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Psychotropic drugs as impediments to effective counseling

Abstract

While psychotropic drugs have proven useful in the treatment of a variety of psychological and behavioral disturbances, they simultaneously hinder the counseling process (Matorin and DeChillo 1984). There are so many possible drug side effects that it is increasingly difficult for a counselor to record accurate case notes on a client who is exhibiting drug induced psychological or medical conditions. Matorin and DeChillo (1984) recommended that the professional counselor, the attending physician and the client, if possible, meet to discuss the potential drug side effects thus assuring that the overall functioning of the client is taken into account. When assessing the client, the counselor with the physician's help, will be made aware of the four groups of drugs that are prescribed for the many behavioral and psychological disorders. The four drug groups are, according to Apelgren and Rowles (1975): Antipsychotics, Antidepressants, Antimanics and Anxiolytics (Antianxiety agents).

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PSYCHOTROPIC DRUGS AS IMPEDIMENTS
TO EFFECTIVE COUNSELING

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and Counseling

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Master of Arts

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by

Lois Jeanne Mayne

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While psychotropic drugs have proven useful in the treatment of a variety of psychological and behavioral disturbances, they simultaneously hinder the counseling process (Matorin and DeChillo 1984). There are so many possible drug side effects that it is increasingly difficult for a counselor to record accurate case notes on a client who is exhibiting drug induced psychological or medical conditions. Matorin and DeChillo (1984) recommended that the professional counselor, the attending physician and the client, if possible, meet to discuss the potential drug side effects thus assuring that the overall functioning of the client is taken into account. When assessing the client, the counselor with the physician's help, will be made aware of the four groups of drugs that are prescribed for the many behavioral and psychological disorders. The four drug groups are, according to Apelgren and Rowles (1975): Antipsychotics, Antidepressants, Antimanics and Anxiolytics (Antianxiety agents).

Due to the many drug side effects, there is a great risk of misdiagnosis for the counselor who is unfamiliar with psychotropic agents. To make the counselor more clearly aware of the impediments of drug therapy, this paper will define how to choose the appropriate drug, the major psychotropics, the side effects of the

psychotropics, the risks of prolonged use of such drugs, and when to discontinue their use. Also, on the final pages of this paper are complete tables of the four psychotropic categories and their most commonly prescribed drugs listed under both their trade and generic names.

Choosing the Appropriate Drug

The major determinant in the choice of a drug, as documented by Sovner and DesNoyers Hurley (1983), is the proper diagnosis of the condition. Problems arise when an illness is mistaken for a psychological disturbance, because the drugs for each disorder are as different as is the therapy. It is essential for the doctor to make the correct diagnosis before the drugs are prescribed. The counselor needs to be aware of the correct diagnosis to select the appropriate intervention technique (Matorin and DeChillo, 1984).

Sovner and DesNoyers Hurley (1983) proposed that drugs should be selected by assessing the symptomatic conditions that the client exhibits. These conditions, Sovner and DesNoyers Hurley (1983) reported, can easily be separated into two broad groups: the well-defined mental illnesses such as affective disorders, and the behavioral disorders that are maladaptive or disruptive

to others. In addition to strongly believing that the drug should reflect the diagnosis, Wender and Klein (1981) asserted that while psychotropics do not cure the psychological problem, they do allow the patients to live outside institutions.

Another consideration in the selection of a psychotropic drug is the population for which it is intended. Jinks (1984) proposed that psychotropics are among the most commonly prescribed drugs for the elderly. In nursing homes in the United States 75% to 90% of the residents are on at least one psychotropic agent. Unfortunately, due to the natural aging process, the elderly are the most susceptible to the side effects. One major problem Jinks (1984) added is that the anticholinergics which are prescribed for parkinsonian tremors and other physical problems that accompany psychotropic drug use, increase the persistent dry mouth, constipation and urinary retention, all of which are typical geriatric concerns.

Many doctors find the Physician's Desk Reference (PDR) to be efficient help in the prescription of psychotropics, but it is printed and paid for by the pharmaceutical industry (Huff and Knipping 1985). In conjunction with this, Kline and Angst (1979) asserted that there are so many drug side effects that doctors

often consult the PDR and then prescribe lower dosages than recommended, which hopefully reduces the chances of difficult side effects. Prescriptions can be made even more confusing for the patient, the counselor and the doctor when taking into account the many interchangeable names that are in use for the different psychotropics.

Antipsychotics

Perry, Alexander and Liskow (1981) found that antipsychotics are the drugs of choice in the diagnosis of schizophrenia. The typical symptoms include: difficulty in communication and interpersonal relationships, disordered thought processes and difficulty in reality testing, with withdrawal into a private world (Gallagher 1980).

