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Prescription for critical thinking: A discussion of psychotropic medication and counseling

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Prescription for Critical Thinking:

A Discussion of Psychotropic Medication and Counseling

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Dedication

I dedicate this paper to those who have suffered unnecessarily as a result of psychotropic medication.

I also dedicate this paper to my father, Barton Michael Biggs, who was at once contrarian and open-minded. He, more than anyone, helped me understand the value of examining conventional wisdom with a skeptical eye.

Acknowledgments

I am grateful for all those friends and family members who offered patience, encouragement, and love throughout this project. I am also grateful for my sister Wende, whose curiosity and passion helped to plant the seeds of my interest in this topic. And for my friends Jeff and Andriana, who walked through this process with me and helped keep me on track. And for my friend Anne, who offered technical guidance, a critical eye, and intellectual inspiration; her enthusiasm for the project pushed me to make it better. I am also grateful to the researchers, investigators, commentators, and other truth seekers who have challenged mainstream thought and sought to encourage an honest public dialogue about psychotropic medication – often at great professional risk to themselves. I offer thanks to journalist and author Robert Whitaker, who generously shared his time and his knowledge with me. And finally, I owe a great debt of gratitude to the members of my faculty committee – Dr. Eric Cowan, Dr. Renee Staton, and Dr. Deborah Sturm; their suggestions, ideas, guidance, and patience were critical to making this project an extremely valuable part of my training and professional identity development in the field of counseling.

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Abstract

This paper examines questions about the safety and efficacy of psychotropic medication, and looks at how these questions should impact the field of counseling. The paper first looks at increasing rates of use of psychotropic medication, and establishes that nearly every clinical mental health counselor will work with clients who are taking or considering taking such medication. The paper next examines the scientific literature and establishes that there is a legitimate basis for questions to be raised about the safety and efficacy of these medications. The paper goes on to establish that there is a foundation in ethical codes and counseling competencies for counselors to engage in critical discussion of these medications with clients and in other areas of their professional work. And finally, this paper produces a framework for professional counselors regarding how to work with clients around this issue, and for counselor educators regarding how to address this issue in training programs.

Epigraphs

It seems to me what is called for is an exquisite balance between two conflicting needs:

the most skeptical scrutiny of all hypotheses that are served up to us

and at the same time a great openness to new ideas.

- Carl Sagan

Sometimes people hold a core belief that is very strong. When they are presented with evidence that works against that belief, the new evidence cannot be accepted. It would create a feeling that is extremely uncomfortable, called cognitive dissonance. And because it is so important to protect the core belief, they will rationalize, ignore and even deny anything that doesn't fit in with the core belief.

- Frantz Fanon

Introduction

Over the past quarter century, there has been a dramatic increase in the rate of psychotropic medication use in the United States. The American Psychiatric Association (APA) recommends psychopharmacological treatments as a first line of treatment for many mental health disorders, and most practicing professional counselors must expect to work with clients who are taking one or more these medications.

As with all prescription drugs in the United States, psychotropic medications have been through the Food and Drug Administration's approval process, which requires developers to submit research demonstrating efficacy and safety – in other words, when used to treat the disorders they were approved to treat, all legally prescribed psychotropic drugs have been judged by FDA regulators to be likely to provide benefits to the patient that outweigh the risks and side effects.

However, there is also a substantial body of literature that disputes these findings, questioning the safety and efficacy of many commonly used psychopharmacological treatment protocols for mental health disorders. The least controversial of the criticisms point out that many psychiatric drugs have side effects that can lead to physical and psychological symptoms that the patient did not previously experience, that those symptoms can lead to additional diagnoses and the need for additional treatments, and assert that many psychotropic drugs are not effective enough to justify the side-effects and expense. Other researchers have sought to document the addictive potential of many commonly prescribed psychiatric medications that the public had been led to believe were safe and had a very low addictive potential. Some authors have gone so far as to

suggest that some psychiatric drugs actually exacerbate the problems they are intended to treat. And, perhaps most disturbingly, some critics contend that drastic rises in per capita rates of mental illness in America over the past 25 years or so – including a more than doubling of mental health disability rates -- may be causally linked to a surge in psychiatric drug prescriptions over that period.

