounted, disbelieved, or ascribed to the emergence of yet a new condition or diagnosis by professionals to whom the individuals turn for help. Thus among all the sexual side effects that may emerge or persist, genital anesthesia and ejaculatory anhedonia may provide the most compelling links to the *treatment* rather than to the conditions being treated.

The assumption that sexual functioning returns to baseline shortly after cessation of the medications is deeply embedded in our literature as well as in our approach to practice and prescribing. Yet no original data supports this assumption: no study has followed the course of the sexual dysfunction after discontinuation of the medications for the purpose of determining when and to what degree the side effects resolve. While treatment-emergent sexual side effects probably do resolve for most individuals after discontinuing the medications, since we are not even asking the question of whether the side effects could persist for *some* individuals, we have not built the possibility of finding them into our research designs: at least not intentionally.

One study (Montejo et al, 1999) appears to have inadvertently found evidence of sexual side effects continuing after cessation of medication. The study's purpose was to assess the effects of switching to another medication in patients whose depressive symptoms were being successfully treated with an SSRI, but who had developed treatment-emergent sexual dysfunction. Patients were switched either to amineptine, an atypical tricyclic antidepressant that is no longer available, or to Paxil, and were followed with multiple assessments over a six-month period. Another group of depressed patients, also followed for six months, was treated with amineptine only. The amineptine-only group experienced a less than 4% incidence of sexual dysfunction along with remission of depressive symptoms. In the group switched to amineptine, the incidence of sexual dysfunction dropped from 100% to 55% over the six month period, while depressive symptoms remained in remission. In the group switched to Paxil, sexual dysfunction decreased insignificantly from 100% to 89.7% after six months. The authors interpreted the finding as indicating a ".001 level of confidence that amineptine is an effective antidepressant that is able to significantly improve the SSRI-caused sexual dysfunction, yet maintain the efficacy of the antidepressant treatment used before." An

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*continued on page 10*

## **Advocacy in Service of Psychology & the Public Welfare**

### **Privileges • Prescriptions • Primary Care**

February 8-11, 2007

Bishop's Lodge • Santa Fe, New Mexico

*Time-Honored Classic Among Santa Fe Hotels And Resorts. Come early or stay late at the same special rate. Nestled in the majestic Sangre De Cristo Mountains, the Bishop's Lodge Ranch Resort and Spa offers the perfect balance of soothing luxury and exhilarating recreation in a time-honored setting encompassing 450 acres. Enjoy the miles of trails, perfect for hiking and horseback riding. Skeet and trap shooting is available for those who enjoy wild, Southwestern experiences. The fitness center includes a yoga studio, whirlpool, and tennis court. **Just three miles from the Historic Plaza district of downtown Santa Fe. One hour from Albuquerque International Airport (ABQ) (shuttle services available)***

#### **Objectives**

This conference is planned for all psychologist who wish to develop and enhance advocacy skills. The conference will focus on successful advocacy at a SPTA level in advancing psychology as a health profession and in the public interest. Specific emphasis will be on RxP, appropriate reimbursements, and privileges for psychologists interfacing with primary care.

#### **Who is Invited**

Veterans and neophytes in advocacy are encouraged to come with the goal of building strong grassroots efforts within each state and across states.

#### **Conference Highlights**

Presentations by APA Leaders on the goals of advocacy. Under their leadership, participants will develop a template for integrating State and Division advocacy efforts, which will be forwarded to State Leadership and other appropriate APA bodies

Presentations by leading political figures of New Mexico who will explain what makes Legislators listen to mental health concerns

Presentations by State Administrators regarding effective process of writing bills and legislation

Special breakout groups for RxP, dealing with managed care, and Advocating for Psychologists to primary care