Antipsychotic Side Effects

As noted by Perry, et al. (1981) and Kline (1982), there are many diverse side effects to antipsychotic drugs. The major effects include: ejaculatory dysfunction, anticholinergic reactions such as dry mouth and constipation, dizziness, changes in the heart rate, skin reactions, leukopenia (low white cell count) and liver disease. Other side effects of antipsychotic drugs according to Perry, et al. (1981) include: Malignant Syndrome (muscular rigidity, hyperthermia and

altered consciousness), weight gain, and neurologic disorders such as pseudo-parkinsonism and akathisia (motor restlessness). One positive side effect of antipsychotics, as reported by Mergener (1982), is that they inhibit the vomiting reflex and are often prescribed to those taking chemotherapy.

The four antipsychotic drugs most often prescribed are: Chlorpromazine (trade name: Thorazine), Thioridazine (Mellaril), Thiothixene (Navane) and Haloperidol (Haldol). All four cause moderate to high levels of the previously mentioned side effects (Kastrup, Olin, Schwach, Covington, DiPalma, Hussar, Lasagna, Tatro, and Whitsett, 1986). In spite of these many side effects, however, Perry, et al. (1981) asserted that studies have shown a 40% to 70% improvement in those using the antipsychotics.

Antidepressants

Depression is defined by Wender and Klein (1981) as the most common form of mental disturbance. According to Wender and Klein (1981) depression exhibits symptoms including a general feeling of fatigue, helplessness, boredom, indecisiveness, guilt and a decreased capacity to love. The more severe the depression, the greater the difficulty in dealing with day to day responsibilities (Wender and Klein 1981).

Antidepressant Side Effects

Jinks (1984) stated that the antidepressants have fewer side effects of pseudo-parkinsonism, motor restlessness and muscle weakness than do antipsychotics. Anticholinergic effects such as dry mouth, urinary retention, constipation and blurred vision are all common with antidepressants (Perry, et al. 1981). Antidepressants have one unique side effect, reported Koda-Kimble, Katcher and Young (1978), in that they can simulate pregnancy by causing amenorrhea and producing breast milk. There is also a change in the cardiovascular system as the blood pressure drops, and there may be arrhythmias and possibly heart failure. Perry, et al. (1981) added that the patient may become disoriented and experience memory loss when using antidepressants. These side effects, depending on the individual, may first occur from one week to two months after the administration of the antidepressants (Perry, et al. 1981).

The four antidepressant drugs usually prescribed are: Amitriptyline (trade names: Elavil or Endep), Trimipramine (Surmontil), Imipramine (Tofranil) and Doxepin (Adapin or Sinequan), as listed by Jinks (1984). The sedation effect of each is moderate to high. The

potential for addiction of all these drugs is very low, however a slightly higher addiction potential exists for tranquilizers such as the anxiolytic, Valium (Kastrup, et al. 1986).

Antimanics

Antimanic drugs are used primarily with manic depressive patients. Gallagher (1980) defined manic depression as a severe mood or affect disorder that is accompanied by delusions, abrupt changes of subjects and rapid speech. The mildest form of this condition is called simple retardation while the most severe is referred to as depressive stupor. There is only one antimanic drug of choice: lithium (Perry, et al. 1981).

Antimanic Side Effects

Although lithium is the only commonly prescribed drug for the manic depressive it has many side effects. Perry, et al. (1981) stated that lithium causes changes in the EKG reading, it may cause convulsions, often disrupts the gastrointestinal system and often causes leukopenia (a reduction in the blood's white cell count). Lithium also frequently affects weight gain, causes muscle weakness and tremors, and periodically causes renal damage. Sovner and DesNoyers Hurley (1985) found that lithium, unlike the previous two psychotropic drug groups, does not cause pseudo-parkinsonian tremors

or akathisia (motor restlessness). A very serious condition, lithium toxicity, may occur where patients are drowsy, have muscle twitches, may have convulsions and may become comatose or die (Sovner and DesNoyers Hurley 1985).

Anxiolytics

Anxiolytics, according to Schwartz (1985) are used for the treatment of the various anxiety disorders such as phobias and obsessive-compulsive neuroses. These conditions, stated Gallagher (1980) are also accompanied by somatic difficulties such as fatigue, insomnia, headaches, nausea and tremors. Schwartz (1985) proposed that Benzodiazepines, or tranquilizers such as Valium, are the most commonly prescribed anxiolytics in the United States. The three most commonly prescribed anxiolytics drugs, as documented by Apelgren and Rowles (1975), are: Chlordiazepoxide (trade name: Librium), Diazepam (Valium) and Oxazepam (Serax). The side effects of these anxiolytics are varied, as explained in the following paragraph.

