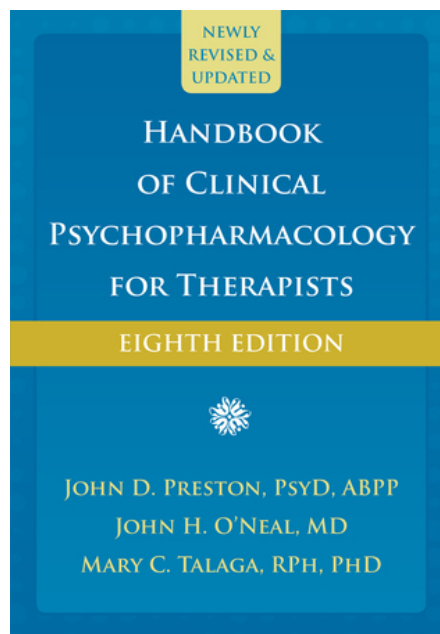




Handbook of Clinical Psychopharmacology for Therapists

John D. Preston , John H. O'Neal , Mary C. Talaga

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The Handbook of Clinical Psychopharmacology for Therapists is the go-to resource for mental health clinicians looking for clear, reliable information about the treatment of mental health issues. Organized by disorder and, within each disorder, by medication, this book is designed to familiarize clinicians and students with the basic terminology and models of pharmacokinetics.

This fully revised and updated eighth edition provides essential information on new medications and treatment options and includes the latest research on side effects, contraindications, and efficacy of all major medications prescribed for mental health disorders. The book also features an important new chapter on the effects of withdrawing from psychopharmacological medications.

This handbook makes it simple to: get the facts about drug interactions and side effects; find out how medications affect adults, children, and adolescents differently; learn how different cultures view medical treatment, vital information for anyone who treats clients from a variety of backgrounds; and discontinue medication safely when needed.

This essential guide to psychopharmacology has been adopted as a textbook at universities nationwide and is an important resource for every therapist's library.

Handbook of Clinical Psychopharmacology for Therapists Details

Date : Published March 1st 2017 by New Harbinger Publications (first published June 1st 1994)

ISBN : 9781626259256

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Format : Hardcover 376 pages

Genre : Psychology, Counselling, Textbooks, Medicine, Psychiatry, Reference, Social Science, Social Work, Nonfiction, Health, Mental Health, Academic, School

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Bob says

ugh.. But necessary...

Jackie says

Excellent reference - clear and concise.

Pam says

For COUN 549 Psychopharmacology class

Andy says

Before I lavish praise on this book, first let me make a disclaimer: the information packed into this tome is astonishing - not to mention extremely informative. However, it is what it says: clinical. And therefore quite daunting. So as such, I'm really not actually 'recommending' that anyone run out and buy this book, because (1) the price tag is \$60, and (2) you have to really, really want to know about this stuff; which I did. Happily there wasn't a single page that disappointed me! You could open this book to any random spot a couple days a week, and become amazingly enlightened each time.

So having made that disclaimer, I can now say that this is truly an incredible book and worth the \$60. I would justifiably call it the 'bible' for clinical mental illness. Here's my feeble attempt at why: Firmly rooted in standards set in the DSM-IV, the book starts off with a primer on pharmacology and neurobiology, which is a small book unto itself. You could stop right there and be completely satisfied. It then moves successively through an in-depth, chapter by chapter discourse of all mental illnesses, using various pharmacological models and how they've been applied to given case studies. Having covered all that ground, the second half of the book then moves into the pros and cons of every form of psychotropic medication being used today in the field of clinical psychiatry (mood stabilizers, old and new antidepressants, antipsychotics, etc.) I'm leaving out so many things, but even if you just read the many sidebars that are sprinkled generously throughout this book, you would gain seriously invaluable knowledge.

Let me also say that this book is not just about taking pills. The pills don't do any good if you don't know what they are, how they work, and how to use them with a concerted program of therapy and education. That's what this book can give you. This is a very important and complex field, and I have found that educating the people who have these illnesses can be the crucial difference between a successful recovery and failure.

If you want to understand the hard-core science - and I mean hard-core science - behind bipolar disorders, personality disorders, psychotic disorders, et al, (and you should if you are close to anyone who suffers from these conditions), this book may allow you to save someone's life; someone who never would have dreamed you knew about all this.

