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PRACTICE

Unanticipated Psychotropic Medication Reactions

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Research from a variety of sources demonstrates that psychotropic medications have induced a number of unanticipated physiological and psychological client reactions. Although a great deal of literature is published concerning potential expected side effects from psychotropic medications, little is understood regarding other unexpected reactions that may cause significant client discomfort. These unanticipated psychotropic reactions may be considered as effects that may be rare and therefore not accounted for in randomized clinical drug trials. Like any medication, psychotropic medications do not produce the same effect in everyone. Some people may respond better to one medication than another. Mental health counselors are advised to be aware that some unexpected reactions can be important in determining client outcomes. In this article, we discuss the client's right to be informed about unanticipated side-effects of their medication regimen and the ethical question as to how much information to give clients.

Treatment of diagnosable mental health disorders with psychotropic medications can be problematic. While some mental health professionals propose that psychotropic medications have little or no therapeutic value, and in certain cases may produce damaging side effects (Breggin & Cohen, 2000; Glasser, 2003; Glenmullen, 2001), others recommend caution in the use of psychotropic medications and stress that side effects cannot be predicted (Burns, 1999; Ingersoll, Bauer, & Burns, 2004). Still other professionals suggest that mental health counselors who do not refer for psychotropic medication evaluation as an adjunct treatment to mental health counseling may risk unethical practice (Buelow, Hebert, &

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Buelow, 2000; King & Anderson, 2004). Regardless of the position taken, few advocates discuss the *unanticipated* reactions that clients may have to psychotropic medications. While some clients experience annoying expected side effects, other clients may experience completely unanticipated effects, and still others may experience no known side effects. Variables such as age, sex, body size, body chemistry, physical illnesses, drug interactions, diet, and habits such as smoking can influence the medication effect. These unanticipated reactions are rare and they are not usually accounted for in randomized clinical drug trials conducted by pharmaceutical companies. More common side effects, which are discovered during these trials, are normally conveyed on drug warning labels issued by the U.S. Food and Drug Administration.

Furthermore, when clients take multiple psychotropic medications or other prescription medications, there is a possibility that their body's unique chemical biology may create symptomatology that cannot otherwise be accounted for. If unanticipated effects do occur, clients may incorrectly believe they are suffering from an additional unrelated physiological or psychological malady. This may lead prescribing physicians to presume that these unexpected symptoms are evidence of a new medical condition that requires further assessment and perhaps additional medication treatment. Alternatively, family members, mental health counselors, and others may be tempted to dismiss clients' symptomatology as psychosomatic presentations. These issues can be challenging for mental health counselors who may be the first to hear of their clients' unanticipated reactions (King & Anderson, 2004; Sansone, Gaither, & Rytwinski, 2004). Moreover, the ethical issues surrounding unanticipated medication reactions can be crucial to client well-being. Mental health counselors would do well to systematically and ethically address the issues of unanticipated effects from psychotropic medications. This begins with a basic understanding of psychopharmacological effects.

PSYCHOPHARMACOLOGY AND THE MENTAL HEALTH COUNSELOR

Essential Knowledge

Education of basic psychopharmacology is of "paramount importance" (Scovel, Christensen, & England, 2002) to competent and ethical mental health practice (King & Anderson, 2004). Ingersoll and Rak (2006) explain that codes of ethics advise mental health counselors to be "knowledgeable about all treatment options that clients may encounter" (p. 48) and ethical guidelines for mental health counselors mandate "knowledge of relevant scientific and professional information related to the services

they render, and recognize the need for ongoing education" (American Mental Health Counselors Association [AMHCA], 2000, Principle 7). Psychopharmacology is one of these scientific treatment options. Basic and on going knowledge of scientific developments related to psychopharmacology is essential because "the interface of mind and brain, psychology and biology, and pharmacotherapy and psychotherapy is the cutting edge of neuroscience in our new millennium" (Gabbard & Kay, 2001, p. 1961). Specifically,

> The brain has emerged as the central focus for studies of mental health and mental illness. New scientific disciplines, technologies, and insights have begun to weave a seamless picture of the way in which the brain mediates the influence of biological, psychological, and social factors on human thought, behavior, and emotion in health and in illness. (Satcher, 2000, p. 7)

Mental health counselors are further advised to receive graduate-level training to identify "basic classifications, indications, and contraindications of commonly prescribed psychopharmacological medications so that appropriate referrals can be made for medication evaluations and *identifying effects and side effects of such medications*" (Council for Accreditation of Counseling and Related Educational Programs [CACREP], 2001, p. 90; emphasis added). When given permission by their clients, mental health counselors can report unusual or significantly disturbing effects to their clients' prescribing physicians.

