

CHAPTER FOUR

Psychological, Social,
and Cultural Issues in
Psychopharmacology

This chapter is divided into four sections. Section One provides an overview of issues surrounding adherence and compliance with medication prescriptions. Section Two addresses how to speak with clients about medications. Section Three covers the new subdiscipline of ethnopharmacotherapy and Section Four provides an overview of how institutions like pharmaceutical companies are impacting mental health practice.

SECTION ONE: ADHERENCE AND
COMPLIANCE WITH MEDICATION
REGIMENS

Learning Objectives

- Understand the difference between compliance and adherence.
- Be able to discuss the different ways clients conceptualize their symptoms.
- Be able to discuss common reasons people do not comply with medication regimens.
- Know the predictors of noncompliance and therapeutic ways to work through them with clients.

Many psychological issues that clients have related to psychotropic medications are illustrated in discussing **compliance** with medication. Even when a person suffers from terrible **ego-dystonic symptoms**, if taking medication is incongruent with the person's self-image, noncompliance or nonadherence may be

an issue. Compliance is the overall extent to which a client takes medication as prescribed. **Adherence** is more specific, referring to the extent that the client takes the prescribed medication at the exact time and in the correct dose (Demyttenaere, 2001). We include adherence in our general discussion of compliance.

We recall one client (Agnes) who interpreted taking a medication as a sign of weakness that she avoided thinking about. Agnes had lost her husband one month before she consulted a physician for her "nerves." Her physician was torn as to the best course of action. Under earlier diagnostic manuals (e.g., *DSM-IV-TR*, APA, 2000), she was experiencing uncomplicated bereavement, which is a developmentally normal event following loss of a loved one. However, she was not eating or sleeping, and met the *DSM-5* (American Psychiatric Association [APA], 2013) criteria for a Major Depressive Episode. *DSM-5* omitted the exclusion not to diagnose someone with depression if they had just lost a loved one [a move many in the field are critical of (Frances, 2013)].

Agnes asked if there were medication to "calm her nerves" but then became agitated stating that taking the medication would be a sign of weakness. The doctor wisely refrained from prescribing and connected Agnes with grief counseling. In the counseling sessions, Agnes revealed that the bottom line was "anyone who would take a pill for their mind is crazy." Her response was clearly related to her own perceptions of psychotropic medication, which reflected the cultural stigma attached to

mental/emotional disorders, particularly for a woman in her 70s.

Understanding such stigma is an important variable in understanding clients who may resist or feel conflicted about taking medication (Knudsen, Hansen, Traulsen, & Eskildsen, 2002), but the stigma seems to vary from generation to generation; from culture to culture (Britten, 1998; Priest, Vize, Roberts, & Tylee, 1996). Mental health professionals must be willing to commit the time with clients to explore issues such as stigma. For Agnes, cognitive techniques helped her reframe and metabolize her grief but ultimately her mind was made up about psychotropic medication and, right or wrong, it was not of therapeutic value to challenge it.

CLIENT REACTIONS TO THE MEDICAL
MODEL OF MENTAL ILLNESS

Some qualitative studies examine the way clients perceive the medical model description of their symptoms. In one study of women suffering from symptoms of schizophrenia (Sayre, 2000), most of the sample seemed to have been given a medical model explanation of their symptoms (e.g., "Schizophrenia is a brain disorder"). Client responses fell into six general categories. The members of one group more or less accepted the disease explanation and viewed their problems as related to some externally caused illness that could be treated with medication. The members of another group (labeled the "problem group") saw their symptoms as arising from personal qualities and behaviors that were the root causes. The members of a third group (the "crisis group") viewed their symptoms as a response to some crisis or other recent stressor. In a fourth group (the "ordination group"), the members saw their symptoms as a sign of special powers or responsibilities. Although this explanation is similar to tales of initiation told in shamanic traditions of many indigenous people, in this case the explanations were more consonant with the symptom profile than any spiritual crisis. In the fifth group (the "punishment group"), members saw their symptoms as punishment for past actions. In the final group (the "violation group"), members viewed their hospitalization as an

attack on them by hospital staff and the idea that they had an illness an excuse for detaining them. In the case of schizophrenia, although there is strong support for a theory of biological etiology, the symptom presentation is still heterogeneous.

Even if a clinician believes the etiology of a disorder is more physical than mental (e.g., more brain than mind), it is important for the therapeutic relationship to consider the way a client makes meaning of his or her symptoms. Clearly, some perceptions of illness recorded in the Sayre (2000) study may reflect the illness more than they represent any personal or cultural aspects of the client. For example, **illusions** or **hallucinations** may be perceived as a sign of special powers (as in shamanic initiation) but also may reflect **megalomania**, which manifests in many people suffering from severe disorders such as schizophrenia or Bipolar I Disorder.