I bought this book (3rd Edition) as soon as I saw it, and although that was in 2002, it is not 'outdated' by any

stretch of the imagination. There is a 4th Edition published in 2004 that includes a "new chapter on medicine and children." I would assume mostly in response to fears that popped up a few years back concerning children and the use of these very powerful - and admittedly somewhat unpredictable - medications.

Jan says

Very, very useful

Jillian says

Useful, relatively compact, and written with clarity

Deborah says

What can I say, I'm kinda geeky when it comes to all things psychological/medical. It was informative, unbiased and useful.

Brandt says

As someone who frequently pitches a tent in the anti-psychiatry camp, I found myself utterly amazed at the straightforward presentation on the impacts of psychopharmacological medication presented in the text. As a textbook, it helped me learn the essential information about why individual's take the medications they are taking and what the probable next steps of treatment might be. Further, as a reference book, there are many tables, figures, and illustrations that allow the therapist to easily look up either the medication and/or diagnosis of an individual and easily review side effects, dosing, and the reasons for using that medication. The information is presented in a user-friendly and refreshingly clear format.

While reading this book, I took the time to reflect on what I had read and present it below as part of a further understanding of the important questions and implications this book presented to me. Notwithstanding these personal reflections, I would recommend that this book be part of any therapists' professional library and referred to whenever the subject of psychopharmacological medication arises in the therapeutic process.

While reading the text, the question I have revolves around comorbidity and the etiology of specific mental disorders. I have a strong tendency to view mental disorders as constructs (meaning they are an inanimate object that does not have a physical presence). Concomitant with this understanding is my skepticism at viewing the way we diagnose and treat mental health as if it were like a tangible object (for example, a broken leg). Ultimately, I think the medical model is not congruent with my views on mental health. As a result, I view counseling as both an art and a science. Once this is recognized, it is easy to see how one single manual (DSM-5) can be perceived as containing scientific truths. Nevertheless, there may be room to

consider that the DSM-5 is really a rough draft based on expert consensus. Although it is important to learn it and utilize the constructs contained within, it is equally important to remember that they are constructs; hence, everything contained therein might not apply to this particular person at this particular time. So, the final question presents itself as this: will I ever reach a point where I am comfortable with the knowledge I have about the impact of medication on clients? This book helps, but is it enough to overcome my skepticism?

I was particularly struck by both the easiness (maybe, dismissive-ness) in which the changes between the DSM-IV-TR and the DSM-5 were discussed. Moreover, at the beginning of part two, *Clinical Syndromes: Etiology, Diagnosis, and Treatment Implications* (p. 63), there was a mention of the International Classification of Diseases (ICD) – 10; however, there was no mention of the differences between it and the DSM-5 in chapters 6 or 7. I do think that the conversation would benefit from some previous knowledge of the changes within the DSM-5 and how it relates to the ICD-10 (or not). Additionally, although important aspects of delineating between personality and other disorders were discussed, I thought that it dismissed some important characteristics of the DSM-5 (alternate presentations of personality disorders) that may have enhanced the importance of diagnostic criteria; especially as it pertains to medication.

I thought that the section on Substance Abuse (Use) was a little broad. Based on experience, I think that this is a big area that needs special attention. Specifically, how the DSM-5 looks at substance use disorders, the treatment methods, and the applicability to other co-occurring disorders. This is an area of particular interest to me because I am not confident in arguing for either a substance use disorder as a primary diagnosis, nor am I comfortable in diagnosing a person with another disorder that may have been exacerbated by previous or current substance use.

While reading Chapter 14, *Substance-Related Disorders*, I realized that their terminology was reflective of the criteria set in the DSM-IV-TR, and not very indicative of the current criteria of the DSM-5. This realization of how labels and categories change, forced my reflection for these chapters to be on the problems associated with the boundaries between substance use and addiction. The two terms, *use* and *addiction*, provide a perfect example of the problems involved with delineating disorder from normality.

Think about this: In our society, most people drink alcohol. Further, *heavy* use of alcohol and binge drinking is not uncommon. For the sake of brevity, I will only state that statistics about alcohol abuse may be greatly inaccurate. Additionally, although accurate statistics are not yet available, it is reasonable to predict that states, like Oregon, where marijuana use is legal, will probably show similar prevalence to the statistics on alcohol.

