Counselors' knowledge of psychotropic medication and attitudes toward their use in counseling settings: Professional and curricular implications.

RUNNING HEAD: Counselors and Psychotropic drugs

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Abstract

The research reported in this article explores the attitudes of counselor in training toward the use of psychotropic medication in counseling settings. Furthermore, basic knowledge on psychotropic medication is assessed throughout a simple multiple-choice test.

It is argued that despite the acceptance of benefits of medication for a majority of patients, counselors lack basic knowledge on their use and limitations. Curriculum implications for training and for practice are discussed.

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Introduction

The recent wide spread use of multidisciplinary teams in The mental health field requires that all members working together - counselors included -are acquainted with the prescriptive use of medication, its major side effects and the expected gains of pharmacotherapy in improving the client's life.

Geroski, Rodgers and Breen (1997) claim that counselors are increasingly being called upon to participate in mental health service delivery systems and suggest that counselors establish collaborative relationships with physicians and other health providers.

In this article, it is argued that when clients are prescribed psychotropic medication, specific goals must be sought in the counseling process. Some of the most important goals are to: 1) foster adequate medication intake; 2) prevent treatment drop out; 3) identify unwanted effects; 4) facilitate communication with physician(s); and 5) decrease the probabilities of over use or dependency.

This work does not attempt to advocate for or against the attainment of prescription powers for counselors. In the mental health field the non-medical prescription

privileges seem to be a long-term battle, as judged from the results so far achieved by The American Psychological Association (APA).

In fact, conflicting views on who should prescribe psychotropic medication goes beyond professional organizations seeking dominance. It has complex financial, professional, political and even philosophical implications.

Purpose of the study

This work explores the attitudes and knowledge of students in counselors education programs about the use of psychotropic medication and describes the status of psychopharmacology training in these programs.

By focusing on professional responsibilities, one can argue that the knowledge of psychopharmacology is necessary for counselors working in clinical settings. Thus, training in this area may better prepare counselors to meet the challenges of their jobs.

This work was developed to assess the need of preparation in this area and the feasibility of incorporating psychopharmacology courses in counseling education programs. Curricular changes are considered in order to improve professional competencies and to facilitate counselors’ performances in multidisciplinary teams.

Theoretical Framework

Counselors and Psychopharmacology

The interest from professional psychologists in training in psychopharmacology has been echoed by only isolated voices in the counseling profession. The scarcity of articles on the relationship of counseling and psychopharmacology in American Counseling Association (ACA) publications and journals, contrast with the enormous interest in psychotropic medication shown by publications sponsored by APA.

The lack of scholarly interest in the role of psychopharmacology for the counseling profession might be explained if one considers that the struggle for prescription privileges in the United States appears to be more of a political battle over prescription powers, than an effort to objectively justify the need for psychopharmacological knowledge to fulfill professional demands. In fact, despite numerous articles on the matter, empirical research to demonstrate the need for training in psychopharmacology for counselors is scarce.

Counselors working in clinical settings are frequently confronted with clients under psychotropic medication. Those working in school and industrial settings are required to identify clients that need referral for psychopharmacological support.

The fact is that many clients take some sort of psychotropic medication. Hence, it is important for counselors to acquire knowledge in psychopharmacology. Hayes, (1997) quotes the comments of a practicing counselor as follows:

> My job is to be a good ear or listener for clients and to advise them to consult with their physician if there were any problems or concerns with the medication; the fact of the matter is that most counselors are not well trained in the area of psychopharmacology, and this is an area in which little knowledge can be a dangerous thing. (p.2)

In addition, many clients will come to the counseling setting with a multiple medications (polypharmacy), many times prescribed by more than one physician. Thus the counselor must know the interaction of medications and be able to coordinate efforts of different physicians by establishing adequate communication among them and with the client. Counselors may also help the client design a schedule to take medication and monitor both progress and side effects. Koshes, R. (quoted by Hayes, 1977) suggests that counselors can monitor side effects and help clients decide which are tolerable.