It is important to remember that some clients prefer to use the medical model perspective to explain their symptoms. In such cases, a psychological perspective can help counselors understand why some clients have this preference. Although ideally clients will become able to face all the variables related to their symptoms, this may take time. In some cases of depression, the medical model may provide a good explanation; however, where the depression is **overdetermined**, the medical model may serve as what Yalom (1995) called an "explanatory fiction"—an explanation that is more allegory than fact corresponding to some external truth. One client (let's call him James) had low **self-efficacy** and was actively suicidal. This followed a series of difficult life events, including the loss of a job, being dumped by a longtime girlfriend, and the death of his mother from pancreatic cancer. Clearly, these life experiences were strongly related to his depression but for James, the explanatory fiction of his depression as a medical illness made it easier to accept help in the form of counseling and antidepressant medication. James took the antidepressants for eight months while also engaging in counseling. After eight months, his doctor titrated him off the medication. James terminated the counseling relationship after one year, at which time he was functioning much better.

The medical model as explanatory fiction or useful metaphor is illustrated in the notion that alcoholism (or any substance dependence) is a “disease” with a biological etiology. This notion is not supported by science or logic (Ross & Pam, 1995), but rather on the agenda of the group defining it. The Veterans’ Administration does not refer to alcohol dependence as a disease while the American Medical Association does. Defining alcohol-related problems as a “disease” can also steer us away from research supporting moderation management in some drinkers [e.g., some people can have an alcohol problem at one point in their life then return to moderate drinking (Hester, Delaney, & Campbell, 2011)]. On the constructive side, the metaphor of alcohol dependence as a disease has helped some clients avoid becoming crippled by guilt and self-recrimination so they can more fruitfully engage in treatment. Certainly the reverse holds true as well—some clients use the metaphor of alcoholism as a disease to avoid taking any responsibility for their drinking (“I can’t help it—I have a disease”). Ethically, the clinician needs to know when the medical model perspective seems to be the best explanation for symptoms and when it seems the best metaphor to help the client engage in treatment. When metaphors are mistaken for facts, however, the potential exists for damaging word magic. One example is that in many polls, Americans believe that people who once have a problem with alcohol must abstain totally for the rest of their lives (Lillienfeld, Lynn, Ruscio, & Beyerstein, 2010) while more and more research supports that some (but not all) people can learn moderation management (Hester, Delaney, & Campbell, 2011).

Another example of metaphor gone wrong was a case of a fifth-grade student that I (Ingersoll) consulted on. The student was diagnosed with attention-deficit-hyperactivity disorder (ADHD), with an inattentive specifier (in *DSM-5* criteria). The school counselor and I learned that the diagnosis had been made in a physician’s office without an assessment of the child’s behavior across several settings. The child appeared inattentive because in school she would unpredictably stare off into space or get up and meander around the classroom. The physician told

the parents that their child had a “chemical imbalance.” They took this to mean that the medication (a stimulant in this case) would correct the problem. Although the medication seemed to help the daydreaming, it also seemed to exacerbate the behavior of getting out of her chair and wandering around the room. The school counselor and I referred the child to a specialist who helped children with mild to moderate symptoms of ADHD. The parents agreed, and the counselor worked with the student on learning how to concentrate and helped the parents and teacher at the school cue and reinforce appropriate behavior in the student. After six months, the child was able to be titrated off the medication. Had the parents continued under the assumption that their child had “a chemical imbalance,” the child might not have received the help she needed or would have received it later than she did.

Even though a client may prefer a medical model explanation of symptoms because it is less threatening to his or her sense of self, mental health professionals must resist being caught up in the word magic of the medical model. We recall attending a presentation at a professional conference where the presenter lectured for three hours on the biological bases for mental disorders, without producing one reference or fact to support his thesis. He seemed far too mesmerized by the medical model to bother to provide factual support for his claims. Even though he was trained in psychosocial interventions, he did not mention the ones we know are effective for many of the disorders he covered (such as ADHD). In addition, this psychologist supported the movement to give psychologists the legal power to write prescriptions for psychotropic medications. As such, he was clearly biased. A better approach would have been to set his presentation in the context of his position that psychologists should be allowed to prescribe psychotropic medications.