Collaborative Treatment

With the escalating influence of managed care, the practice of employing a psychiatrist or other physician to prescribe psychotropic medication while a mental health professional, (e.g., psychologist, social worker, or mental health counselor) provides psychotherapy is becoming a standard for treating mental health disorders (Gabbard & Kay, 2001; Glick 2004). The literature refers to this approach as split treatment, collaborative treatment, concurrent care, or shared treatment (Beitman, Blinder, Thase, & Safer, 2003; Bradley, 1999; Meyer & Simon, 1999). When this approach is used, the prescribing physician typically conducts a brief 15-minute medication management session three or four times a year and a mental health counselor meets with the client in weekly or biweekly counseling sessions. Of course, this split treatment approach does not take away responsibility from the prescribing physician, but rather creates an advantageous collaborative relationship between the client, the mental health counselor, and the client's physician to maximize treatment adherence and effectiveness (Bentley & Walsh, 2000; Diamond, 2002; Himle, 2001; Meyer & Simon, 1999; Sansone, Gaither, & Rytwinski, 2004).

In this split treatment approach, mental health counselors who have frequent contact with their clients (Sansone, Gaither, & Rytwinski, 2004) are in a prime position to become aware of potential negative psychotropic side effects (CACREP, 2001; Faiver, Eisengart, & Colonna, 2000). In addition to self-reports by their clients, counselors can routinely inquire about how the client is responding to medications and record changes in reactions in case notes or case conceptualization software. With the client's approval, mental health counselors can and should report significant findings to prescribing physicians (Ingersoll & Rak, 2006; King & Anderson, 2004).

Empirical research demonstrates the reality of enhanced client treatment outcomes when counselors and prescribing physicians work together. For example, Katon et al. (1996) found that a multifaceted model for the treatment of major depression, founded on client education and a two-way relationship between mental health professionals and prescribing physicians, consistently resulted in improved medication adherence, increased client satisfaction with depression care, and greater cost-effectiveness of treatment compared to usual care by primary physicians alone. This example suggests that "although medication side effects, drug interactions, and prescription refills are medical, a patient's worsening depressive symptoms fall into both the therapeutic and the pharmacologic realm" (Meyer & Simon, 1999, p. 244).

Counselor Roles

Bentley and Walsh (2000) elaborated on the specific roles that mental health counselors can take in identifying effects and side effects of psychotropic medications. In particular, mental health counselors may serve the role of (a) *assistant to the physician*: supporting recommendations of medication use; (b) *consultant/collaborator*: performing preliminary screenings to determine clients' possible needs for medication, making referrals to physicians, and regularly consulting with the physician and client; (c) *advocate*: assisting clients and family members in relating to physicians; (d) *monitor*: evaluating positive and negative effects of the medication regimen; (e) *educator*: providing clients and family members with information relevant to medication usage; and/or (f) *researcher*: using case reports and research designs to study how medications affect client behavior, how the medications interact with other interventions, and how to maintain collaborative relationships among the treatment team. Finally, Ingersoll and Rak (2006) believe "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" (p. 48). These authors describe how supervisors, within the appropriate

scope of practice as mental health professionals, can utilize assessment, monitoring, advocacy, and issues of diversity to monitor how their supervised clinicians discuss medication side effects with clients.

Similarly, Scovel, Christensen, and England (2002) confirmed the need for mental health counselors to function within these roles. They also noted how the prevalence of psychotropic medication use finds its way into everyday psychotherapy practice (see also Sansone, Gaither, & Rytwinski, 2004). Their survey of members of AMHCA revealed that 89% of the respondents work with clients who are taking one or more psychotropic medications. Mental health counselors must therefore understand how these medications impact their client's lives and the reactions their clients may experience in order to properly respond to unforeseen reactions. Furthermore, Scovel, Christensen, and England also reported that 90% of the respondents believed that mental health counselors should receive graduate-level training in basic psychopharmacology. Resources such as Ingersoll (2000), King and Anderson (2004), and Patterson and Magulac (1994) provide suggestions related to texts, class structure, student resources, teaching methods, and instructor qualifications pertaining to master's-level training in psychopharmacology. In summary, "knowledge of the use of psychiatric medications is clearly becoming a necessary step in the development of the science and art of psychotherapy" (Buelow, Hebert, & Buelow, 2000, p. 2). Knowledge of these issues is helpful in understanding possible psychotropic reactions that are often unanticipated.

UNANTICIPATED PSYCHOTROPIC REACTIONS

Unexpected effects of medication can be categorized by the timing of their occurrence in the course of pharmacotherapy treatment. Medawar, Herxheimer, Bell, and Joffre (2002) identified client concerns regarding (a) *unanticipated initial reactions* that occur almost immediately after the introduction of a psychotropic medication; (b) *unexpected reactions* that take place later during the course of pharmacotherapy, which are significantly abnormal or severe; (c) *discontinuation reactions* that happen when use of a medication is reduced or terminated; (d) *unsuccessful discontinuation reactions* that occur when the client experiences disturbing side effects during termination and, therefore, feels compelled to resume taking the drug; and (e) *sensitization reactions*, which take place if the client is terminated from the medication but at a later time it is prescribed again and unanticipated effects are then experienced. To better understand how these reactions can affect client outcome, a detailed evaluation of each of these potential negative effects is presented.