This paper does not aim to establish which side of the argument is stronger, and arriving at a conclusive answer to the question of whether psychotropic medications are safe, effective, and useful in the treatment of various mental health disorders is well beyond the scope of this project. Instead, this paper will establish that professional counselors and counselors in training should be aware that there are valid questions about the safety and efficacy of psychotropic medication and that there is legitimate controversy surrounding the increasingly widespread prescribing of these medications. This paper will further establish that it is appropriate for counselors to engage in substantive discussions about the safety and efficacy of psychotropic medication with clients who are on this type of medication, or considering going on it. Finally, this paper will produce recommendations for professional counselors regarding how to work with clients around this issue, and for counselor educators and counselors in training regarding how to train counselors to address this issue.

This paper is divided into a literature review and recommendations section. The literature review is further divided into three parts, with various subheadings within those parts. Part I of the literature review provides data documenting the increasing use of psychotropic medication in the United States, with the aim of establishing that

professional counselors will likely work with clients impacted by these trends. Part II of the literature review examines the criticisms of the current methods and outcomes of a pair of common classes of psychotropic medications in order to provide an overview of this controversy and establish that there is valid scientific basis for questions to be raised about the safety and efficacy of these drugs. Part III of the literature review examines ethical codes, competencies and training guidelines for the field of counseling, as well as published commentary by professional counselors, in order to establish that it is appropriate for counselors to engage in discussions about the safety and efficacy of psychotropic medication with clients and to support them in thinking critically about these medications through psycho-educational and advocacy interventions. The final section of this paper is the recommendations section, which presents suggestions and models for existing professional counselors, counselors in training, and counselor educators that will help members of the counseling profession to be better able to engage in these activities.

Note About Classes of Medication Covered

While this paper is intended to encourage counselors to educate themselves and to think critically about psychotropic medication in general and to work with their clients in a manner that encourages them to do the same, the scope of the project precludes extensive examination of all the major classes of psychotropic medication. For that reason, the literature review section of this project focuses primarily on antidepressants (which are the most-prescribed class of psychotropic medication in the U.S.) and antipsychotics (which are the highest revenue producing class of psychotropic medication in the U.S.) (IMS Institute for Healthcare Informatics, 2012). Three other major classes of psychotropic medication -- anti-anxiety drugs (anxiolytics), mood stabilizers, and central nervous system stimulants (frequently used to treat attention-deficit/hyperactivity disorder) -- are covered in much less detail.

Note About Sources

Many of the criticisms of psychotropic drugs outlined in this paper run counter to conventional wisdom and common beliefs. Furthermore, some of the most-publicized criticisms of these medications over the past several decades have not been grounded in accepted scientific reasoning, which has often led to characterizing the individuals and groups who espouse these views as “voices from the fringe.” For these reasons, biographical footnotes are provided in this paper to highlight the professional credentials and credibility of frequently or prominently cited sources.

Review of the Literature Part I: Statistics about Psychotropic Drug Use

Psychotropic medications used to treat mental health disorders are some of the most commonly prescribed drugs in the United States and around the world. Data from the healthcare information and analytics firm IMS Healthcare Informatics show that in 2011 antidepressants were the most-prescribed drug class in the United States, and spending on antidepressants ($11 billion) ranked seventh among drug classes (IMS Institute for Healthcare Informatics, 2012). Spending on antipsychotics ($18.2 billion) ranked fifth highest among all drug classes (IMS Institute for Healthcare Informatics, 2012). Two psychotropic drugs are among the ten most-prescribed medications in the United States; they are the antidepressant Cymbalta (number six on the list) and the central nervous system stimulant Vyvanse (number eight on the list), used to treat attention deficit/hyperactivity disorder. Two antipsychotics, Abilfy and Seroquel, are among the top six revenue-producing drugs, each totaling well over $5 billion in sales annually.

The following statistics on trends in the prescribing of psychotropic drugs are taken from a 2011 analysis conducted by healthcare benefits management firm Medco Health Solutions. The analysis examined prescriptions from four classes of psychotropic medication – antidepressants, atypical anti-psychotics, benzodiazepines prescribed as anxiolytics (anti-anxiety drugs), and central nervous system stimulants. The study did not examine the use of other commonly prescribed psychotropic medications such as mood stabilizers (often used to treat bipolar disorder), non-benzodiazepine sedatives, hypnotics, and tranquilizers, and a variety of others.

As of 2010, more than one in five American adults was taking psychiatric medication from at least one of the four classes of medication studied, and that rate represented a 22 percent increase from a decade earlier. Among women, the figure was about 26 percent, while among men it was about 15 percent (Medco Health Solutions Inc., 2011).