A study of adolescents with mental/emotional disorders summarized their perceptions of treatment. These teenagers shared the common negative perception that staff relied too much on the medical model to explain depression. They reported that the staff seemed to just want to give them medication

and to not talk to them about what was really bothering them (Buston, 2002). What was “really bothering them” in this case were psychological and cultural variables that they saw as related to their depression. These adolescents wanted to discuss their psychological perspectives with clinicians rather than just have their symptoms described as a disease process treatable with pills. More recent studies confirm that children and adolescents will often resist taking medication (Worley & McGuinness, 2010) many times for reasons that can be addressed in counseling like fearing personality changes, social stigma, and concerns about addiction (Hamlin, McCarthy, & Tyson, 2010).

COMPLIANCE AND ADHERENCE

Perhaps the best way to begin this section is to ask the reader a simple question. Have you ever (1) not taken a medication as directed, (2) taken more of a medication than prescribed, (3) taken less of a medication than prescribed, (4) stopped taking a medication before your doctor recommended it, (5) resumed taking a medication left over from an earlier prescription without checking with your doctor for the new episode? If you have done any of these, you have not followed—technically, you have been noncompliant with—a medication plan. (When we ask this question in class, 80 to 90% of our students raise their hands; we do, too.) Researchers estimate that only 50% of people on any prescription medication always take it as prescribed (Patterson, 1996).

Although there is no absolute way to predict which clients will be most compliant with medication regimens, some characteristics can be assessed. We have long known that adherence rates vary across racial/ethnic demographics (Cuffs et al., 2013; Diaz, Wood, & Rosenheck, 2005) with people of color reporting adherence rates between 66 and 77% while Caucasians report adherence rates around 90%. We also know that the younger the person taking the medication, the less adherence they exhibit (Worley & McGuinness, 2010). In general, people who follow medication plans are usually emotionally mature, in stable family situations, employed, and pay for their own or part of

their treatment. This profile implies that the further along a client is developmentally, the more likely he or she is to follow a medication plan. Although there are dozens of lines of development, some key lines such as cognitive, emotional, and ego development seem particularly germane here. When you talk to a client about medication, you must consider his or her developmental level as well as lifestyle to get a sense of how compliant that person is likely to be. Predictors of noncompliance include being male, being young, and experiencing severe side effects (Demyttenaere, 2001).

It is also important to examine the clinician’s attitude toward compliance. Many interns go into a mental health field with the misconception that part of their job is to make sure the client stays on prescribed psychotropic medications. This is untrue and may reflect anything from unresolved power issues, to poor training, to the unresolved power issues of their supervisors in the field. It is not the job of a mental health professional to make sure clients stay on their medications. It is the job of a mental health professional to help clients weigh the benefits and risks of taking medications, to help clients process conscious and unconscious resistance to medication, and to work with any number of theories to explore the risks and benefits of medications and how the medications relate to the goals a client has set in counseling. In the end, it is always the client’s choice whether or not to take medications, even when not doing so will likely result in incarceration or confinement in a more restrictive treatment setting.

REASONS THAT CLIENTS MAY NOT COMPLY

When the noncompliance issue arises, mental health professionals must explore it with clients. Noncompliance can be caused by many things, including cost of the treatment, forgetfulness, and client values and beliefs (Demyttenaere et al., 2001). Beck, Rush, Shaw, and Emery (1979), who initiated research on irrational beliefs that contributed to noncompliance, concluded that clients on antidepressants were often noncompliant because of irrational thoughts about their medications. These researchers found

the following three irrational thoughts among the primary ones associated with medication noncompliance: "The medication won't work," "I should feel good right away," and "My depression is incurable."

The Medication Won't Work

Sometimes the client just thinks the drug will not work, without any evidence to support that notion. You may find the client has a pessimistic worldview—part of what Beck et al. (1979) called the *cognitive triad of depression*. Another possibility is that perhaps the client is involved in what is called a negative feedback loop. In a **negative feedback loop**, the client for some reason stopped getting reinforcers that up to a point were satisfying. An example is when a client suffers the breakup of a romantic relationship that he or she experienced as reinforcing. The result of losing these reinforcers was depression, but the depressive symptoms then began prompting reactions in other people, reactions that became reinforcing. In the latter example, assume the client then started getting more calls from friends who were concerned about him or her. Those calls then become reinforcing and, rather than seeking out another relationship, the client may come to rely on those calls. This pattern is colloquially referred to as "getting some secondary gain from the symptoms." In such cases, clients prefer to believe no drug will work for their symptoms, because if they lose the symptoms they lose the secondary gains.

I Should Feel Good Right Away

It would be ideal if all medications worked immediately. But that simply is not the case with most psychotropic medications, particularly antidepressants, that may take anywhere from two to six weeks for the full therapeutic effects to manifest (when they do work). Counselors and other therapists must help clients deal with the early onset of side effects and later onset of therapeutic effects. It is wise to let the client describe how he or she is feeling before the counselor asks direct questions about non-life-threatening side effects. In some instances (outlined by Greenberg & Fisher, 1997), side effects actually have some placebo value in that the client may interpret them as the medication "working."