For a variety of cases, counselors should be aware of the benefits of combining psychotherapy and pharmacotherapy.

For example, whereas in major acute depression psychotherapy is only warranted as and adjunct to pharmacological treatment. Cognitive therapy and other approaches are more useful in relapse prevention. In other conditions, such as Obsessive Compulsive Disorder (OCF) Finenberg (1996) acknowledges the concurrent use of behavioral therapy and medication. Counselors must realize that psychotherapy and psychopharmacology, although they have many specific uses on their own, they are not mutually exclusive approaches.

This article argues that although the prescription of medication is yet a responsibility beyond the boundaries of the counseling profession, counselors must have at least minimal basic information on the uses and limitations of psychotropic drugs. Furthermore, it is contended that counselors should have knowledge on the additive value of psychotherapy. In studying psychopharmacology, counselors must consider the risks and benefits of psychotropic drugs, legal liability, ethical principles, as well as their desire to deliver the best possible care to clients.

Overview of psychotropic drugs

Despite the contribution of psychotropic drugs to reduce the incidence of mental disorders and their valuable role in decreasing institutionalization, the arsenal of psychotropic medication currently available remains rather limited.

When compared to developments in other medical fields, there are few psychotropic drugs that are safe, efficient, easily available, and affordable. Psychopharmacology is a limited field with a trend to use a basic set of drugs for a great variety of mental disorders. The majority of them have undesirable side effects,

In this section, the main families of psychotropic drugs will be broadly reviewed; focusing on the basic knowledge counselors should possess for practical purposes. For further information on psychotropic drugs commonly taken by clients attending counseling, the reader is referred to Ponterotto's article published by the Journal of Counseling and Development in 1985.

Anxiolytics, sedatives and hypnotics

Anxiolytics or tranquilizers, also called sedatives, or hypnotics, are the most commonly prescribed psychotropic drugs. They are used to treat a variety of conditions characterized by anguish and anxiety, for example, panic disorder, social phobia, and stress-related disorders.

Most anxiolytics belong to the family of benzodiazepines. Generally speaking, benzodiazepines inhibit the Central Nervous System. Frequent anxiolytics found in the counseling setting are buspirone (Buspar), diazepam (Valium), chlordiazepoxide (Librium), oxazepam (Serax), clorazepate (Tranxene), lorazepam (Ativan),

alprazolam (Xanax), clonazepam (Klonopin), and triazolam (Halcion).

Anxiolytics have potential adverse side effects such as: clumsiness, dizziness, drowsiness, blurred vision, slurred speech, headaches, sleepiness. These medications are commonly called 'Nerve Pills' and because of their psychological and physical addictive nature, their use should be monitored.

Counselors could help clients comply with the prescribed regimen since many will modify their dosages or combine these drugs with other substances with agonistic or potentiating effects (alcohol, antihistaminics, beta-blockers) or with antagonistic effects (caffeine, diet pills).

In addition, by identifying clinical signs of use or overuse, counselors can confront clients consuming these drugs without the appropriate medical supervision. Many of these drugs can be obtained illegally and have 'street value' Maxmen & Ward, 1995).

When working with clients under anxiolytic medication counselors must be aware of the restrictions in driving, drinking alcohol, and using heavy equipment. Also, counselors should be aware that anxiolytics will worsen or promote depression and should appropriately monitor symptoms.

Antidepressants

Antidepressants are used to treat mood disorders, anxiety, complicated bereavement, and chronic pain. Their clinical effectiveness has been widely documented (Gitlin, 1996).

One can identify four main categories of antidepressants: Tricyclics, Selective Serotonin Reuptake Inhibitors (SSRI), Monoamine Oxidase Inhibitors (MAOIs), and Atypical antidepressants.