Roughly six percent of American children were prescribed medication from at least one of the four drug classes in 2010, with boys outpacing girls by a rate of seven percent to five percent. The rate of increase from a decade earlier among children was approximately 20 percent (Medco Health Solutions Inc., 2011).

The highest rate of use of the drugs overall was among women aged 45 and older, while men aged 20-44 showed the fastest rate of increase, nearly doubling their per capita use during the 10-year period studied. Among children, girls showed a larger per capita increase than boys. The most commonly used class of psychotropic medication for both sexes was antidepressants (Medco Health Solutions Inc., 2011).

The researchers divided the United States into nine geographic regions, with usage rates ranging from more than 23 percent of the population in the east-south-central region (Kentucky, Tennesse, Mississippi, Alabama) to slightly less than 15 percent of the population in the east-north-central (Michigan, Wisconsin, Illinois, Indiana, Ohio) (Medco Health Solutions Inc., 2011).

The study did not examine rates of polypharmacy, but other researchers have pointed to a sharp increase in the practice of prescribing more than one psychotropic

medication to the same individual concurrently over the past 20 years (Olfson, Marcus, & Weissman, 2002; Mojbatai & Olfson, 2009).

Overall, these statistics demonstrate that psychotropic medications are widely prescribed in the United States for both adults and children, and that the rate of per capita use of these drugs has risen sharply during this millennium. Psychotropic medication in combination with counseling is considered the standard of care for many mental health disorders (King and Anderson, 2004), and in a 2002 survey found that 89 percent of counselors reported working with clients on psychotropic medication (England, 2002). In light of the trends towards increasing use of medication since the publication of the studies cited above, there is no question that nearly every practicing counselor will experience clients who are on psychotropic medication, and understanding the ethical and practical implications of working with these clients is an important part of the work of a counselor.

Review of the Literature Part II: Controversy over Medication

All prescription medications in the United States have been through the Food and Drug Administration's approval process, which requires developers to submit research demonstrating efficacy and safety. Critics contend that the FDA approval process is severely flawed; they point to a variety of factors that call some of this research into question, including the short term nature of most of drug trials, biased study designs, lack of research that is independent of pharmaceutical industry funding or influence, conflict of interest among members of review boards, and a phenomenon known as the "file drawer effect" that allows research that did not support safety or efficacy to go unpublished (Angell & Relman, 2002; Murray, 2006; Stip, 2002; Whitaker, 2010). Nonetheless, it must be acknowledged that for all legally prescribed psychotropic medications there is a body of research judged by FDA regulators to demonstrate a degree of efficacy and an acceptable risk profile when used to treat the disorders they were approved to treat.

However, there is also a substantial body of literature that disputes these findings, questioning the safety and efficacy of many of today's commonly used psychopharmacological treatment regimes for mental health disorders. This literature review does not aim to establish which side of the argument is stronger, and arriving at a conclusive answer to the question of whether psychotropic medications are safe, effective, and useful in the treatment of various mental health disorders is well beyond the scope of this project. Instead, the aim is to establish that there are valid scientific questions about the safety and efficacy of psychotropic medication, and legitimate controversy surrounding the increasingly widespread prescribing of these medications.

Given this goal, literature supporting efficacy and safety will not be examined in detail here. The general statistics regarding the increasing rates of prescribing psychotropic medication cited in the preceding section of this paper attest to the fact that considerable attention has already been paid to this research, and considerable power and influence has already been provided to those who give it credence. Instead, this discussion will delve into some of the major areas of concern that have been identified by researchers and other expert commentators who are skeptical about or critical of the science behind these drugs. This section will begin with a discussion of literature that disputes a major assumption upon which the use of these medications is based -- the assumption that there is an established physiologic basis for most mental illnesses that can be treated, corrected, or cured by introducing medication into the body. Next, this section of the literature review will address direct effects of psychotropic medications on the patient, examining literature that moderates or contradicts findings of efficacy safety in three major psychotropic drug classes (neuroleptics, antidepressants and anxiolytics). Finally, this section of the literature review will include a discussion of literature that argues that psychopharmacological treatment may negatively impact overall rates of mental illness.