Unanticipated Initial Reactions

These reactions occur almost immediately after the client begins to take a psychotropic medication. Medawar et al. (2002) reported findings of unexpected reactions related to the introduction of the antidepressant paroxetine, a selective serotonin reuptake inhibitor (SSRI) antidepressant. Paroxetine is sold under the trade name Paxil in the United States. A generic version of the drug is advertised as Pexeva. In Europe, paroxetine is sold under the name of Seroxat (Schatzberg & DeBattista, 2002). Ten cases noted immediate problems when the individual began taking the medication that included chronic hyperventilation syndrome, suicidal ideation, "electric shock sensations" to the brain, extreme nausea, numbness in the hands, legs, and feet, and panic attack. These symptoms usually occurred within a few hours of the first dose of the drug and clients described reactions as severe. Although some of the symptomatology was similar to the drug's known side effects (e.g., nausea), the rapid onset of effect and the severity was not anticipated.

In consulting with a psychiatric nurse practitioner, we learned of two additional cases of clients who experienced unanticipated initial reactions (S. Knowles, personal communication, March 12, 2004). In one case, a client reported that a previous physician prescribed Paxil for her. Almost immediately after she began taking the medication, she noticed an extremely discomforting psychological reaction in which she described "brain shocking" sensations. Her physician regarded these symptoms as normal side effects and kept the client on the drug. The client said that the physician had told her that it would take one or more weeks for the medication to reach its full effect. Apparently the doctor assumed the side effects would dissipate if given enough time. After an attempted suicide, the client said that she took herself off the medication.

In the second case, an elderly client was given Effexor XR at the usual starting dosage of 75 mg. Within hours this 86-year-old woman began to experience uncomfortable tremors in her limbs. The dispensing nurse immediately ordered the termination of the medication and the side effect subsequently disappeared. It is unlikely that the prescribing physician could have anticipated the client's tremors, although asthenia (loss or lack of bodily strength) is a related side effect of Effexor XR (Keltner & Folks, 2001). This case also underscores the relationship between age and dosage. Often, individuals in advancing years experience much stronger reactions to new medications (Keltner & Folks, 2001). By halving or quartering the initial dosage, they may avoid unexpected responses. In this case, the client was subsequently restarted on the medication but this time at one quarter of the recommended dosage. The medication was gradually

increased to normal dosage levels and she experienced no negative effects.

Regardless of whether the initial reaction was listed as an expected side effect, clients experiencing these almost immediate unanticipated reactions may be frightened or lose confidence in their physician or the consulting mental health counselor if a referral was made. Prior to starting a medication regimen, clients should be informed that every individual reacts uniquely to each medication and unexpected reactions may occur. If an unexpected reaction does occur, the client should be told to inform the prescribing physician or to seek emergency medical services. Mental health counselors can work with prescribing physicians to help clients understand how to best deal with these situations.

Unanticipated Reactions While Taking the Prescription

This category of reactions takes place later during the course of pharmacotherapy. The side effects are usually described by clients as unexpected and severe. The extent and the severity of listed side effects cannot be fully predicted. Breggin and Cohen (2000) noted that atypical effects may be due to a number of intervening variables such as increased stress levels, new physiological changes due to accident, disease or infections, or other environmental factors. Environmental factors include unusual reactions to psychotropic medication and drug interactions when two or more medications are taken. For example, if a prescribing physician introduces additional prescriptions into the client's medication regimen, there can be immediate or belated drug interactions. In other cases, clients may develop delayed onset or adverse side effects from psychotropics. Furthermore, some clients may get less of a therapeutic effect from their psychotropic prescriptions after taking them for an extended period of time. Mental health counselors are advised to be aware of generally expected side effects so they can recognize reactions that are not anticipated. In some situations, clients respond to medications with effects noted in the literature but in ways that are not expected or understood. Because counselors typically have regular client appointments, they are generally more likely to become aware of their clients' reports of unanticipated effects (King & Anderson, 2004). These reports may be indicative of drug interactions.

Today, many pharmacies provide their customers with computer-generated drug interaction information (Julien, 2001). When clients purchase all of their medications from one of these pharmacies, a customized printout of adverse drug interactions is available. Clients need to request these printouts so that they can become more informed about potential drug interactions when taking two or more prescriptions. Mental health coun-

selors may consider asking their clients for prescription interaction printouts if they are available. Counselors can encourage their client to consult with their physician regarding drug interactions especially if a client has more than one prescribing physician. In any case, counselors ought to closely monitor clients who are taking a combination of psychotropic or other medications for any unanticipated interactions including the possibility of injury to self or others.

Discontinuation Reactions

Discontinuation reactions happen when an attempt is made to reduce or terminate the use of a medication and the client experiences unusual side effects. In recent years, some medications, particularly the antidepressants have received scrutiny for what is sometimes referred to as withdrawal symptoms (Keltner & Folks, 2001). Because a number of individuals experience symptoms when the medication is discontinued, some have suggested that psychotropic medications may be addictive substances similar to heroin, nicotine, or alcohol (Dean, 2002). Addictive substances typically have a reward effect that occurs within seconds or minutes of drug inhalation, injection, or ingestion (Stevens & Smith, 2004). Repeated use of these drugs results in tolerance to the psychoactive chemicals leading to withdrawal symptoms when the client stops using the drug. Compulsive drug seeking and use, despite significantly negative personal and interpersonal consequences, characterize the fundamental nature of drug dependence (Stevens & Smith, 2004).