My Depression Is Incurable

If a client seems to feel his or her depression is incurable, here again counselors should investigate what possible secondary gains the person may be getting from the symptoms (the negative feedback loop may be operating). This belief may also be a manifestation of one aspect of the **cognitive triad of depression**. Readers may recall that Aaron Beck stated that the cognitive triad of depression was comprised of negative feelings about self, the world, and the future. A third possibility is that the client actually has a subtle death wish and is mentally prepared to decompensate (decline in functioning) to the point where he or she may have the nerve to attempt suicide. A final possibility is that the client has engaged in several unsuccessful treatments and has come to believe there is no treatment for his or her condition. Taking a thorough treatment history is invaluable in identifying this last dynamic.

Patterson (1996) added that clients may not comply with their medication plan because of trouble with routines, or inconvenience; medication as evidence of an undesirable self; misinformation; and other issues.

Trouble with Routines, or Inconvenience

Trouble with routines, or inconvenience, is often a problem for clients with impaired cognitive functioning. The client may forget or become confused about the medication regimen, grow tired of taking the medication, or may not be able to afford the medication (or believes she or he can't afford it). Clients who do shift work, for example, may have changes in routine that hinder remembering when to take medication. This is one reason pharmaceutical companies try to develop medication formulations that allow once-daily doses or even intramuscular injections that let a client get the medications injected once a month.

Problems of inconvenience often relate to side effects. One client we treated felt lethargic and sedated when taking her medication. She worked in a university setting as a recruitment coordinator. Her job required enthusiastic presentations and campus tours throughout the day. This particular client felt the side effects made her job much

more difficult. The extra effort to get through the workday was so inconvenient that she responded by stopping her medication.

Medication as Evidence of an Undesirable Self

The notion that taking medication shows undesirable personal traits is particularly important when considering the client's psychological perspective. Such a client may believe that requiring medication is a sign of weakness or indicates some flaw or stigma related to mental illness. The client may be embarrassed at the prospect of other people finding out about her or his taking medication. Other clients may say they feel they are not their "real selves" while on medication. Although this may in fact be true, it is also possible that the client has been experiencing symptoms for so long (as in **Persistent Depressive Disorder** [previously called **Dysthymia**] in *DSM-IV*) that he or she has included the symptoms in his or her definition of "real self." Generally speaking, clients who negatively interpret taking medication are concerned about losing control over their lives. They may feel their symptoms have taken control of their lives to some extent and that the medications further decrease their control. This resistance can be complicated by paranoia that is part of the client's symptom profile or that arises when the client (sometimes for good reasons) does not trust the therapist or prescribing physician.

In such cases, one excellent strategy is based on Rogers's (1957) six core conditions of constructive personality change. First, make sure the client is capable of making psychological contact. Clients with psychotic or manic symptoms may not be able or willing to make psychological contact. Second, if the client is able/willing to make psychological contact, Rogers's conditions posit that he or she is in a state of incongruence between ideal self and what he or she currently perceives as the self. In this situation, we assume that the lack of congruence is related to mental/emotional symptoms and the prospect of taking medication for those symptoms. Third, Rogers stipulates a therapist who is congruent, meaning that he or she is aware of both the client's ideal and current sense of self, how they overlap and where they may not. Fourth, the counselor experiences

unconditional positive regard for the client. In this case, unconditional positive regard includes a non-judgmental acceptance of the client's conflicts about taking the medication, including an acceptance of extreme feelings (e.g., some clients say they would rather die than take medication). Fifth, the counselor experiences an empathic understanding of the client's perspective, and sixth, when the counselor experiences this empathic understanding of the client he or she conveys it to the client. When these conditions are met the stage is set, according to Rogers, for constructive personality change—in this case, dealing with medication issues. If you are using another model of counseling, remember that it is most helpful to clients to work with a counselor who is empathic and willing to talk with them about their fears related to psychotropic medications.