#### **Presented by:**

**Division 55: The American Society for the Advancement of Pharmacotherapy  
and**

#### **Co-sponsored by:**

**Division 18 – Psychologists in Public Service**

**Division 31 – State, Provincial and Territorial Psychological Association Affairs**

**Division 42 – Psychologists in Independent Practice**

**New Mexico Psychological Association**

**Other State Associations**

**Other Divisions**

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#### **COSTS**

**Conference fee: \$300.00**

**Includes:**   Two evening receptions  
                  One breakfast  
                  One plenary dinner

**CEUs:** \_\_\_\_\_

**Bishop's Lodge Room Rate: \$155 a night**

#### **Return form and payment to:**

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1395 Missouri Avenue  
Las Cruces, NM 88001  
Phone: (505) 522-5466  
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**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City/State/Zip:** \_\_\_\_\_

**Home phone:** \_\_\_\_\_

**Work phone:** \_\_\_\_\_

**E-mail:** \_\_\_\_\_

## Plan to Attend, Success Depends Upon You!

Dear Division 55 Member:

Have you had an opportunity to look at our ambitious program for the Advocacy Conference? It takes place in Santa Fe, New Mexico, at the elegant Bishop's Lodge February 8-11, 2007.

You probably know by now that we have a number of goals for this summit. We are bringing together RxP experts from across the country to facilitate the advancement of RxP laws. We have broadened the scope of the conference to advocacy in RxP and primary care so that others will better understand that psychologists are developing a new integrative model of care that is crucial to the future of psychology.

A number of leaders and colleagues from within Division 55 and other divisions are already involved in planning and presenting. This is a partial list:

Glenn Ally	Keith Hulse	Susan Patchin
Nancy Bacher	Marlin Hoover	Bob Resnick
Debra Baker	Lance Laurance	Ana Rivas-Vaxquex
Laura Barbanel	Bob McGrath	Beth Rom-Rymer
John Bolter	Kevin McGuiness	Wendy Stock
James Bray	Marci Manna	Lynette Summers
Sharon Brehm	Elaine Mantell	Randy Taylor
Anita Brown	Mario Marquez	Tommy Thompson
Pat DeLeon	Jeff Matranga	Anton Tolman
Chuck Faltz	Jim Meredith	Steve Tulkin
George Kapalka	Robin Miyamoto	Luis Vazquez
Carol Goodheart	Mike Murphy	Lenore Walker
Kathy Harowski	Russ Newman	Dee Yates
Margy Heldring	Kathryn Nordal	Robert Younger
Sallie Hildebrandt	Jim Quillin	

Their experience and expertise will lead to great synergy. ***However, the success of the conference depends upon you.*** The presenters are the backbone. Your attendance will provide the body for the Advocacy Summit to serve its purpose.

*If you are new to the advocacy arena, this conference is for you.* We will be visiting the Capital building and the Legislature, which will be in session. We will have presentations by state administrators as well as lobbyists and legislators to edify you, step by step, about the legislative process.

*If you are well grounded in advocacy efforts, this conference is definitely for you.* This Summit provides an opportunity to plan strategies with experts from around the country and to take our advocacy efforts across the states to a new level, by combining our resources with our APA leaders and uniting efforts through divisions and state associations, and with primary care agendas and the media. In addition, we need our seasoned leaders to help groom the new generation of advocates who will attend.

You will find a registration form on a separate page of the Tablet. We hope you will register for the Summit and make your room reservation soon. After we receive your registration, we will be sending you a questionnaire requesting in which program alternatives and break out groups you wish to participate. That way, we will assure that the logistics for each part of the program are well planned. In addition, some members of the New Mexico Psychological Association have volunteered to pick up participants at the Albuquerque airport and drive them to the elegant Bishop's Lodge. If you would like a ride, it would be helpful to know that very soon.