Now, with the change from the DSM-IV-TR to DSM-5 there is no longer a categorical difference between substance addiction and substance use. Consequently, how will use be distinguished from addiction for psychopharmacological purposes (See the DSM-5, page 485, the last paragraph before “Substance-Induced Disorders,” for a clearer understanding of my confusion).

The point is that deciding what is or is not clinically significant in diagnosing a substance use disorder (SUD) is now only a judgment call. So, the question becomes: “What does the diagnosis depend on?” For

example, if someone loses their marriage or job due to substance use, is this due to substance use (cause-effect relationship)? Or, is it possible that either of these two scenarios would have happened anyway, regardless of substance use? The DSM-5 seems to suggest not. What does this mean for considering psychopharmacological interventions for the treatment of other types of disorders when substance use may be the primary problem?

With the modifications in the DSM-5, there is sure to be even more diagnoses of SUD. As a result, the question is, "how does this diagnosis interfere with whatever may be the primary diagnosis for psychopharmacological intervention?" To me, it really all depends on an assessment of the impairment which was diagnosed without a clear boundary delineating addiction from using too much. At what point is a client that drinks too much impacting their social, educational, or work opportunities? The answer is obvious in a severe case (loss of employment due to an alcohol-related incident or drug use); however, in the more common cases of a person who *binge drinks* or is a *heavy* drinker, the answer is less clear as to how it impacts the social, work, and education areas that are required for a diagnosis.

Ultimately, having knowledge of SUDs, recovery, and psychopharmacological interventions will be instrumental in helping me to develop an understanding; however, my biggest fear remains the same, is the diagnosis correct and how does having that diagnosis inform the proper psychopharmacological treatment plan for the individual; specifically, from a substance-use disorder perspective.

The text did a thorough job of describing important aspects of antidepressants. The charts (especially, the algorithm for treatment-resistant depression) were very useful in capturing the intricacies of treatment for depression. I found the small section devoted to electroconvulsive therapy (ECT) to be extremely valuable as an explanatory tool for those who may understand the full history, use, and value of this type of therapy.

Some of the more concerning areas, for me, were the discussion on seasonal affective disorder (SAD) and postpartum depression. The line of reasoning, explaining SAD seems very unscientific in causal explanation for the need of a distinguishing category (why not just keep it in the typical depression format?).

The section on postpartum depression seemed somewhat different from the current information in the DSM-5. Although this section did a fairly good job of explaining, I am curious why they stuck with the postpartum tag instead of the perinatal designator, as used in the DSM-5. As expressed in the DSM-5 it seems more applicable that the stressors exist both leading up to and after birth. I am not sure how environmental factors, as expressed in this chapter, only impact the women after the birth of the child. Moreover, I think an important consideration is the well-being of the mother during childbirth, and more research needs to be done about the impact of the mother's psychological stressors that could impact the fetus during the pregnancy. As a result, I think it is more appropriate to specify it as perinatal (whether part of a bipolar or a depression cluster diagnosis) and that could help with treatment outcomes prior to the actual birth of the child.

I have always struggled with the idea that *clinical judgment* plays such an important role in the differential

diagnoses of bipolar and related disorders. Additionally, the multitude of specifiers and severity coding challenge my understanding of the differences between some presentations of bipolar and related disorders. Specifically, with the difference between bipolar I and bipolar II. I am still not clear on why hospitalization is the distinguishing factor between mania and hypomania.

Lastly, I think there is a tendency to not understand the term chronic illness. There is a propensity, especially prevalent in medical thinking, that illness is something you recover from. Therefore, I (1) insist on calling diagnosable conditions from the DSM-5 disorders; and (2) always make sure that people understand the subtle definitional differences between terms like acute, illness, disorder, chronic, and terminal. However, I think that the reading furthered my knowledge of the bipolar and related disorders and gave me a better understanding of the available treatments. For this, I am satisfied.

I appreciated the thorough discussion on the history of the drugs used to treat anxiety in Chapter 18. As I read chapter 9, I was constantly thinking about the common perception of anxiety and its relation to the actual clinical presentation of a disorder from the anxiety cluster. I am glad the book mentioned the Freudian view of anxiety (specifically neurotic anxiety); however, I would have liked to see more discussion on the existential view of anxiety (particularly through the work of Kierkegaard and May). I do think that the textbook had it right in saying that psychotherapeutic treatment is the best first-line treatment; however, I also think that if the counselor could help distinguish anxiety as a normal part of being human and anxiety as an inappropriate reaction to life's stressors, there would be far fewer diagnoses of, specifically, general anxiety disorder, and more recognition of abnormal reactions.