Disputing Assumptions

In a 2006 literature review published in the Journal of Mental Health Counseling, Thomas L. Murray[1] concludes that "no valid diagnostic tests exist to determine a physical

[1] Thomas L. Murray is the clinical director of counseling services at the University of North Carolina School of the Arts, and an assistant professor at the Wake Forest University School of Medicine.

disease process for the great majority of diagnoses found in the Diagnostic and Statistical Manual of Mental Disorders [DSM]" (p. 310). Murray (2006) points to several different authors in asserting that those disorders listed in the DSM for which a clear disease process has been demonstrated (such as alzheimers disease or dementia), or a clear genetic defect has been identified (such as Rhett's disorder), fall under the prevue of neurology rather than psychiatry. In a March 2005 article in the American Journal of Psychiatry, Kenneth Kendler[2] sums it up as follows:

> We have hunted for big, simple neuropathological explanations for psychiatric disorders and have not found them. We have hunted for big, simple neurochemical explanations for psychiatric disorders and have not found them. We have hunted for big, simple genetic explanations for psychiatric disorders and have not found them. (pp. 234-235)

One of the most commonly held misconceptions about a physiological explanation for a mental health disorder is the widespread belief that research has established that depression is caused by a chemical imbalance in the brain (Deacon & Baird, 2009; France, Lysaker, & Robinson, 2007; Kirsch, 2010; Lacasse & Leo, 2005; Leo & Lacasse, 2008; Pescosolido et al., 2010; Whitaker, 2010). There is general consensus among the scientific community that this theory has not been demonstrated to be true (Blease, 2014; Kirsch, 2010), and Irving Kirsch[3], the director of the Program in

[2] Kenneth Kendler is a distinguished professor and the director of the Virginia Institute of Psychiatry and Behavioral Genetics at Virginia Commonwealth University. He has authored over 700 papers, and is recognized by Thomson Reuters' Science Watch as one of the most cited psychiatry researchers over the past two decades.

[3] Irving Kirsch is the director of the Program in Placebo Studies at the Harvard Medical School and Beth Israel Deaconess Medical Center. He is a professor emeritus at the Universities of Hull and Plymouth in the United Kingdom, and the University

Placebo Studies at the Harvard Medical School, writes that not only is the chemical imbalance hypothesis unproven, "it's about as close as a theory gets in science to being disproven by the evidence" (Kirsch, 2010). However, the idea that a brain chemistry imbalance causes depression is still promoted by the pharmaceutical industry and the psychiatric profession at large (Kirsch, 2010; Leo & Lacasse, 2008), and as much as 80 percent of the American public may believe in the chemical imbalance theory (Park & Ahn, 2014; Leobwitz & Ahn, 2013).

It follows, then, that if there are no proven physiological causes for most mental health disorders, then there is also no proven biological or biochemical mechanism in which psychiatric medications treat those disorders (Blease, 2014; Kendler, 2005; Murray, 2006; Whitaker, 2010), and the observed efficacy of some of these medications with some patients is not fully understood. Yet most of the general public is under the impression that psychotropic medications are well understood by researchers, and many medical professionals do not acknowledge the deficit in knowledge when prescribing these medications (Blease, 2014; Whitaker, 2010). In an April, 2014, article in the Journal of Medical Ethics, Charlotte Blease[4] sums up the issue as follows:

> Taking the case of depression as an entry point … medical researchers and physicians need to pay serious attention to the explanations given to patients regarding their diagnosis. Studies on lay understanding of depression show that there is a common belief that depression is wholly caused by a 'chemical

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of Connecticut. He has authored or edited over 200 scientific journal articles and 10 books, including a 2009 book on depression and SSRIs titled The Emperor's New Drugs.

[4] Charlotte Blease is a research fellow at the University of Leeds in the U.K., and a research affiliate at Harvard Medical School. She has published extensively on ethics in medicine and psychotherapy.

> imbalance' (such as 'low serotonin') that can be restored by chemically restorative antidepressants, a claim that has entered 'folk wisdom'. However, these beliefs oversimplify and misrepresent the current scientific understanding of the causes of depression: first, there is consensus in the scientific community that the causes of depression include social as well as psychological triggers (and not just biochemical ones); second, there is significant dissensus in the scientific community over exactly what lower level, biological or biochemical processes are involved in causing depression; third, there is no established consensus about how antidepressants work at a biochemical level; fourth, there is evidence that patients are negatively affected if they believe their depression is wholly explained by (the vague descriptor) of 'biochemical imbalance'. (p. 225)