Anxiolytic Side Effects

While the side effects of anxiolytics are varied, they usually pertain only to the central nervous system. Anxiolytics sometimes produce paradoxical excitement and

rage or hostility, they can cause drowsiness and body weakness and they may depress the respiratory system. In addition, the elderly often experience confusion when taking anxiolytics (Perry, et al. 1981). According to Sovner and DesNoyers Hurley (1982a) aggressiveness is a side effect of many psychotropic agents but is particularly evident with antianxiety drugs, and the aggression is often misdiagnosed as a behavioral disorder. Akinesia (muscle weakness) is a frequent misdiagnosis of depression, sexual dysfunction as psychogenic impotence, incontinence as behavioral regression and mania as a hyperactivity disorder (Sovner and DesNoyers Hurley 1982a).

This paper has now listed a brief description of the four psychotropic drug groups, the major drugs that are prescribed in the four categories of the psychotropics, and their side effects. The paper will now address under what conditions the doctor and counselor may recommend discontinuing the drug therapy.

Discontinuing Drug Therapy

There are three reasons for discontinuing the use of psychotropics: 1. if inappropriate behavior remission has been reached, more drugs are superfluous, 2. the drug, itself, may not have made the behavioral change

but, for example, an environmental stimulus change was responsible, and 3. continued use may result in irreversible drug side effects, such as tardive dyskinesia (Sovner and DesNoyers Hurley 1984).

There are two stages of physical side effects that are indicators for the discontinuation of psychotropics. The two stages are the early, or distonic stage and tardive dyskinesia (TD). As documented in Kastrup, et al. (1986) pharmacists and doctors alike strongly recommend that psychotropic drug blood levels and dosages should be checked at least every three months to detect the onset of the distonic phase. Mergener (1982) and Koda-Kimble, et al. (1978) reported that the distonic reactions such as tics, facial grimaces, and contractions of the skeletal muscles usually occur in the first four weeks of use and 90% occur by the fourth day. The distonic reactions, according to Sovner and DesNoyers Hurley (1982b) are more common in the under 50 age group and are twice as likely to occur in men, presumably due to a hormonal influence. Distonic reactions are, however, reversible if discovered early enough and medication reductions or changes are made.

Akathisia (motor restlessness) is another form of distonic reaction. There is a 90% chance of a person developing akathisia within the first 73 days of drug

treatment and women are twice as likely to develop it, probably due to hormones (Sovner and DesNoyers Hurley 1982a). Akathisia mimics many psychological disorders and often, unfortunately, doctors mistake it as such and prescribe even more psychotropics which only increases the activity. This creates circular causality and if not checked in time becomes the irreversible tardive dyskinesia (Perry, et al. 1981, and Jinks 1984).

Sovner and DesNoyers Hurley (1982a) stated that tardive dyskinesia is the result of the prolonged use of psychotropic agents left unmonitored and that the classic characteristic symptoms of TD are varied. Movements include body rocking, and tongue and facial twitches that make the persons assume bizarre expressions. According to Sovner and DesNoyers Hurley (1982b) TD becomes more pronounced when the individual is under stress but that its symptoms disappear during sleep. Tardive dyskinesia also creates pseudo-parkinsonian tremors. Treatment must be undertaken before the distonic stage reaches the TD stage. Mergener (1982) and Kastrup et al. (1986) found that the best way to prevent TD is to periodically change the medications or to reduce them as increasing the dosages only increases the uncontrollable movements.

Conclusions

It is apparent that there are indeed many side effects of the various psychotropic agents. Professional counselors generally dislike the use of drug therapy as a first treatment choice, but many others also believe that counseling alone is sometimes insufficient (Matorin and DeChillo 1984). Doctors need to learn more about the psychotropics that they sometimes prescribe indiscriminately, and they need to thoroughly investigate and diagnose the true medical conditions so that when drugs are necessary, patients receive the appropriate ones. Psychotropic drugs, added Matorin and DeChillo (1984) and Sovner and DesNoyers Hurley (1984) have become an easy way for doctors to treat clients when other methods might be just as, or more, successful.

Sovner and DesNoyers Hurley (1984) also hoped that doctors stop prescribing medicines out of expediency rather than necessity. It is the duty of counselors who work with those taking psychotropics in particular to familiarize themselves with the drugs, the typical drug dosages and their possible side effects in the interest of creating more comprehensive case notes and better quality care for their clients (Matorin and DeChillo 1984). By understanding the diagnosis, the psychotropic

agent and the possible side effect, the counselor can choose the appropriate counseling technique as, for example, the drug induced depressive client may not be responsive to Rational Emotive Therapy. Matorin and DeChillo (1984) also recommend that counselors take additional courses in medications and in psychology to help round out their educations.