*Please, join us in February!*

*Elaine*



*Visit the  
Division website,  
for up-to-date  
information!*

**www.Division55.org**

## Hawaii RxP Legislation Makes Significant Progress in 2006

### *Legislative Session 2006 in Review*

The Hawaii Psychological Association (HPA) continues to make steady progress to secure prescriptive authority (RxP) for psychologists who work in medically underserved areas across the state. Psychologists employed in federally qualified health centers and other Native Hawaiian clinics have maintained support from physicians, other allied health professionals, and associations (for eg., the Hawaii Primary Care Association and the Hawaii Medical Services Administration, as the largest health insurance company in the state) because of their work within these primary care settings where psychiatrists are scarce and mental health needs are vast. More legislative support was gained during the past 2006 session through the work of Rep. Josh Green, M.D. (D-Kona), an emergency room physician who lives and practices in rural West Hawaii (Big Island), and serves as the vice-chair for the House Health Committee. Representative Green's unique contributions, derived from the combination of a health practitioner's understanding with legislative experience, provided tremendous help in sustaining this year's bill (H.B. 2589) through the House Health and Consumer Protection Committee hearings, where lively debates were heard as both proponents and opponents delivered testimony that kept hearings in session for at least 2-3 hours. H.B. 2589 passed successfully out of the House for the first time in Hawaii's RxP history with a 29-21 vote (1 excused).

The RxP bill continued on in the Senate with slightly more of a challenge: it had been killed during the 2005 session in a floor vote that resulted in grid-lock (12 aye, 12 no, 1 excused). The senator who had not been present for the vote later indicated that he would have voted in support but fell ill the day of the vote; as luck would have it, this was his first and only vote absence during his 13 year tenure as a state senator. The Senate champion for the bill remains Senator Roz Baker, Chair of the Health Committee and vice-chair of the Senate Consumer Protection Committee, who fought valiantly for the bill and refused to allow psychiatry to embellish their testimony with "outrageous and melodramatic" claims. Unfortunately, the Chair of the Senate Consumer Protection Committee, Senator Ron Menor, was unshakable in his final decision to not move the bill out of his committee. What did result was a committee approved resolution, SCR 113, which calls for a study to be conducted by the Legislative Reference Bureau (LRB). The rationale for the study is to rescue the bill from yet more obstacles from the opposition. The training curriculum and patient safety data will be, again, examined and presented by an objective legislative body. This should discourage the medical establishment's fact distortions that confuse lawmakers and other groups (i.e., consumer advocates) and frighten them away from voting for the bill.

#### **The Next Steps**

The HPA RxP Committee has already provided the LRB with all the relevant materials to help document the history and legitimacy of the training curriculum and its proven success as indicated by various reports and articles written about the Department of Defense's Psychopharmacology Demonstration Project. Understanding the nature of this study, committee representatives have been in contact with those in charge of the study to offer assistance as requested, however, remain respectful of the process in order that the final report issued will serve its intended purpose to provide an objective appraisal of the issues that surround the Hawaii RxP legislation. It's reinforcing to know that the action to complete this study has begun, since the final report will play a significant role in the next legislative session scheduled to reconvene in January, 2007.

*Visit the  
Division website,  
for up-to-date  
information!*

**www.Division55.org**

## Recent Actions by the Board

### Robert McGrath, Ph.D.

This is the inaugural piece in what we expect will become a regular series to keep you updated on the actions of the Division 55 Board.

At the division business meeting at the APA convention in New Orleans, a motion was approved unanimously requesting that the Education Directorate withdraw two letters it submitted to ASPPB/NR last year that suggested certain restrictions on the types of programs that were consistent with the APA guidelines for a model curriculum in psychopharmacology. To read about this issue and the Education Directorate's response, please go to [I'll have a web link shortly].

The Board also approved the following as division policy on the endorsement of candidates for office in APA:

If any candidate for office in APA contacts a member of the board requesting official endorsement of their candidacy, the board will then contact other individuals running for the position if the board deems that individual may be appropriate for their endorsement. After gathering the response to those inquiries, the board will make a determination as to the endorsement of any candidates for that position.

The Board also approved a motion to donate \$300 to the Psych Shield fund in California, which is to be used for continuing work to implement the CAPP v. Rank ruling. For an update on this important struggle, please go to <http://www.apa.org/monitor/may06/privileges.html>

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## Hawaii RxP Legislation

### continued

The Hawaii political scene is also facing an election year which can only be characterized as tumultuous. No less than 12 candidates, 6 of whom currently serve in the State Legislature, are vying for the U.S. Congressional seat, which is to be vacated by Representative Ed Case. Adding to the chaos is that 5 of the 6 candidates have nothing to lose as, under Hawaii law, they are allowed to hold their current state elected offices while seeking election to a national seat. The unwanted fallout of this election anomaly is that important political issues have taken a backseat to grandiose campaign promises and political deal-making.