As referenced by Blease in the above quote, research has also demonstrated that public misperceptions about the scientific understanding of the etiology of psychological disorders can substantially impact the course and outcome of psychotherapy. In the case of depression, for example, client belief in the chemical imbalance model has been shown to reduce self-blame, but at the cost of increased pessimism about the prospects for recovery and the efficacy of non-medical treatments (Deacon & Baird, 2009). Other research demonstrates that relapse rates are significantly higher for patients treated with medication as compared to patients treated with psychotherapy, and that the difference increases over time (Kirsch, 2010). Research demonstrates that clients who hold the false belief that their symptoms are wholly due to a chemical imbalance tend to experience less autonomy, have a more negative view of their prognosis, are more likely to believe that psychosocial interventions will be ineffective, take less responsibility for their own well being, and are less likely to make behavioral and lifestyle changes that could aid their recovery (Blease, 2014; Deacon & Baird, 2009). Furthermore, measures of community attitudes showed belief in biological etiology of mental health disorders is associated with

increased sigma and community rejection of individuals with those disorders (Deacon & Baird, 2009; Pescosolido et al., 2010).

While this discussion has primarily focused on misperceptions regarding the etiology of depression, Pescosolido and colleagues (2010) and Whitaker (2010) argue that there is a widespread belief that most common psychological conditions, including schizophrenia, anxiety disorders, and drug addiction have a well-established and well-understood genetic and/or biochemical causes, and can be treated using a disease model -- similar to the model used to treat conditions such as cancer or diabetes.

Efficacy

Some may say that it does not matter how psychotropic medications work, or how people think they work, as long as they do indeed work. But there is substantial evidence in the literature that indicates it is far from clear that these drugs are efficacious.

In the case of the neuroleptics, while recognizing that there is substantial evidence for short-term effectiveness, several extensive examinations of the literature (Dixon, Lehman, & Levine, 1995; Murray, 2006; Stip, 2002; Whitaker, 2010) argue that the evidence for long-term effectiveness is questionable at best. For example, in the May 2002 issue of European Psychiatry, psychiatrist Emmanuel Stip[5] published a review of meta-analyses of the effectiveness of various types of first and second-generation

[5] Emmanuel Stip is a psychiatrist and professor at the University of Montreal in Canada. He specializes in the study of psychopharmacological treatment of schizophrenia, and has published more than 350 scientific papers.

neuroleptics, and concluded that "there is currently no compelling evidence on the matter, where 'long term' is concerned" (Stip, 2002, p. 117). A second example comes from investigative journalist Robert Whitaker[6] in his 2010 book titled Anatomy of an Epidemic -- a extensive, albeit non-peer reviewed, examination of the literature regarding the efficacy and safety of psychotropic medication – in which he writes that neuroleptics "were increasing the likelihood that a person who suffered a psychotic break would become chronically ill" (p.104), and concludes that the balance of the evidence demonstrates that long-term recovery rates are higher for patients who do not receive long-term psychopharmacological treatment (Whitaker, 2010). And in a paper published in 2013 in which he examined the results of several long-term studies, researcher Martin Harrow[7] writes:

> Prolonged use of antipsychotic medications is viewed as a key factor in treatment for schizophrenia, but there is very little systematic evidence for the long-term benefits of antipsychotics. There is even some longitudinal data suggesting the opposite. (Harrow & Jobe, 2013)

Following are brief descriptions of some of the studies on which these reviewers based their conclusions:

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[6] Robert Whitaker is an author and investigative journalist. He won the Pulitzer Prize for Public Service in 1999 after writing a series of articles on psychiatric research published in the Boston Globe. He has published three books on psychopharmacology, and is a founder of the organization Mad In America, which is dedicated to rethinking psychiatric care in the United States and abroad.

[7] Martin Harrow is a widely cited researcher at the University of Illinois at Chicago, and has authored over 250 papers on schizophrenia and bipolar disorders. His research has frequently been funded by grants from the NIMH.

• A 1978 study by Maurice Rappaport and colleagues followed 80 males between the ages of 16 and 38 diagnosed with schizophrenia and found that after three years the group that received placebo at the hospital and were off medication at the 3-year follow up exhibited less severe symptoms (1.7 on a 7-point assessment scale) and lower rates of rehospitalization (8 percent) when compared to three other groups, all of whom who were exposed to medication in the hospital or on medication at the 3-year follow up (symptoms ratings for these groups ranged from 2.79 – 3.51, while rehospitalization rates ranged from 47 percent to 73 percent) (Rappaport, Hopkins, Hall, Belleza, & Silverman, 1978). The authors conclude that while antipsychotic medication often reduced symptoms in the short-term, "Our findings suggest … that antipsychotic medication is not the treatment of choice, at least for certain patients, if one is interested in long-term clinical improvement" (p.107).