By contrast, antidepressant medications do not have a reward effect and clients do not normally crave these drugs. Rarely do clients who take these medications plan their day around securing and using antidepressants, as do many dependent drug users. Although some clients experience negative effects when a medication is reduced or withdrawn, these symptoms do not indicate withdrawal nor do they support the claim that antidepressants are addictive substances (Dean, 2002). A more accurate description of the withdrawal effects phenomenon for most psychotropic prescriptions is *discontinuation syndrome* or *reaction* (Antai-Otong, 2003; Black, Shea, Dursun, & Kutcher, 2000; Sher, 2001). Discontinuation reaction is a more precise term than withdrawal symptoms because there is no client dependency on the medication. The use of this term helps alleviate the confusion surrounding the use and subsequent suspension of pharmacotherapy distinguished from the negative connotations associated with the symptoms of drug withdrawal.

However, it should be noted that some psychotropic medications, particularly those from the anti-anxiety classification (e.g., benzodiazepines), do have characteristics of addicting substances. Withdrawal symptoms

may occur for these medications (Lader, 1983). Therefore, mental health counselors must be alert to problems that their clients may experience when these drugs are reduced or terminated. Counselors also need to be aware that clients may engage in drug seeking and addiction related behaviors if they have become dependent on these medications. For example, clients may attempt to get multiple prescriptions from several physicians (Stevens & Smith, 2004).

With other psychotropic medications, such as antidepressants, there may be unanticipated discontinuation reactions when the medication is withdrawn. These reactions can occur when clients suddenly stop taking their medications because they believe their symptoms have become intensified or, conversely, they believe their symptoms have been eliminated. Abrupt drug termination can also take place when clients feel a need to be free of the perceived or real stigma of having to be dependent on medication. One controlled study noted that 24% of clients discontinued their antidepressant medication unilaterally without consulting their physicians (Demyttenaere et al., 2001). Psychotropics with shorter half-lives have a higher risk of a discontinuation reaction when they are suddenly halted. Presentation of a discontinuation reaction might be exacerbated by the presence of substance abuse, dehydration, or a concurrent physical illness (Antai-Otong, 2003). Possible discontinuation reactions, resulting from the use of a SSRI anti-depressant may include dizziness, insomnia, impaired concentration, irritability, and suicidal thoughts or behavior (Black et al., 2000, Medawar et al. (2002).

In a case reported by Medawar et al. (2002), a client was given a prescription for Seraxot, the European designation for Paxil. At the end of the initial prescription, the client stopped taking the medication without consulting his physician. The next day, the client noted that he became very agitated and irritated. His wife said that he underwent a complete personality change, going from someone who was kind, gentle, caring and strong, to a person who could not think straight, became aggressive, insulting, and totally believed he was someone else. Family members reported that his behavior was entirely foreign to his character. The rapid discontinuation of this medication, which has a short half-life, is likely to have contributed to his sudden outbreak of violence. It is interesting to note that the client was also taking a prescription to lower his blood pressure. The interaction effects between the antidepressant and the drug pressure medication are not known but may have also played a part in the client's abnormal reactions.

Unanticipated discontinuation reactions can occur with a wide variety of psychiatric medications. Clients and mental health counselors should be aware that very rare symptoms might be presented. Cases of unusual

effects have been reported even when the client is slowly reducing the dosage under the guidance of a physician (Medawar et al., 2002). Medawar et al. noted these symptoms were frequently interpreted as a relapse of the originally diagnosed disorder. In these situations, physicians may re-prescribe the original psychotropic medication. The diagnosis of a relapse might be presumed if the symptoms subsequently diminish (Fava, Ruini, & Sonino, 2003) and may lead to a misdiagnosis of a recurrent disorder. In these cases, physicians may be predisposed to prescribe unwarranted prolonged or lifelong pharmacotherapy. Of course, the diagnosis of relapse may be valid. In other cases, however, the client's presenting symptomatology may be evidence of a discontinuation reaction rather than the recurrence of primary symptoms or other mental health disorder (Ditto, 2003).

Discontinuation and relapse symptoms can be especially difficult to distinguish when discontinuation reactions and the original presenting symptoms overlap (e.g., insomnia, impaired concentration, irritability, and suicidal thoughts or behavior). Mental health counselors need to understand the difference between discontinuation reactions and relapse of the original presenting psychological problem (Curtin & Schulz, 2003). Consulting knowledgeable pharmacists and prescribing physicians with expertise in psychiatric medications is often a key factor in accurately differentiating these conditions (Stevens & Smith, 2004). Mental health counselors and prescribing physicians can collaborate to ensure that they are following differential diagnostic criteria when evaluating a client's symptoms. This is especially important if symptoms are related to a general medical condition or a psychoactive substance-induced disorder including the possibility of a drug discontinuation effect (*DSM-IV-TR*, American Psychiatric Association [APA], 2000; Glick, 2004).