### Call for Support

In the lessons learned category, HPA now realizes that we can no longer sit on the sidelines of Hawaii's political games. We are humbly asking for financial support at a local and national level as we prepare to fill our coffers in preparation for the upcoming elections and the 2007 legislative session. It is in 2007 that we are fervently hoping to join the ranks of New Mexico and Louisiana by becoming the third state to obtain prescriptive authority for psychologists. Donations, large and small, are welcome, payable to HI-PSY PAC. These donations can be mailed to Hawaii Psychological Association, ATTN: Carol Parker, 1188 Bishop St., Ste. 912, Honolulu, HI 96813.

Jill Oliveira, Ph.D. and Robin Miyamoto, Psy.D.  
Hawaii Psychological Association  
Co-chairs, RxP Committee



## Editor's Column

continued

regarding general issues in psychopharmacology. They made certain that I had studies, CDs, videotapes and useful handouts, such as the Ham-D, Zung Depression Scale, Mood Disorders Questionnaire, OCD and Social Phobia assessment tools, and other materials for the classes which I teach. And, yes, I must admit I have accepted some pads of note paper which my wife (who does not prescribe) has used to decorate the refrigerator rather than use a PDA!

You can rest assured that the content of my teaching is not swayed by the drug industry. My statements to my classes at the beginning of every course include a clear "disclosure statement" which also cautions students not to be misled by hype and advertising from the pharmaceutical industry. These statements also mention appreciation to ALL the companies and their representatives who provide teaching materials. All videos and other materials are also discussed to eliminate as much as bias as may be present.

The pharmaceutically-sponsored local continuing education programs which I have chosen to attend have often been presented by researchers and clinicians who are very well known, not only in Boston, but in other areas of the country. Not surprisingly, a slide set was most frequently supplied by the sponsoring company, Bias? Of course. Enough to sway decision-making? Not for this writer. What is really interesting however, is that the post-presentation period with many speakers was always a great free-for-all, unbiased, unfettered by constraints, sometimes lasting hours, and always very helpful in terms of patient care. My co-editor, Jeff, has appropriately noted that by occasionally attending such programs, we help establish ourselves as professionals who are "psychopharm savvy." This has, at least in my own case, been extremely helpful.

Perhaps most importantly, I don't know of many instances, at least in my own circle of colleagues, in which medication choices were influenced or pressured by pharmaceutical companies or their representatives, though on a greater scale this may or may not be the case. Indeed, the anecdotal comments from many reps regarding medication choice frequently included comments, pro and con, that they had learned along the way. The prescribers with whom I worked have spent many a lunch hour explaining to reps why they were NOT using their particular brands of medication.

Yet, like most large industries, the pharmaceutical industry views itself as big business needing to sell a product and make a profit. Indeed, articles and websites report that there are most likely still pharmaceutical companies who "reward" prescribers for prescribing, and providers who gladly accept (for example, see <http://bmj.bmjournals.com/cgi/content/full/321/7276/1563>). Other issues are brought up at [www.newstarget.com/019179.html](http://www.newstarget.com/019179.html) and [www.newamerica.net/index.cfm?pg=article&DocID=1540](http://www.newamerica.net/index.cfm?pg=article&DocID=1540), to list but a few sources of information and opinions.

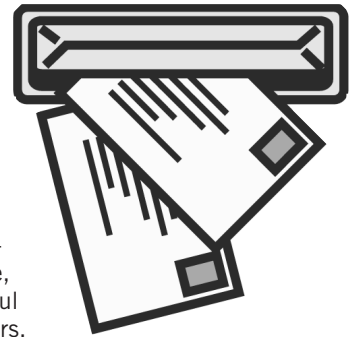
As is the case with corporations, there are clearly opportunities for each one of us to step into areas which are definitely unethical, and perhaps in some cases, illegal as well. But let me state that

I do not feel my colleagues and I are naive. We understand the nature of the business world. We understand profit motives, stockholder needs and other mundane, frustrating issues. But I am hopeful that as psychologists and prescribers, our medication decisions are, and will be, based on experience, results, our understanding of how to read studies (we know that figures can lie and that liars can figure), and the gathering of as much information about medications as possible. We may, by virtue of our training as psychologists, have a somewhat better shot at separating the "wheat from the chaff" when it comes to what does and does not influence our professional decisions.