• A 1978, a study conducted by Loren Mosher and Alma Menn known as the Soteria study followed 129 newly diagnosed schizophrenia patients deemed in need of hospitalization. The subjects were broken into two groups – one that received psychosocial treatment with minimal use of medication, and another that received crisis-oriented treatment involving neuroleptic drugs as the principle treatment. At the end of two years it was found that there was no significant difference the two groups in ratings of symptoms and rates of hospital readmission, but the minimal medication group used significantly less outpatient care, showed significantly better occupation levels, and were more able to live independently (Mosher & Menn, 1978).

• In 1977 the National Institutes of Mental Health (NIMH) conducted a study examining 49 acute schizophrenia patients who received a psychosocial treatment that minimized the use of drugs, and compared their outcomes to 73 similar patients who had been treated principally with neuroleptic drugs. Follow-up at one year and two years showed a "small but significantly superior outcome" for the minimal medication cohort (Carpenter, McGlashan, & Strauss, 1977). The NIH researchers raised the possibility that allowing patients to work through psychosis may benefit long-term outcomes:

> Patients reported experiencing more anguish with our treatment approach, whereas they felt a greater sense of frustration and of being 'frozen in the psychosis' in settings emphasizing drug treatment …. insofar as the psychotic break contains potential for helping the patient alter pathological conflicts within himself and establish a more adaptive equilibrium with his environment, our present-day practice of immediate and massive pharmacological intervention may be exacting a price in terms of producing 'recovered' patients with greater rigidity of character structure who are less able to cope with subsequent life stresses. (Carpenter et al., 1977)

The NIH authors also proposed that neuroleptic medication may render patients less resistant to future relapse:

> There is no question that, once patients are placed on medication, they are less vulnerable to relapse if maintained on neuroleptics. But what if these patients had never been treated with drugs to begin with? … We raise the possibility that antipsychotic medication may make some schizophrenic patients more vulnerable to future relapse than would be the case in the normal course of the illness. Thus, as with tardive dyskinesia, we may have a situation where neuroleptics increase the risk for subsequent illness but must be maintained to prevent this risk from becoming manifest. (Carpenter et al., 1977)

• A more recent long-term study of outcomes parallels these earlier findings. Harrow and Jobe (2007) followed a group of 64 individuals from diverse backgrounds diagnosed with schizophrenia. At a 15-year follow up, he found that 40 percent of those who were off medication were "in recovery," 16 percent of them were found to be faring "uniformly poor," and 28 percent of them suffered from psychotic activity. Among the medication group, only five percent were judged to be "in recovery," 49 percent were rated as faring "uniformly poor," and 68 percent were actively psychotic (Harrow & Jobe, 2007). The researchers concluded that "the off-medication subgroup tended to show better global outcomes at each followup" (p.411).

• In the July 3rd, 2013 issue of JAMA Psychiatry, researcher Lex Wunderlink and colleagues published the results of a randomized, controlled trial of two treatment models for psychotic patients who had been stabilized using medication, and found that the group that received reduced medication or discontinued medication after stabilization had dramatically higher rates of recovery than the group that was maintained on a standard dose of medication. They concluded that trials for antipsychotics needed to include long-term follow-ups and to use recovery or functional remission rates as the primary outcome measure (Wunderink, Nieboer, Wiersma, Sytema, & Nienhuis, 2013).

Commenting on the Harrow and Wunderlink studies, Thomas Insell[8], the Director of the National Institute of Mental Health, wrote in a 2013:

[8] Thomas Insel has served as the director of the National Institute of Mental Health since 2002. Prior to that he was a professor of psychiatry at Emory University, where he served as director of both the Center for Behavioral Neuroscience and the Center for Autism Research. He has published over 250 scientific papers and four

> What does this say about the long-term use of antipsychotics? Are they potentially harmful? Are they necessary for an individual's entire lifetime? … we need to ask whether in the long-term, some individuals with a history of psychosis may do better off medication. (Insel, 2013)

• The largest study of this sort was a 2-year NIMH trial that examined more than 400 patients who had experienced first-episode psychosis, and broke them into one group that received an integrated treatment that involved minimal medication, and a second group that received standard treatment. According to initial results published in the fall of 2015, at the end of the two-year study the minimal medication group had lower symptom ratings and higher quality of life ratings than the standard care group (Kane et al., 2015).