Tryciclics are the oldest medications used to effectively treat depression. Examples of drugs of this family are. imipramine (Tofranil), amitriptyline (Elavil) and desipramine (Norpramin). These drugs usually sedate the client, but take about three weeks to show significant antidepressant effects.

The SSRIs have gotten the most recent attention because of their high tolerance levels, their quick effect (about a week) and the ease to administer the drug (commonly one pill a day). Frequently heard in the counseling setting are fluoxetine (Prozac), paroxetine (Paxil) and setraline (Zoloft).

MAOIs are less used nowadays because of dietary restrictions and adverse side effects. Atypical drugs such as venlafaxine (Effexor) and buproprion (Wellbutrin) portray the same advantages described for SSRIs.

Antidepressants have adverse affects such as: dry mouth, constipation, nausea, blurry vision, and impotence. Antidepressants typically require 10 to 14 days on a therapeutic dose to start working and their full effect may take up to six weeks.

Counselors need to be aware of the type of antidepressant and of the dosage prescribed. Contrary to conventional wisdom, many antidepressants do not have powerful addictive effects since they do not cause euphoria as some people belief. Counselors should explain to clients the possible adverse reactions and expected effects.

Natural products such as St. John’s Wort and Kava Kava will come up in discussions with clients. Discouragement of natural products should only be made when evidence of harmful effects exists. Counselors must foster medication intake and avoid replacement of prescribed medication. In addition, counselors must be aware that depression usually requires long-term treatment and that clients tend to have poor motivation because of their disease.

Antipsychotics

Antipsychotics are indicated when a client has lost touch with reality and presents delusions, hallucinations or delirium. One may conveniently divide antipsychotic drugs in two broad classes. The first, includes traditional neuroleptics derived from phenothiazides such as

clorpromazine (Thorazine) and thioridazine (Mellaril), or more powerful substances derives from butyrophenones such as haloperidol (Haldol). The second class of antipsycotics emerged recently and they are known as ‘atypical’ or ‘new antipsychotics’ such as: clozapine (Clozaril), olanzapine (Zyprexia) or sertindole (Serlect). The new antipsycotics seem to be as effective as their predecessors are but with significantly fewer side effects (Kane, 1997). Indeed, traditional antipsychotics would almost inevitably cause extrapyramidal effects, such as drug induced Parkinsonism, akathisia and involuntarily movements and muscle spasms. In the long term, traditional antipsychotics are known to cause tardive dyskinesia, an irreversible condition largely characterized by involuntarily facial movements.

Stimulants and Appetite suppressers.

Many clients, particularly women, would present anguish, anxiety or somatic symptoms due to the use of appetite suppressants. Counselors should be able to identify these symptoms and assess use and abuse of diet pills. Investigating use of anorexic drugs must be a routine in clients with a history of bulimia and when concerns about body weight or self-image arise during the counseling session.

Similarly, client agitation, psychotic-like behavior and anxiety show abuse of amphetamines. Counselors must be

aware that stimulants are widely available and used beyond medical supervision. Night workers, truck drivers and students should be asked routinely about stimulants intake.

Attitudes toward psychopharmacology

It is not uncommon to notice reluctance to promote the use of psychotropic medication in both counseling and psychological settings. Even, some general physicians tend to avoid their use or have little specific training in handling these drugs.

Despite the above, the efficacy of psychotropic drugs in treating a number of conditions seen in counseling setting is unquestionable. It is a fact, that many clients have concerns regarding medications and these are frequently addressed in the counseling session. How prepared are counselors to respond to these concerns? What can counselors realistically expect from medication? How does pharmacotherapy influence the counseling process? These fundamental questions remain unanswered in most of the counseling literature. Counselors must reflect upon the implications of these questions particularly in relation to counselor training programs.

Tatman, Peters, Greene, & Bongar (1998) reported that graduate students, predoctoral interns and training directors strongly supported prescribing privileges for psychologists, but they were less enthusiastic about

training to such prescribe drugs. Similar results were reported by Ax et al (1988) who concluded that prescribing solely by example, without appropriate training, was not desirable.