Misinformation

Misinformation can be an easily remedied reason for noncompliance. In some cases, fixing **misinformation** simply requires referring the client to a credible source of information or sharing that information in the counseling session. One problem is related to the labels categories of the medications have. One client, who was taking olanzapine (Zyprexa) to control his symptoms of Bipolar I Disorder, heard that the medication was an "antipsychotic" and promptly replied, "Well, I'm not psychotic, so that must be the wrong medicine." A good part of an entire session was spent discussing how such medicine categories are labeled and how they really do not relate well to different uses with different clients. To the notion of misinformation we add the idea of disinformation contamination. **Disinformation** is the intentional spreading of information that is patently untrue, for political or other purposes. When disinformation concerning drugs (such as "All drugs cause addiction") contaminates a client's consciousness, it is possible that person may then assume any drug, even one that could help, is more dangerous than it actually is. The U.S. government's "war on drugs" has been built on disinformation for political purposes, such as labeling marijuana and heroin "narcotics," which gives the impression that they are similar substances (they are not). Another example is when the government

sponsored researchers who claimed their studies showed that the drug 3,4-methylenedioxymethylamphetamine (MDMA) caused literal holes in the brain (Ricaurte, Yuan, Hatzidimitriou, Cord, & McCann, 2002). When his conclusions could not be replicated and were challenged Ricaurte claimed that the facility that dispensed the drug for his study gave him methamphetamine instead of MDMA (a labeling error he claimed). He later retracted the paper (Ricaurte, 2003). Disinformation like this only makes citizens more mistrustful of government spokespeople. Until the government accepts a reasonable policy on drug use and tells the truth about what we do know, disinformation will continue to contaminate the thoughts of the public regarding all medications.

Other Issues

Sometimes, when symptoms are controlled, a client believes she or he is cured (as with an antibiotic) and stops taking the medication. This is another illustration of how different psychiatry is from other branches of medicine. In the **allopathic treatment model**, symptom cessation often means the condition has in fact been cured. This is not necessarily so with the many mental/emotional disorders where “cure” is not possible yet or not necessarily due to medications. Clients suffering from depression that appears psychological in origin may take medications such as antidepressants for six months and engage in counseling at the same time. For many such clients, the medication provides a chemical window of opportunity wherein they get the energy to deal with the psychological issues related to the depression. Once they have resolved some of the psychological issues, their doctors can titrate them off the medicine. Other clients may suffer from psychological symptoms that seem to have a strong biological component (such as symptoms of Bipolar I Disorder). These clients may be facing years or a lifetime of some medication regimen and face different issues from those who need medication for only a short period.

At the other end of the spectrum is the client who stops taking the medication after a short period because she or he does not notice any effect. As we emphasize throughout this book, many of these

medications may take weeks before their therapeutic effects begin. In addition, some clients who discontinue their medication do so because they do not like the side effects. Our experience is that such clients would do better to contact their prescribing professional to see if there is a different medication they may be better able to tolerate. Although mental health clinicians cannot make specific recommendations about medications, they can refer clients back to their doctors when necessary.

Patterson (1996) also noted that some clients believe their medications are not working because they have unrealistic expectations for the medication. One client we recall who was taking an antidepressant was astonished at how sad she became at the funeral of a beloved aunt. She had a history of being overwhelmed by powerful depressive episodes and had developed a defense of warding off strong feelings, assuming that if she could do that, she could maintain emotional control. She said she sobbed throughout the funeral as if she hadn't cried for years (and in fact she hadn't). This client had an unrealistic expectation that the medications were akin to a vaccine against sadness. With her counselor, the client came to see her emotional expression at the funeral as a personal victory in that she expressed her true feelings and was able to grieve with loved ones but wasn't overwhelmed by the grief. Whether this victory was the result of the therapy, the antidepressant, or both could not be differentiated, but it was one of the first signs of improvement in quality of life for this client.

Another problem (although not as common as supposed) is clients who abuse their prescription medication because they like the effects or get a “high” from the medication. Of greatest concern among the psychotropic medications are the benzodiazepines and amphetamines, which can be abused to induce an altered state of consciousness and can potentially induce dependence. Although this is a concern for a minority of clients, most clients on these medications do not abuse them and once government disinformation is sifted out, the risk is relatively minor.

Perhaps the most problematic situation is when the medication seems to work for the client but it is

precisely these therapeutic effects that the client does not want. This may be the case particularly when the symptoms are pleasant or somehow reinforcing for the client. We recall one client (Jacob) who suffered from Bipolar I Disorder and who really missed the manic “highs.” When Jacob suffered from mania his “highs” eventually became incapacitating, leading him to high-risk behaviors that twice ended with his incarceration. He said that although the medication seemed to preclude the mania, it made him feel “normal.” For Jacob, “normal” was not as good as he felt in a manic phase. The client tried three times to titrate off his medication over a period of five years. Each time he relapsed within eight months. This was truly frustrating for him, because his manic episodes always ended with him incarcerated or in an inpatient treatment facility. In cases such as Jacob's, an existential counseling approach is very helpful. Such approaches help clients develop a sense of meaning in the middle of difficult or even unacceptable existential givens (such as illness, infirmity, and mortality). John Brent's (1998) article on time-sensitive existential treatment is an excellent synopsis of an approach that can be used with clients such as Jacob. In Jacob's case, he had to work through the difficult reality that every time his doctor titrated him off his medication, he relapsed within one year. The existential givens for Jacob included a nervous system that seemed to require medical intervention for Jacob to be able to function in Western society.