• A series of studies in the 1990s and 2000s used animal research and magnetic resonance imaging techniques to suggest that psychosis is linked to increased sensitivity to dopamine in the brain – known as the dopamine supersensitivity theory -- and to demonstrate that prolonged use of antipsychotics leads to an increase in number and sensitivity of brain receptors that respond to dopamine (Gur et al., 2014; Samaha, Seeman, Stewart, Rajabi, & Kapur, 2007; Seeman et al., 2005). These studies point to a possible explanation of why some patients may experience decreased efficacy with long-term use of antipsychotics. The authors of one of the studies explained it as follows:

> Thus, the loss of antipsychotic efficacy is linked to an increase in D_2 receptor number and sensitivity. These results … demonstrate that "breakthrough" supersensitivity during ongoing antipsychotic treatment undermines treatment efficacy. (Samaha et al., 2007)

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books, and has received the Outstanding Service Award for the U.S. Public Health Service.

• A 1987 World Health Organization study and subsequent 5-year follow up showed "considerably better course and outcome" for schizophrenia treatment in developing nations (where patients were maintained on neuroleptics only 16 percent of the time), compared to recovery rates in developed countries (where neuropleptics were used as a long-term treatment 61 percent of the time) (Jablensky et al., 1992). A 15-year follow up concluded that this outcome differential held up over time, finding that in developing countries 53 percent of study subjects were never psychotic anymore, and 73 percent were employed (Hopper & Wanderling, 2000).

It is beyond the scope of this paper to cover every study on neuroleptics that produced similar findings to the research cited above. Data from Australia, Finland, Germany and the U.K. adds to the evidence that there is a legitimate reason to wonder about the efficacy of neuroleptics over the long-term (Aderhold, Weinmann, Hägele, & Heinz, 2014; Gleeson et al., 2013; Johnstone, Macmillan, Frith, Benn, & Crow, 1990; Seikkula et al., 2006). Overall, there is abundant evidence to conclude that doubts and questions about the efficacy of long-term use of neuroleptics are legitimate. Here's how the former editor of the British Journal of Psychiatry, Peter Tyrer[9], put it:

> It is time to reappraise the assumption that antipsychotics must always be the first line of treatment for people with psychosis. This is not a wild cry from the distant outback, but a considered opinion by influential researchers . . . [there is] an increasing body of evidence that the adverse effects of [antipsychotic] treatment are, to put it simply, not worth the candle. (Tyrer, 2012)

[9] Peter Tyrer is a professor for community psychiatry in the Centre for Mental Health at Imperial College in London. He stepped down as the editor of the British Journal of Psychiatry after 10 years of service in 2013.

Turning now to the subject of antidepressants, as with neuroleptics, there are numerous literature reviews that question the efficacy of these medications. Whitaker (2010) argues that demographic data and research from the pre-drug era indicates that depression was once considered to be a relatively rare disorder that primarily affected older people and was rarely chronic, and suggests that modern conceptions of the disorder as progressive and chronic are at least partially due to the increasingly widespread use of antidepressants over the past 25 years. Another major review of four meta-analyses as well as a large NIMH-funded trial finds that "antidepressants are only marginally efficacious compared to placebos," and asserts that there is "profound publication bias that inflates their efficacy" (Pigott, Leventhal, Alter, & Boren, 2010). The authors conclude that, "The reviewed findings argue for a reappraisal of the current recommended standard of care for depression" (p.1). And Italian academic Giovanni Fava[10] has conducted several literature reviews on the efficacy of antidepressants; he concludes that:

> Antidepressant drugs in depression might be beneficial in the short term, but worsen the progression of the disease in the long term, by increasing the biochemical vulnerability to depression . . . Use of antidepressant drugs may propel the illness to a more malignant and treatment unresponsive course. (Fava, 1994)

And Irving Kirsch of the Harvard Medical School (see footnote 3), wrote a book

[10] Giovanni Fava is the editor-in-chief of the journal Psychotherapy and Psychosomatics. He is a professor of clinical psychology at the University of Bologna in Italy.

in 2009 aimed at publicizing the research on depression and SSRIs, concluding that "Depression is not caused by a chemical imbalance in the brain, and it is not cured by medication" (Kirsch, 2010), adding that:

> Depression is a serious problem, but drugs are not the answer. In the long run, psychotherapy is both cheaper and more effective, even for very serious levels of depression. (Kirsch, 2010)

Again, this paper will examine some of the research on which these reviewers base their conclusions.