Black, Shea, Dursun, and Kutcher (2000) proposed diagnostic criteria for SSRI discontinuation syndrome—which mirrors the *DSM-IV-TR* (APA, 2000) criteria for the presence of a mental health disorder by ruling out diagnosis based on the presence of a general medical condition. This reflects thoroughness in evaluation and consultation among health care providers. Their criteria include the following:

A. Discontinuation of or reduction in dose of an SSRI after a period of use of at least 1 month
B. Two (or more) of the following, developing within 1 to 7 days of criterion A:
   - Dizziness, light-headedness, vertigo or feeling faint
   - Shock-like sensations or paresthesia
   - Anxiety

- Diarrhea
- Fatigue
- Gait/instability
- Headache
- Insomnia
- Irritability
- Nausea and/or emesis
- Tremor
- Visual disturbances

C. The symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or important areas of functioning.
D. The symptoms are not due to a general medical condition and are not better accounted for by recurrence of symptoms of the mental disorder for which the SSRI was originally prescribed, or by concurrent discontinuation (or reduction in use) of another psychoactive substance (p. 258).

Discriminating between a discontinuation reaction, a general medical condition or a relapse of a mental health disorder requires accurate recording of the client's symptoms via case notes and mental status exams. Comparing client records with original presenting symptomatology case notes may provide evidence to confirm if the symptoms are due to a discontinuation reaction, a medical condition, or a relapse. If the symptoms that the client experiences after the medication is withdrawn do not match his original presenting symptoms, the physician and the mental health counselor may suspect the client is experiencing a discontinuation reaction. Another source of information is to ask clients to keep a daily log of their problematic moods. Additionally, family member or others who live in the client's household may also supply vital information in assessing if the client relapsed. These individuals can often describe the client behaviors and moods before a psychotropic prescription was taken and after it was discontinued that are out of the client's awareness. Black et al. (2000) noted that this can be a difficult differential diagnosistic process. In this regard, mental health counselors ought to understand the limitations of their scope of practice and consult with appropriate medical physicians who have the primary responsibility for diagnostic determinations.

Both physicians and mental health counselors should also be aware that the use of SSRI antidepressants or discontinuation from them might contribute to a manic phase (Ditto, 2003). It is critical to consider a wide range of factors in treatment. For example, a client's original presenting

symptomatology may have met the criteria for the diagnosis of a major mood disorder. A regime of an antidepressant might have been successful in reducing or eliminating the symptoms and the client may request to be withdrawn from the medication. If unusual or unexpected symptoms arise at this point, it is possible that the original diagnosis missed the differential indications of bipolar disorder. In some situations, a mild case of bipolar disorder might become more pronounced by the use of an antidepressant and therefore, the symptoms could become more visible. In these cases, the physician should consider changing the pharmacotherapy to treat for bipolar disorder. After consulting with the physician to confirm the new diagnosis, the mental health counselor should change the client's treatment plan accordingly.

In any event, counselors should not assume that symptoms that originate when the client is withdrawn from a medication provide clear evidence of a relapse. Likewise, they should not presuppose that these symptoms are proof of discontinuation effects. Mental health counselor competency within the context of pharmacotherapy is multifaceted and requires "substantial skill to perform competently" (Dewan, 1992, p. 107). This includes the ability to understand when consultation with the prescribing physician is crucial for the welfare of clients and to the competent practice of mental health counselors.

Unsuccessful Discontinuation Reaction

Unsuccessful discontinuation reactions occur when the client experiences disturbing side effects during termination and therefore feels compelled to resume taking the drug. Medawar et al. (2002) reported cases in which Paxil prescriptions could not be discontinued because clients developed severe effects from attempts to discontinue. These situations, however, did not indicate a recurrence of depressive symptoms. For example, one client noted, "Seroxat (the trade name for Paxil in Europe) can be an absolute lifesaver—it was for me at first (but) is the only drug I have been prescribed that had severe enough withdrawal symptoms that I have had to keep going back on it because I feel so ill" (p. 165). Another client stated, "I was at suicide's door because of my depression, but it did help me get better, however, weaning myself of this was really bad, the head shocks would sometimes be (so) bad that I vomited" (p. 166).

These two cases do not necessarily mean that either client could not successfully stop the use of Paxil. Switching to another antidepressant with a greater half-life and then reducing the dosage can lead to effective termination (Katon et al., 1996). In both of these cases, however, the clients believed that they could not stop using the drug even if the dosage was gradually reduced. Situations such as these can be frightening to

clients if they believe they are compelled to continue taking a prescription psychotropic. Data related to unsuccessful discontinuation reactions of medications are not known, and while these reactions may be rare, mental health counselors should be aware that they do exist in order to ensure that they do not misinterpret what the client is reporting.