Review Questions

- What is the difference between compliance and adherence?
- What are four different ways clients may conceptualize their symptoms?
- What are common reasons clients do not comply with medication regimens?
- What are predictors of noncompliance? What are some therapeutic ways to work through them with clients?

SECTION TWO: TALKING TO CLIENTS ABOUT MEDICATIONS: KNOW AND EDUCATE THYSELF

Learning Objectives

- Be willing to examine your own personal and countertransference issues regarding medication.
- Be able to discuss supervision issues that arise in assessing and monitoring clients taking psychotropic medications.
- Understand the important advocacy role mental health professionals play.
- Assess your own willingness to be an advocate for your client.

The variation on the **Delphic motto** (“Know thyself”) in the subheading for this section is another good mantra for any mental health professional in training. Your own attitudes about and past experiences with psychotropic medication can seriously affect your work with clients. It is of the utmost importance that all mental health counselors be aware of their own psychological issues with medication to preclude countertransference reactions. Recall that countertransference occurs when a client's issue triggers unresolved issues in the therapist, which the therapist may not be aware of. If left unaddressed, these can then render the therapist less effective with the client.

One counseling student we worked with had been an excellent student and had done equally well in her internship until she got her first client being treated with mood-stabilizing medication (lithium). She felt the client should stop taking the medication because of the severe side effects and almost went so far as to say that in a session with the client. This intern, who was normally open, interested, and very present in counseling and supervision sessions, became emotionally “closed off.” In supervision, it turned out she had had a sister who suffered from schizophrenia and had committed suicide. The intern had experienced a great deal of anguish in watching the effects of the

medication on her older sister and to some extent blamed the low quality of her sister's life—and her eventual suicide—on the medication. Although the counselor's sister had been on a different medication (haloperidol/Haldol), the issues the counselor's client was dealing with were similar enough to trigger the counselor's own unresolved issues related to psychotropic medication.

If your client is on medication, take a minute to check in each session with the client about therapeutic effects, side effects, and compliance. If there seem to be problems with compliance, shift the focus of the session to that. Remember, however, that the aim of counseling or psychotherapy is not to make sure your client stays on his or her medication. Clients have a legal right to refuse medication and some studies suggest counseling is the most common response to medication refusal even in inpatient settings (Carey, Jones, & O'Toole, 2013). Your client is another human being who has a right to make choices about her or his life and the treatment of his or her symptoms. Many beginning therapists are so consumed with worry over their client's compliance with a medication regimen that they cannot be present—attentive—for the client in the session. Some researchers have found that even clients with severe mental disorders can learn to assume responsibility for their medication management (Dubyna & Quinn, 1996; Mitchell, 2007). We will discuss adherence issues when children and adolescents are taking psychotropic medications in the chapter devoted to children and adolescent issues. The issues related to adherence are even more complex where children and adolescents are involved partly because most psychotropic medications do not have on-label approval for pediatric use (Dean, Witham, & McGuire, 2009).

When mental health therapists are talking to clients about medication education is a critical component (American Academy of Child & Adolescent Psychiatry, 2009; Patterson, 1996). As indicated by many of the irrational thoughts about psychotropic medication just described, most people are not aware of what such medications can and cannot do for them. Patterson points out that the therapist must emphasize that these medications are treatments, not cures, and that the client ultimately

must manage his or her own life. Understanding the main effects, the side effects, and how the medication is supposed to alleviate the symptoms is important knowledge for the client. Patterson also recommends, when talking to clients, using the word *medications* rather than *drugs*, because the latter term may be confused with drugs of abuse—about which very few people actually have good information, as we noted earlier in the chapter.

Ingersoll (2001) noted that the mental health clinician is in the role of “information broker,” which requires some real work. To be a good information broker, you must first be able to differentiate good information from bad information. For our purposes, good information draws from clinical case summaries, peer-reviewed literature, and one's own clinical observations. The biggest problem with peer-reviewed literature is that it may be biased toward the medical model, for reasons we discuss later in the book such as being funded by the pharmaceutical company making the drug. Because of this bias, peer-reviewed literature should also be complemented with clinical case observations published in medical journals and newsletters on psychopharmacology. In addition, it is always important to read the sections of peer-reviewed articles that describe who funded the research. Research funded by a pharmaceutical company may be biased toward that company's products. Obviously, to be a good information broker, you also need at least an adequate understanding of research design. This enables you to see the difference between a study that truly supports the efficacy of a drug and a study design that merely supports a particular *view* of a drug.