I have always struggled with the idea of conceptualizing differential diagnoses between bipolar and schizophrenia disorder clusters. It really seems that the Kraepelinistic (1976) dichotomy of schizophrenia as a chronic illness and bipolar as an intermittent disorder has shaped the way I think about these disorders. I think that if it were possible to show that both bipolar and schizophrenia disorders are rooted in multiple diatheses rather than a single one, an easier diagnoses differentiation could be possible. One of the biggest concerns I have, in reading the chapter, is that if a diagnosis is incorrect, (e.g. Bipolar I or II with mood-incongruent features or with catatonia versus schizophrenia) would the medication used in either of these diagnoses mask the actual presenting disorder? Further, it seems that schizophrenia presents differently in each person and is subjective. Considering, what I perceive to be, the severity of side-effects equated with antipsychotic medication, it makes me hesitant to even want to consider ever having to make a diagnosis of schizophrenia or bipolar.

For me, the section on alternative medicines is a dual-edged sword. In many respects, I understand the arguments that lead some people towards these solutions (e.g. lack of personal care from a treating physician, overwhelming anecdotal evidence that appeals to those unable to critically evaluate the efficacy and magical beliefs about benefits of "natural" products). However, I am always ashamed by the kernel of truth in these arguments that give them lasting power (e.g. the pharmaceutical company is, in fact, in the business of making money; consequently, a claim that drug companies want to make money is true; however, the addition of other premises to a true conclusion does not make the argument valid (or sound)).

Additionally, I was amazed that no information was presented in this chapter about marijuana [CBD and/or

THC]. If I had to guess, this is probably a crossover substance that sits on the line between alternative medicine and illegal/controlled substance. I am sure that people do get relief from some properties of marijuana (what property that is, probably needs research); however, I am not sure if the risk outweighs the rewards. Nowhere in the text was there a mention of cannabis (not even in the substance-related disorders chapters) and I am overly curious why that is. In many respects, I can use the DSM-5 criteria for cannabis use disorder (or the ICD-10 criteria) and would be able to easily diagnose many people who feel they are using the substance for the relief of the previously mentioned ailments (anxiety, depression, chronic pain, etc.). However, I have never felt compelled to do the same for someone using essential oils in the same manner.

For example, let's replace the word cannabis with the word eucalyptus oil in the diagnostic criteria for cannabis use disorder in the DSM-5, and only highlight two (the required amount) of symptoms in Criterion A. Symptom 6. Continued eucalyptus oil use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of eucalyptus oil. Client: I have no friends because everyone says I smell like a koala bear, but I **must** use my eucalyptus oil. Symptom 10. Tolerance as defined by either of the following: a. A need for markedly increased amounts of eucalyptus oil to achieve intoxication or desired effect (client: I can't help if I use so much oil, I've used it so much that I need more in order to smell it and know that it is having the desired effect on my allergies) and, b. Markedly diminished effect with continued use of the same amount of eucalyptus oil (client: I am just not getting the same effect by only using the eucalyptus oil in the morning. I keep a bottle with me and periodically, throughout the day, I must apply a little to my wrists to ensure my airways stay clear) (APA, 2013, pp. 509-510).

I know that sounds goofy, but my point is that it may be a bigger problem than just the use, or *want* to use alternative medicines. For some, it may be a pattern of an inability to think rationally that may be indicative of another thought disorder that needs to be explored in counseling.

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Happy Reading!

Tim Tuttle says

For a med book this was not all bad... useful info for non medical practice

Ender says

I feel like I learned more than a therapist needs to know, presented in a comprehensible way.

Justin says

A very good introduction and breakdown of treatment via meds for those of us unable to prescribe. Each chapter provides a fairly logical outline of disorders followed by a later chapter on treatment.

My only major issue is with the bipolar medications chapter which did not seem treat the side effects of lithium and other bipolar meds with the appropriate intensity.

Carol says

Required reading for my MFT program. Liked it because it was written for the lay or first time reader in the area of psychobiology/psychopharmacology. Helped me understand the highly technical reading in the other assigned text.