The gathering of information about medications would be very difficult were it not for the sales representatives and their speakers bureau (I get paid for speaking, too, but not for or by drug companies). If given the opportunity to prescribe, I am certain that my choices, upon which the health of my patients rests, would be based on deciding what is best, and not upon which antidepressant manufacturer had given me the most pens or the largest pizza! The same can be said for those prescribers with whom I have worked over the years. The problem lies in the basic question of whether ANY material or financial compensation is appropriate, a question whose answer, I believe, ultimately lies in the hands of each individual practitioner (though institutions such as PHOs, hospitals and universities can and do set more global policies).

We can choose to ban all sales representatives, eliminate sampling, and just stick with the medications with which we have past experience. We can meet with prescribing friends and colleagues and discuss our mutual experiences with a new medication, but how do we get everyone together? How do we get the time to find and peruse studies on our own if we have busy practices and families? Do you have enough time to read each journal and periodical? I don't. Perhaps we need to strike an individual balance with the drug industry, and learn when to say "No thank you" and walk away if we feel our integrity is being compromised.

So if the pharmaceutical companies would like to advertise in the *Tablet*, why not? If they want to have booths at APA, why not? If they want to underwrite post-doctoral training with *unrestricted* educational grants, why not? Of course, by so doing, they are telling us that they are viewing us as a potential new market, which, as prescribers, we will indeed be. We will, as consultants and prescribers, be dealing with their products, like it or not. We are intelligent, well-trained, can read statistically-based information with understanding, and are quite capable of making evidence-based, sound decisions. We each must make individual choices as to what is, and is not, acceptable to us. We all live in the real world, and big pharmaceutical companies exist. I don't see them disappearing anytime soon. We don't have to sleep with "the enemy" to adjust to its presence. And as for pizzas, I'm trying to lose weight, so the whole food issue is academic!



## President's Message continued

tively "clean" source of information, and felt comfortable establishing a relationship with them. I also enjoy thinking about the fact that the ASAP logo will now appear on every marketing publication from one of the nation's leading providers of continuing education in pharmacotherapy.

We have been hard at work developing the 2007 midwinter conference, which is discussed in greater detail in a separate article by Elaine LeVine (see pages 4 & 5). I will only add that she has put a tremendous amount of work into pulling this event together. This has been a great opportunity for us to forge new alliances within APA.

Lexi-Comp and ePocrates are widely considered the leaders in the field of electronic databases in psychopharmacology for both the desktop and PDAs. We have negotiated a 25% discount on all their products for members of Division 55. Thanks to Morgan Sammons and Keith Hulse in particular for heading the task force that brought this arrangement to fruition.

We have created a series of new committees, including committees on the media, pediatrics, and geriatrics, and an inter-divisional task force with Div. 18 on prescribing in the public sector. The committees are all eager for more members, so if you're interested please use the contact information at the bottom to learn more. One in particular I would like to mention: we have established a committee to develop a proposal to ABPP for a new board to offer specialty certification in RxP. Our thanks to Beth Rom-Rymer for her efforts to get this program going.

The practice guidelines have been reviewed by several organizations within APA. At this point we are making revisions on the basis of the comments we have received. The revised draft will be submitted to the Board of Professional Affairs in November. With any luck, they will be sent to APA Council of Representatives next year to be enacted as association policy.

A number of our members will be actively involved in the APA Task Force on Psychopharm Curricula. By the time you read this, the task force will have met at least once, and the process will be underway. More to follow!

Perhaps it really is about too many irons in the fire instead of procrastination! There are so many opportunities, so many things to be done, in creating a movement of this scope in our profession. Fortunately, there is tremendous zeal out there. I thank again all those I've mentioned already, and also the dozens of people who have worked in various ways to move us forward, the John Courtneys, and Jack Wigginses and John Reeveses and Debra Dunivins and Glenn Allys and Elizabeth Carlls and Art Aaronsons and so many others, who contribute in ways great and small to we are doing. If it is true that if we don't quit we will win, then victory is ours, because I can never imagine these people quitting.