Before discussing prescription privileges, training needs must be clearly established. Regarding prescription powers, considerable debate persists. For example, whereas Sammons, Sexton & Meredith (1996) argue that medication will enable psychologists to practice "as independent, full-fledged health providers" (p. 230), others such as Strickland (quoted by Sleek, 1997) claim that prescription privileges would lead psychologist to medicate difficult cases, especially those from a culture the clinician does not understand and would be tempted to seek shortcuts.

In sum, those in favor of prescription privileges for psychologists will claim that appropriate training (usually at a postdoctoral level) should enable psychologists to prescribe a limited set of medications just as nurse practitioners, optometrists, podiatrists, and dentists. Those against argue that medication would distract psychologist from the primary emotional and behavioral interventions they are trained to do.

The apparent disagreement toward prescription privileges in psychologists was also demonstrated in the survey conducted by Plante, Boccaccini and Andersen (1998)

with members of the American Board of Professional Psychologists. They reported that the distribution of scores regarding prescription privileges question was bimodal, with 36% of respondents strongly opposed and 31% selecting strongly in favor. They concluded that psychologist feel strongly toward this issue regardless of the direction.

There is little research regarding the attitudes of counselors toward psychopharmacology and prescription privileges. The only significant precedent in the JCD regarding this issue was Ponterroto's (1985) article with a psychopharmacology guide for counselors, which provoked controversy and a sharp replay. Indeed, Walker (1986) debated the ethical and philosophical implications of this matter. His final open questions summarized his concerns: Is chronic intoxication the answer to problems in living?

Pontorroto's (1986) responded to Walker's criticism: "... for psychopharmacological issues are so important but so neglected in the counseling literature, I hope this debate continues...."(p.66). The authors, 13 years later, echoed this hope.

Method

Subjects

Counseling Education program Directors

A list of the programs in the Council for Accreditation of Counseling and related educational programs (CACREP) was used to mail a survey form to each program director or chair of counselor education programs across the US. The total listed population was 102, return rate was 62 (63 %).

Students

An exploratory survey with students was developed by Eighty-nine counselor education students from 3 medium size Universities in the mid-west to respond a pencil and paper questionnaire. The sample was conformed conventionally by asking 6 different professors to administer the instruments to those students attending their class and that voluntarily consent to participate in the study. The majority of respondents were women (87%), with a mean age of 32 years old. All were master's degree students with some experience working in counseling settings.

Instruments

Questionnaire for students

This Instrument contained three sections. The first investigated the theoretical orientation of students, their area of concentration and previous training in psychopharmacology.

The second contained an 8-item scale regarding attitudes towards psychotropic medication.

The third consisted in a 12 items multiple choice quiz on general knowledge on the use psychotropic drugs commonly seeing in counseling settings.

Questionnaire for Department Chairmen

This was a one page survey requesting information regarding: 1) the level of the programs they offered; 2) the availability and nature of courses in psychopharmacology offered; 3) the reasons for offering, or not, a course on psychopharmacology; and 4) their opinion on the need of to implement a course of this kind.

The answer sheet included information that facilitated its return via fax.

<u>Procedures</u>

Department chairs were contacted by mail. A letter of presentation explaining the purposes of the research was sent along with a survey four that could be returned either by mail or fax.

Department chairs from three major Midwest universities collected student's data. They were asked to randomly request two teachers to administer questioners to their groups and return data to the investigators.

All data was gathered, coded and analyzed. For quantitative information the SPSS computer package was used.

Results

Students Responses

A Third of the students (34%) considered themselves without a specific theoretical orientation, 19 (21%) claimed to be humanistic, 11 (12%) Eclectic and 10 (11%) behaviorist and 8 cognitive. The rest indicated some other theoretical orientation.