PSYCHOTROPIC DRUGS

Antipsychotics:

Generic Name	Trade Name
Chlorpromazine	Thorazine
Thioridazine	Mellaril
Thiothixene	Navane
Haloperidol	Haldol
Trifluopromazine	Vesprin
Mesoridazine	Serentil
Piperacetazine	Quide
Acetophenazine	Tindal
Carphenazine	Proketazine
Fluphenazine	Prolixin, Permitil
Fluphenazine Deconate/Evanthate and Perphenazine	Trilafon
Trifluoperazine	Stelazine
Chlorprothixene	Taractan
Molidone	Moban, Lidone
Loxapine	Loxitane, Daxolin

These two pages of tables are a composite of information taken from Perry, Alexander and Liskow (1981) and Apelgren and Rowles (1975).

ANTIPSYCHOTIC DRUGS, Cont.

Antidepressants:

Generic Name	Trade Name
Amitryptyline	Elavil, Endep
Imipramine	Tofranil
Doxepin	Sinequan, Adapin
Desipramine	Norpramin, Pertofrane
Nortriptyline	Aventyl, Pamelor
Protriptyline	Vivactil

Antimanics:

Generic Name	Trade Name
Lithium	Lithium

Anxiolytics:

Generic Name	Trade Name
Chlordiazepoxide	Librium
Diazepam	Valium
Oxazepam	Serax
Chlorazepate	Tranxene
Prazepam	Verstran
Lorazepam	Ativan
Meprobamate	Equanil, Miltown

REFERENCES:

Apelgren, S.E., & Rowles, B. (1975). Clinical pharmacy handbook for patient counseling. Hamilton, Illinois: Drug Intelligence Publications, (1st Ed.].

Gallagher, B.J. (1980). The sociology of mental illness. Englewood Cliffs, New Jersey: Prentice-Hall, Inc.

Huff, B., & Knipping, W. [Eds.] (1985). Physicians desk reference. Oradell, New Jersey: Medical Economics Company.

Jinks, M.J., (1984). Psychotropic drugs in the elderly. Pharmacy Times. 8, 86-97.

Kastrup, E.K., Olin, B.R., Schwach, G., Covington, T.R., DiPalma, J.R., Hussar, D.A., Lasagna, L., Tatro, D.S., & Whitsett, T.L. [Eds.] (1986). Facts and comparisons. St. Louis, Missouri: J.B. Lippincott and Company.

Kline, N.S. (1982). Advances in pharmacological treatment of schizophrenia. Pharmacy Times. 1, 70-78.

Kline, N., & Angst, J. (1979). Psychiatric syndromes and drug treatment. New York: Jason Aronson, Inc.

Koda-Kimble, M.A., Katcher, B.S., & Young, L.Y. [Eds.] (1978). Applied therapeutics for clinical pharmacists. San Francisco, Cal.: Applied Therapeutics, Inc., [2nd Ed.].

Matorin, S., & DeChillo, N. (1984). Psychopharmacology: Guidelines for social workers. Social Casework. 10, 579-589.

Mergener, M.A. (1982). Side effects of antipsychotic drugs. Pharmacy Times. 1, 54-59.

Perry, P.J., Alexander, B., & Liskow, B. (1981). Psychotropic drug handbook. Cincinnati, Ohio: Harvey Whitney Books.

Schwartz, R.D. (1985). Anxiety and antianxiety drugs. Pharmacy Times. 1, 102-111.

Sovner, R., & DesNoyers Hurley, A. [Eds.] (1982a, December). Psychotropic drug side effects presenting as behavior disorders. Psychiatric Aspects of Mental Retardation Newsletter. 1, 45-48.

Sovner, R., & DesNoyers Hurley, A. [Eds.] (1982b, May). Tardive dyskinesia. Psychiatric Aspects of Mental Retardation Newsletter. 1, 29-32.

Sovner, R., & DesNoyers Hurley, A. [Eds.] (1983, May). Psychotropic drug therapy: An overview. Psychiatric Aspects of Mental Retardation Newsletter. 5, 17-20.

Sovner, R., & DesNoyers Hurley, A. [Eds.] (1984, November). Discontinuing psychotropic drug therapy: Rationale, guidelines and side effects. Psychiatric Aspects of Mental Retardation Reviews. 11, 41-44.

Sovner, R., & DesNoyers Hurley, A. [Eds.] (1985, June). Drug profiles I.: Lithium. Psychiatric Aspects of Mental Retardation Reviews. 4, 21-26.

Wender, P.H., & Klein, D.F. (1981). Mind, mood, and medicine: A guide to the new biopsychiatry. New York: Farrar, Straus and Giroux.