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## Post SSRI Sexual Dysfunction continued

alternative interpretation is that for 55% of individuals switched to a medication not associated with sexual dysfunction and whose depressive symptoms remained in remission, the SSRI-induced sexual dysfunction persisted at least six months after discontinuing the first medication.

Consumer reported information about persistent sexual side effects comes from the SSRIs internet community. Founded in January of 2005, SSRIs now includes a diverse membership of over eight hundred men and women who are struggling with sexual side effects that reportedly began on an SSRI/SNRI, but that have persisted months and years after stopping the medications. The group's purpose is support, the generation of hypotheses about what may have led to the persistent sexual dysfunction side effects, the sharing of information about attempted solutions, and the hope of enlisting researchers and professionals in collaborative efforts to understand and resolve the problem. Along with an ongoing moderated conversation among the membership that now includes over six thousand postings, this well-organized site includes a data base where individuals may describe their case history, and numerous voluntary polls related to particular side effects and their duration, specific medications and how long they were taken, and remedies attempted along with their results. Though the group has not yet been systematically surveyed, based on member postings and informal poll information, it appears that while any and all sexual side effects that start on the medications may continue after stopping them, reduced genital sensitivity, reduced intensity of orgasm, and severely diminished libido are characteristic of the condition which the group membership has termed Post SSRI Sexual Dysfunction (PSSD). It appears that a shared persistent effect of these medications is that they profoundly diminish the physical capacity to experience sexual pleasure. The day to day conversation among the geographically, ethnically and age-diverse-membership related to the problem of living with PSSD, for most a worse condition than the one they originally sought to treat, has created an unfolding collective narrative whose weight and substance urgently needs to be reconciled and integrated into our existing knowledge base.

There are a couple of recent case reports of PSSD in our literature. Csoka and Shipko (2006) reported three such cases, all involving severely decreased libido, and reduced genital and/or orgasmic sensation persisting for years beyond SSRI discontinuation. They suggest a number of hypotheses about why the side effects persist. Bolton, Sareen and Reiss (2006) reported a case of genital anesthesia and ejaculatory anhedonia persisting six years beyond cessation of a brief course of Zoloft in an otherwise healthy young man with normal premorbid sexual functioning. The authors concluded the young man's symptoms were more likely a 'conversion disorder' than a medication effect, based on the absence of similar reports in the literature and the indications in our literature that genital anesthesia and ejaculatory anhedonia are rare. The young man was offered an interpretation related to sexual numbing as an unconscious wish to protect himself from rejection, a rejection having been the trigger for the initial and long since resolved depressive symptoms. He was offered a course of psychodynamic therapy, which he refused, maintaining the conviction his symptoms were a result of his past medication use.

We are not negligent as professionals when we turn to our formal literature to inform ourselves. However when our formal knowledge base is inadequate or inaccurate, we are all left vulnerable to practicing in ways that may be less than ideal, to offering hurtful interpretations or misleading information to our clients in spite of our best intentions and best efforts to inform ourselves. The inadequacies and inaccuracies in our knowledge base have complex informed-

*continued on page 11*



## Post SSRI Sexual Dysfunction

continued

consent implications. A careful informed consent process includes accurate acknowledgment of our limits of knowledge. These limits would appear to be more far-reaching than we may have realized given the possibility of medication-induced sexual dysfunctions persisting for an unknown number of people, and the near impossibility of gaining a clear picture of how these medication may affect those individuals who have no well-established baseline of sexual functioning or are undeveloped sexually, such as adolescents and children.

The burden and responsibility of providing informed consent falls to us all, but falls even more squarely on the shoulders of those who hold or will hold prescription privileges. I appreciate Division 55's invitation to contribute this article and demonstrated high level of concern for accurate informed consent.

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Websites: <http://health.groups.yahoo.com/group/ssrisex/>  
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## President's Message

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