Their area of concentration depended from their program of registration and the stage they were. Thirty-three (37%) were in School counseling, 30 (34%) were in community counseling, the rest (29%)were in general introductory counseling courses and they have not chosen an specific field yet.

Seventy four (83%) students reported no previous training in the use of psychotropic medication. However, 17 (19%) students reported they had received some sort of information regarding the use of psychotropic drugs, mostly as workshops in their workplaces.

Regarding these students' feelings about the use of psychotropic medication, Table 1, depicts the rank order of response to presented items.

Table 1, Personal feelings regarding psychotropic medication

Item	Media	Ds
As a counselor, I should not get involved	2.31	1.15

in psychopharmacology		
I believe counselors should seek prescription rights for psychotropic medications.	2.75	1.15
I think psychotropic medications are as effective as psychotherapy	2.79	1.04
I will work with client taking psychotropic medication	3.89	1.05
I need specific training in psychopharmacology	4.26	1.06
I need to have more information about psychotropic medications	4.80	.50

The most commonly expressed opinions related to the need of receiving more information and formal training in the use of psychotropic drugs because of the likelihood of seeing clients under medication.

About their knowledge on psychotropic drugs, table 2 depicts those more frequently responded correctly and that least responded rightly.

Table 2. Items more often responded correctly and incorrectly.

Items correctly responded	F
The new SSRI antidepressants staring acting: Within a week	30

Which medications are generally used for depression: Tricyclics	28
Valium (diazepam) is a(n): Muscle relaxant	27
Items responded incorrectly	F
Valium (diazepam) is a(n): Muscle relaxant	54
Amphetamines are used for: ADDH	50
Extra-pyramidal signs (EPS) are basically affect: Motor activity	50

In general students showed little knowledge about the effects of drugs commonly used in counseling settings, the average for the sample was 3.3 with a sd of 2.4(maximum of 8 points).

Chairmen of Counselor Education Programs

From the 106 chairmen listed in the CACREP registry of counselor education departments, 51 returned the survey (return rate of 49%). 23 that both Ph.D. and masters degree programs, and 28 had only masters programs. Responses were collected from 41 different states.

Chairmen reported that their programs did not offered specific training in the use of psychotropic medications.

Reasons argued for not offering such courses were:

1) Not included in the curriculum (41%); 2) they have equivalent courses (18%); 3) it is not necessary or it is unrelated to the field of counseling (18%); 4) the

department does not have the faculty properly trained to do it (15%), and other reasons (8%)

Reasons argued for eventually offering these kind of courses were:

1) It is important to have information related to psychotropic medication (40%); 2) It is important to validates studies regarding the use of psychotropic medication in counseling settings (20%); 3) Information on psychotropic medication is or should be included in other subjects offered (20%).

Twenty argued that additional faculty members, with specific training in psychopharmacology were needed. They also stressed the need of having free slots in the curriculum (12%).

Major problems to implement courses in psychopharmacology were the lack of interest from their faculty (12%) and scarce didactic resources. Forty six percent of respondents did not address this question.

Conclusions and Discussion

The need to implement courses in psychopharmacology is evident when addressing the feelings of students whom foresee working with clients using psychotropic medication. It should be a source of concern for curriculum developers and counseling departments the relative lack of knowledge regarding psychotropic drugs that many clients presents mostly in clinical and medical settings. Counselors working with clients using psychotropic drugs should be aware of major side effects, and be able to address some of the concerns of the client.

On the other hand chairmen stress the need of faculty specifically prepared in psychopharmacology and the need of establishing a space for this kind of information in the curriculum. Mixed feelings are evidently on whether this should be a specific course or information on psychotropic medications should be included as topics in other courses.

Independently of the reader's opinion regarding this subject, it remains a fact that counselors will confront at some point a client under psychotropic medication. The questions remains open: To which degree should the counselor be prepared to face this challenge?

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