SPECIFIC SUPERVISION ISSUES

The student intern case discussed in the last section gives one example of how supervision plays an important role in dealing with clients who take psychotropic medication. In all supervision, the key is assuring quality treatment for clients. For clinicians in nonmedical fields such as counseling and psychology, supervisors are there to monitor client welfare by assuring that clinicians comply with legal and

ethical standards as well as standards of good practice. An important component of supervising mental health clinicians is discussing medications that clients are taking and how the clinician is talking about these with clients. As stated earlier, there are no clear prohibitions against nonmedical mental health professionals discussing psychotropic medications with clients, and codes of ethics and standards in counseling, psychology and school psychology state that clinicians should be competent including knowledgeable about treatment options that clients may encounter. Buelow, Herbert, and Buelow (2000) note, legal problems are currently more likely to arise from mental health clinicians *not* learning about psychotropic medications than from discussing them. The types of supervision issues will vary depending on the mental health professional and the setting. Of the nonmedical mental health professionals, psychologists have the broadest practice guidelines (depending on training) and thus will have more complex supervision issues. The American Psychological Association [APA] (2011) set forth guidelines for psychologists practicing at three points on a continuum regarding psychotropic medication. The first point is for those rare psychologists who have prescribing privileges. The second is for psychologists actively collaborating in medication decisions. The third and most common is when psychologists provide information that may be relevant to prescribing professionals. That is the practice point we focus on here as it is most common for psychologists and social workers, school psychologists, counselors, and other nonmedical mental health professionals.

What are some of the important supervision issues relevant to psychopharmacology? Berardinelli and Mostade (2003) have listed the following categories of responsibilities, which include activities for supervisors and supervisees: assessment, monitoring, and advocacy.

ASSESSMENT

In the assessment phase of a counseling relationship, the mental health clinician needs to learn what current medications clients are taking, including dosage, frequency, and formulation. In addition, clinicians

need to assess the client's use of other licit or illicit recreational drugs. Fulfilling this responsibility assumes some knowledge of the categories, effects, and side effects of psychotropic medications on the part of the supervisor and the supervisee. As Ingersoll (2001) notes, this is where training in psychopharmacology becomes important, particularly for supervisors. The APA has created curricula for three levels of training in psychopharmacology, and the first level (or its curricular equivalent) (APA, 1995) should be required for supervisors of mental health professionals.

The assessment phase should include getting a signed release from the client to view copies of the file on the client kept by the prescribing professional. Many large providers like hospitals are using electronic note systems like Epic and Avatar. Each of the charts in these systems have sections on client medication but sometimes they are broken into current medications and all previous medications. Obviously it is important to know when clients started and stopped medications so you can understand what has worked and what has not for each client. Assessment may also include (with client permission) contacting the prescribing professional for consultation and to let her or him know (again, only with the client's release) what you are treating the client for, and ask about the professional's sense of how the medication is working for the client (along with any other questions you may have). This is an opportunity to at least establish a connection with the prescribing professional, learn about his or her prescribing style, and make a good first impression. With that in mind, you should know what symptoms the prescribing professional has prescribed the psychotropic medications to treat and be familiar with the medications prescribed. While prescribers may speak in terms of diagnoses, always try to get them to specify particular symptoms because clients with the same diagnosis can present quite differently. Supervisors will want to make sure the supervisee is following these guidelines and adequately understands the topics relevant to his or her clients at each stage of assessment.

Berardinelli and Mostade (2003) also noted that supervisors should monitor exactly how supervisees

are discussing medication side effects with clients. Although it is important to make sure the client is aware of potential side effects, we must avoid leading questions that elicit complaints of side effects (e.g., "are you having headaches with this medication?"). There is clearly more art than science to this. The initial topic can be discussed with open-ended questions about how the client is feeling, whether he or she has followed the medication prescription, and how he or she thinks the medication is working. Depending on the client, opening a session with specific questions that list side effects such as "Are you experiencing any sexual side effects, headaches, dizziness, or nausea?" may not be the best strategy unless there are compelling reasons to take this approach. Some clinical judgment is necessary here. Clients who are more prone to obsessively worrying about side effects may respond to such concrete questions as a list of things they then imagine they are experiencing. However, clients who are functioning at a concrete intellectual level may need direct questions to share side effects that are occurring. Unless you feel direct questions are necessary (as in the case of clients who are concrete thinkers), you can begin asking open-ended questions to elicit the client's thoughts about how the medication seems to be working.