Sensitization Reactions

Sensitization reactions occur if the client is terminated from the medication but at a later time it is prescribed again for the client and then side effects develop. In some cases, physicians report that a client who has stopped taking a psychotropic cannot successfully resume taking it at a later date. This occurs after the client has completed the regimen of a medication, the client's symptoms recur, and upon reintroduction of the medication it is noted that the client has become sensitized to the drug and can no longer take it (Medawar et al., 2002). For example, one client reported taking Paxil successfully for six months then discontinuing the use of it "cold turkey" with minimal effects. When her previous symptoms recurred five months later, the client was given another prescription of the same medication. The client reported, "Since then I have tried to come off it and haven't been able to due to the common side effect: head shocks. I've tried to wean myself off but I still get this horrible sensation" (p. 164). In this case, the client noted that after completing a regimen of the prescription, she became sensitized to it and also experienced discontinuation reactions. From her self-report, there is a sense that she felt trapped in a cycle of trying to stop using Paxil but was then forced to resume the prescription in order to avoid experiencing what she describes as "head shocks." Similar complaints have surfaced regarding Effexor XR (Antai-Otong, 2003).

These descriptions by clients do not automatically inform researchers or clinicians that the reported outcomes are evidence of unanticipated drug side effects. Nevertheless, the clients' reality is concrete for them. Mental health counselors would be less than authentic if they failed to acknowledge these symptoms. It is not in clients' best interests to dismiss their experiences simply because their self-report does not match typical clinical expectations. To further appreciate how mental health counselors need to be cognizant of unanticipated side effects, an example case study is provided.

ILLUSTRATIVE EXAMPLE

In one situation, a couple was being seen for marriage counseling. During the course of the first session, it became clear that the couple was

experiencing a number of sexual problems including the wife's loss of libido and the husband's erectile dysfunction. The husband said that the wife no longer wanted him to touch her and the wife rationalized this because she was repulsed by her husband's previous use of pornography. The couple also reported they were no longer affectionate towards each other. The mental health counselor noted that there was a cycle of his protests that she had little sexual desire and her complaints regarding his inability to satisfy her. The counselor observed that their postures indicated emotional distance.

Toward the end of the session, the wife indicated that she was currently taking Topamax for a previous diagnosis of bipolar disorder. When she asked if this medication could be having an impact on her low sexual interest, the mental health counselor suggested that she might want to discuss this concern with her prescribing physician. She indicated that she had an appointment scheduled with her doctor in a few days and said she would bring this up at that time.

Two weeks later, the mental health counselor again met with the couple. At this meeting, the counselor noticed increased affection between the husband and wife. When he inquired about their relationship, the wife said that her libido was back "in full gear." The husband also reported a considerable reduction in his erectile dysfunction and stated, "It is hardly a problem anymore." The wife said that her physician had changed her medication from Topamax to Lexapro. This client and her husband were convinced that substituting Lexapro for the Topamax was the causal factor in increasing her sexual desire and in improving her relationship with her husband.

This case study offers three factors for consideration. First, there is no direct evidence that the withdrawal of Topamax or the initiation of Lexapro had an affect on the client's level of sexual interest. The client's change in libido could have been attributed to other intervening variables. Second, although causality cannot be fixed, the wife reported at the second session that soon after she was prescribed Topamax there was a loss of sexual interest. Since the resumption of sexual interest occurred shortly after she stopped taking the Topamax, the wife and the husband strongly believed, as the wife stated, "Topamax was the culprit." Third, in researching three medication reference texts, the described Topamax side effects do not include the prospective reduction of sexual interest (Bralow, 2003; Julien, 2001; Keltner & Folks, 2001). Likewise these three references do not indicate that Lexapro has a possible positive sexual side effect. Mental health counselors who consult these medication references would not be informed of any potential decrease or increase in libido.

In this illustration, the mental health counselor was aware of the nor-

mal side effects of Topamax, which are listed in the literature. However, the client's reported low libido did not match any of the medication's usual effects. Because the wife reported her unexpected symptom of low sexual interest, the counselor referred her to the prescribing physician. Her physician made the decision to change the medication presumably to determine whether the Topamax had affected her level of sexual desire. This case demonstrates that clients may experience unusual effects from their psychiatric medications. Informing clients of the possibility of unanticipated psychotropic reactions can be reassuring and can help clients deal with unpredicted reactions if they occur. Regardless of what might have been the cause of the wife's decreased libido, the changed prescription brought about a significant improvement in her sexual interest and in the marital relationship.

ETHICAL AND CLINICAL CONSIDERATIONS

Ethical Scope of Practice

Psychotropic medication has traditionally occupied the exclusive domain of medical practice. Mental health counselors, therefore, "may experience a sense of confusion and uncertainty when considering the more precise nature and associated limitations of their roles" (King & Anderson, 2004, p. 330) when discussing psychotropic medications with their clients and in collaborating with prescribing physicians. A consideration of Bentley and Walsh's (2000) previously presented roles for mental health counselors when working with clients who take psychotropic medications may be useful in this regard (see King & Anderson, 2004 for details for utilizing these roles in the scope of clinical practice). In sum, mental health counselors are in a key position to "assess the risks of medication treatment, *particularly side effects*, possible medication interactions with substances such as alcohol and other medications, and the potential risk for overdose" (Sansone, Gaither, & Rytwinski, 2004, pp. 195–196; emphasis added).