MONITORING

Monitoring is an important component of the therapeutic relationship and supervision. Supervisors should make sure supervisees are checking in with clients at each session about medication, updating medication information as it changes, and keeping records of medication compliance as well as the client's response to medications. The last item is particularly important, especially for clients who do not see the same prescribing professional on a regular basis or for clients who have not given the clinician permission to contact their prescribing professional. The record of client responses to medication is also important in relation to the record of what is happening with the client psychologically.

For example, in one case we treated, the client suffered from Bipolar I Disorder and seemed to

show subtle signs of improvement just before the onset of manic symptoms. This happened twice, with two different medications the client was on. The first time the therapist took the shift as a signal of improvement in mood, but the second time the therapist saw it as the first sign of approaching manic symptoms. The client learned in this case the difference between mood stabilization and the onset of manic symptoms. Genuine improvement in this client appeared similar but was followed by increasing insight and unimpaired reality testing.

In another case, the client's perceptions of how helpful the medication was correlated with how events were unfolding in her personal life. When her personal life was going the way she wanted, she felt the medication (in this case an anti-anxiety medication) was helping. When events in her personal life were not going well, she complained that all she got from the medication were side effects. In tracking this relationship, the issue of locus of control emerged as important in counseling. The client came to realize that she had, over a period of years, established the medication as an external locus of control and that the medication now provided a convenient target when things weren't going well. After six months of work on this locus-of-control issue, this particular client asked her doctor to titrate her off the medication. After a year she was still functioning well without it.

ADVOCACY

Advocacy is actively supporting the client to make sure she or he is getting the best service possible. Where medication is concerned, supervisors must make sure their supervisees' efforts at advocacy do not cross the line between support and actually recommending medication. Although mental health professionals do not recommend medications, they can ask prescribing professionals questions on the client's behalf (e.g., "My client is taking an older antipsychotic with severe side effects. Do you think she would benefit from one of the newer antipsychotic medications?") According to Berardinelli and Mostade (2003), advocacy issues include recognizing client needs and the

particular needs of certain client populations, integrating medication issues into counseling, and knowing when to refer clients for case management and other services. Advocacy in this sense requires that supervisors and supervisees be familiar with community resources, including medication programs and trials, and programs that help clients pay the cost of medications and provide education to significant others and employers when necessary and when desired by the client.

An interesting question is whether mental health professionals should suggest to prescribing professionals that a particular client may benefit from a particular medication. The short answer is no. In the most conservative sense, in this situation the mental health clinician is assuming he or she has the same level of knowledge of psychotropic medications as the prescribing professional. Although this is possible, the most conservative interpretation of such action could be that the mental health professional is practicing medicine without a license. Obviously, cases in which mental health professionals have the proper training and legal mandate to prescribe (as in certain states and territories where psychologists have the right to prescribe psychotropic medications) do not apply here. The long answer is that because reality is complex we must look at the context of the situation and how the clinician approaches the prescribing professional. Ingersoll (2001) noted that much can be accomplished by assuming the "one down" position and approaching the prescribing professional with the attitude of requesting education. For example, if a client is prescribed carbamazepine/Tegretol for Bipolar I Disorder and still relapsing, the mental health clinician may wonder if new antipsychotics have been tried for the manic symptoms. Certainly carbamazepine/Tegretol has efficacy for some clients but if the client is relapsing the question may be worth asking. In this example the clinician may ask, "I've heard that some clients with this disorder take atypicals in addition to other mood stabilizing agents. How do you feel this client would respond to such a combination in treating Bipolar I symptoms?" If a clinician seriously questions the work of a

medical professional, there are several possible approaches. If the work of the clinician appears to constitute malpractice, a report to the prescribing professional's licensing board is in order. If the questions simply revolve around whether the best medication was selected for the client, the clinician can reinforce the client's right to ask the prescribing professional questions or seek a second opinion if that is an option. We emphasize that this advocacy issue is grey and clinicians would do best to exercise conservative judgment here.

Review Questions

- What personal beliefs do you bring to the profession about psychotropic medications?
- What are key issues in assessment and monitoring for supervisors of mental health professionals who treat clients taking psychotropic medications?
- Discuss the extent to which you feel comfortable advocating for a client. If a senior clinician told a client incorrect information about a medication what would you do?

SUMMARY

Many psychological issues arise in our clients when either psychotropic medication is recommended or taken. Clients use several strategies to avoid medication, including irrational beliefs about medications, secondary gains from symptoms, and difficulty with routines.

Multiple truths and realities govern the way clients respond to a course of psychotropic medication. Therapists need to recognize how clients accept psychotropic medications into their intrapsychic and unconscious worlds. It is helpful to talk to our clients about the strengths and limitations of both medications and conventional therapy. In addition, mental health clinicians need to know how to collaborate with medical professionals as well as how to review medication issues in supervision sessions.