Relating to client informed consent, AMHCA (2000) advises mental health counselors to provide a "clear description" (Principle 1, J) of what the client can expect from various therapeutic regimes (see also Corey, Corey, & Callanan, 2003). In particular, clients have a right "to a clear statement of the purposes, goals, techniques, rules of procedure and limitations, as well as the potential dangers of the services to be performed, and all other information related to or likely to affect the ongoing mental health counseling relationship" (Principle 2, E). With this in mind, mental health counselors may well ask: What information should be given concerning side effects and other complications of psychopharmacology?

When is the amount of information concerning potential side effects too much data for a client to understand? Do possible effects establish a probability for psychosomatically developing symptoms in clients' minds?

Beitman, Blinder, Thase, and Safer (2003) suggested guidelines on how mental health counselors may address these questions. In the *acute phase* of pharmacotherapy, the medication is prescribed and clients are informed that a number of individuals do experience some side effects. They are encouraged to become knowledgeable about their prescriptions, ask questions of their physician and pharmacist, and request a pharmacy printout of possible drug interactions. Clients can also be notified that because every person reacts differently to each prescription it is possible for them to have unusual drug reactions. Clients should be requested to inform their prescribing physician about any side effects or other unusual changes they may experience. If clients become concerned about a reaction to their prescription, they should report these effects to their physician or seek emergency medical assistance.

In the *continuation phase* of pharmacotherapy, as the client continues to take the prescription, their physician and mental health counselor should query them about any side effects or other atypical symptoms they experience. Abnormal or severe side effects should be reported as soon as possible to their physician or emergency medical personnel.

In the *maintenance phase*, clients should be alerted to the possibility of unanticipated effects. This may include the client's perception of reduced medication effectiveness. If unanticipated reactions do occur, clients should be informed of their options by their prescribing physician. Mental health counselors should consult with physicians when they become aware of unusual effects because their observations can provide valuable additional information to physicians when they consider alternative prescriptions or possible discontinuation of the psychotropic medication.

Throughout pharmacotherapy, clients can be informed of potential outcomes without overloading them with information about every possible effect. Mental health counselors with at least one graduate course in psychopharmacology can be an important resource for their clients and their clients' physicians (CACREP, 2001). All mental health counselors should educate their clients to immediately report severe symptoms or symptoms that become increasingly more aggravating to their physician or an emergency medical facility. Less acute symptoms could be reported to their prescribing physician and their mental health counselor at their next appointment.

Regarding scope of practice, Ingersoll, Bauer, and Burns, (2004) observed "there are no clear prohibitions against a nonmedical mental health professional talking with clients about psychotropic medications"

(p. 340). These authors draw this conclusion from the research of Littrell and Ashford (1995)—who explored the issue of nonmedical mental health professionals discussing psychotropic medications with clients. Littrell and Ashford observed that state laws do not preclude mental health counselors from discussing psychotropic medications with their clients and concluded, "given the precedent established in other professions, it is unlikely that a [mental health counselors'] discussion of medication could be construed as practicing medicine without a license" (p. 241). They also concluded that there was no basis in case law for assuming that mental health counselors sharing information about psychotropic medication is illegal.

Furthermore, some medical professionals support mental health counselors taking an active interest in psychopharmacology by working together with prescribing physicians (Beitman, Blinder, Thase, & Safer, 2003; Comer, 2002; Riba & Balon, 1999). For example, in a draft document for physicians to use in developing a collaborative relationship with the mental health counselor, Meyer and Simon (1999) encourage the mental health professional to be aware of (a) the client's concerns about pharmacotherapy, (b) the client's possibility of experiencing negative side effects, (c) the importance of the client's adherence to the medication regimen, and (d) the client's use of alcohol or drugs. These components of mental health counselor practice in the context of pharmacotherapy are also advocated by some counselor educators and practicing clinicians (CACREP, 2001; King & Anderson, 2004). Counselors who are trained in pharmacotherapy according to CACREP standards are often in the best position to observe, query, and record prescription reactions on a regular basis.

Knowledge of Side Effects

As discussed, some reactions to psychotropic medications are unanticipated. While some reactions may not be predictable, mental health counselors should be knowledgeable concerning common psychotropic side effects in order to distinguish anticipated reactions from unanticipated reactions. Counselors cannot be expected to have a comprehensive knowledge about every medication but they can cultivate a general familiarity regarding psychotropic side effects and they can consult drug reference manuals as well information posted on the internet by vendors, pharmaceutical companies, and the U.S. Food and Drug Administration.

According to Keltner and Folks (2001), some of the most frequent psychotropic side effects include sexual dysfunction, insomnia, appetite suppression, anxiety, headaches, sedation, diminished mental activity, blurred vision, and psychomotor agitation (see also Antai-Otong, 2004; Perna,

2004). Cognizance of the interactions of psychotropic medications with other substances or medications is essential. For example, counselors should be aware that symptoms such as rapid heart rates, cardiovascular and neurological problems, an increase in the severity of a disorder, or suicidal ideation (Julien, 2001) should be referred to the prescribing physician to determine if these are primary or interaction symptoms. In other cases, clients may report disorientation in a variety of ways that suggest possible neurological discomfort (Reeves, Mack, & Beddingfield, 2003). Serotonin Syndrome (e.g., hypomania, agitation, confusion, restlessness), characteristic of SSRI-based anti-depressants, symptoms related to anti-psychotic medications (e.g., hyperthermia or high body temperature, muscle rigidity, and mental status changes), other characteristics of anti-psychotic-based medications, or possible fatal side effects resulting from the interactions of excessive polysubstance or psychotropic medication use (Birmes, Coppin, Schmitt, 2003; Wren, Frizzell, & Keltner, 2003) are also possible reactions. Typical presentations of discontinuation reaction include lightheadedness, dizziness, headaches, gastrointestinal disturbances, perspiration, fatigue, vivid dreams, flu-like symptoms, and atypical client behaviors (Coupland, Bell, & Potokar, 1996; Fava & Rosenbaum, 1996). Some other effects may be less disturbing but nevertheless stressful such as disorientation or unsettling anxiety (Reeves, Mack, & Beddingfield, 2003). Consultation with the prescribing physician is in order when any of these conditions are presented by the client.

Cautionary Perspective

Mental health counselors should also be aware that prescribing physicians may have difficulty in trying to identify with client complaints when there is little or no medical test corroboration for symptom presentation. Medical physicians rely on blood tests and other measures to confirm or rule out suspected diagnoses. In the overlapping areas between physiological and psychological health, differential diagnosis may be based on art as much as science. For example, counselors and physicians may be tempted to dismiss client concerns as simply psychosomatic. It would be convenient if unanticipated pharmacotherapy effects, such as a discontinuation symptomatology, occurred in "a well-defined syndrome with predictable onset, duration, and offset of action containing psychological and bodily symptoms not previously complained of by the patients" (Lader, 1983, p. 17). Unfortunately, these unexpected reactions are neither easy to understand nor are they simple to analyze. Because mental health counselors generally have more frequent contact with their clients, they are often well placed to note their clients' unusual symptoms. No ethical clinician should dismiss problematic indications merely because they defy

straightforward explanation. Working with their clients and their prescribing physicians, mental health counselors can be attentive to symptoms that may not be included in prescription references.

Psychopharmacology Resources

Because the field of psychopharmacology is rapidly evolving with new and advanced scientific discoveries, mental health counselors can choose from the following resources to become informed of anticipated reactions so as to detect unanticipated reactions:

- The *PDR Drug Guide for Mental Health Professionals* (2004). This portable, non-technical style reference is designed expressly for mental health counselors and offers quick access to detailed profiles of over 80 common psychotropic medications their clients are taking, along with proper usage and administration of each drug and common side effects, special warnings, and contraindications.
- The *Harvard Mental Health Letter*, published monthly by Harvard Medical School, covers a wide range of mental health issues and concerns. It presents the latest thinking, treatment options, therapies, and debate on mental health issues as well as psychotropic medication interactions, controversies, and prescribing physician issues. Subscriptions are available at http://www.health.harvard.edu/newsletters.
- *Clinical Psychopharmacology for Mental Health Counselors* (Koshes, 2002; published by AMHCA and available at www.amhca.org/store) provides mental health counselors with a comprehensive understanding of the clinical use of psychoactive medications. The publication includes a comprehensive text that covers such topics as antidepressants, mood stabilizing agents, treatment of ADHD, anti-anxiety medications, and antipsychotic agents.
- Mental health counselors may also enhance their clinical knowledge of psychotropic reactions by reading *Psychopharmacology for Helping Professionals: An Integral Exploration* (Ingersoll & Rak, 2006) and *Basic Psychopharmacology for Counselors and Psychotherapists* (Sinacola & Peters-Strickland, 2006).
- Medscape.com, sponsored by WebMD, is a comprehensive and user friendly website that provides instant access to current information regarding psychotropic medication side effects, dosage ranges, indications, and contraindications. The second author of this article subscribes to a list serve that sends weekly updates on psychotropic medications.
- Information on medications by the U.S. Food and Drug Administration is available at www.fda.gov/medwatch.

- Epocrates (www2.epocrates.com) is a Web site that offers free access to drug information. More than 3,300 brand and generic drugs are listed including adverse reactions, contraindications, and drug interactions.
- Mental health counselors are encouraged to attend the annual AMHCA conference where workshops on psychopharmacology are frequently presented.

There are hundreds of other references and resources available to mental health counselors and their clients. Within their scope of practice, counselors can consult these resources in order to further their understanding of current information about psychotropic medications and their effects.

CONCLUSION

Psychotropic medications in the United States undergo stringent testing to meet the requirements of the U.S. Food and Drug Administration. During these tests, common potential side effects are specified in the drug's marketing literature and in medication references. However, some clients will experience other effects that may not be expected. The unanticipated psychotropic reactions may become evident during the initiation of the prescription, at some point in the course of pharmacotherapy, at the conclusion of the medication regimen, or at a later time if the prescription is subsequently reinstated. Mental health counselors have an obligation to take notice of their client's complaints if unusual symptoms arise that are not accounted for by the drug's normal side effects. When side effects are reported by clients, mental health counselors should consult prescribing physicians, keep their clients informed, and monitor their reactions to prescribed medications. Consequently, mental health counselors will effectively advance the best interests of their clients and high standards of excellence in ethical practice.

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