• Following the development of Selective Serotonin Reuptake Inhibitors (SSRIs), a review of the clinical data submitted to the FDA for approval of seven of these drugs found they fared slightly better than placebo, but no better than the earlier generations of antidepressants (Khan, Warner, & Brown, 2000), which had already been found to be of dubious efficacy (Whitaker, 2010).

• An analysis of data submitted to the FDA on 12 different types of SSRI found that selective reporting of results had biased the approval process; the researchers found that about half of the clinical trials demonstrated the drugs to be ineffective, but that almost all of the negative studies were either not published, or were published in a manner that "conveyed a positive outcome" (Turner, Matthews, Linardatos, Tell, & Rosenthal, 2008).

• In 2008, Kirsch and colleagues conducted a third analysis of SSRI research submitted to the FDA, looking at 35 trials (which included more than 5000 subjects), and

examining the relationship between efficacy (as defined by superior symptom reduction to placebo) and severity of depression. The analysis concluded that there was no clinically significant benefit to the drugs among all but the most severely depressed patients -- and even among the most severely depressed group, the increase in relative efficacy of the medication resulted from decreased placebo response among those patients (Kirsch et al., 2008).

• In 2004, a NIH-funded study followed 126 patients diagnosed with major depressive disorder and provided psychopharmacological treatment delivered under conditions specifically designed to maximize clinical outcomes. During a series of follow-ups over a 12-month period, the researchers found "remarkably low response and remission rates" (p.50) -- sustained response rates of of 10.5 percent to 14.4 percent, and sustained remission rates of three percent to 5.1 percent (Rush et al., 2004).

• In 2010, the NIMH sponsored the largest study of depression ever conducted – the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) study – which examined various psychopharmacologic approaches to treating major depressive disorder. More than 4,000 subjects enrolled in the trial and were started on an SSRI, but according to an examination of the data published in 2010, only about a quarter of the participants remitted during this first phase of treatment, which included an SSRI alone (Warden, Rush, Trivedi, Fava, & Wisniewski, 2007). Those who did not respond to the SSRI received a sequence of additional treatments designed to maximize the likelihood that patients would achieve remission. Despite a change to a measurement instrument with more lenient remittance criteria partway through the trial, according to Pigott

(2010), only about 46 percent of the subjects remitted at any point during the four phases of the STAR-D study, and only about six percent remitted and stayed well throughout treatment and 12-month follow-up -- the remaining 94 percent failed to remit, remitted and then relapsed, or dropped out (Pigott et al., 2010).

• A NIMH-funded 2006 study the examined the "naturalistic course" of 84 patients diagnosed with major depressive who were not medicated found that 67 percent had recovered after six months, and 85 percent were recovered after 12 months (Posternak et al., 2006). The authors concluded that:

> If as many as 85% of depressed individuals who go without somatic treatment spontaneously recover within one year, it would be extremely difficult for any intervention to demonstrate a superior result to this.

• Longitudinal data from Dutch and Canadian researchers find that depressed patients exposed to antidepressants are more likely to relapse and have longer relapses than those who are never treated with medication (Patten, 2004; Weel-Baumgarten, Van den Bosch, Hekster, Van den Hoogen, & Zitman, 2000).

• A 2012 analysis of data from clinical trials found that the 3-month relapse risk for remitted patients who were on an SSRI was twice as high as for patients who were on placebo (43 percent and 21 percent respectively) (Andrews, Thomson, Amstadter, & Neale, 2012).

• A 2011 animal study demonstrated that SSRIs led to markedly decreased serotonin in nine areas of the brains of rats, and that those deficiencies were associated

with increased depressive and anxious behaviors (El-Mallakh, Gao, & Roberts, 2011). The authors of that study hypothesize that SSRIs may impair serotonergic pathways in the brain of the brain over time, and lead to a state known as tardive dysphoria:

> A chronic and treatment-resistant depressive state is proposed to occur in individuals who are exposed to potent antagonists of serotonin reuptake pumps (i.e. SSRIs) for prolonged time periods. Due to the delay in the onset of this chronic depressive state, it is labeled tardive dysphoria. Tardive dysphoria manifests as a chronic dysphoric state that is initially transiently relieved by -- but ultimately becomes unresponsive to -- antidepressant medication. Serotonergic antidepressants may be of particular importance in the development of tardive dysphoria. (pp. 769-773)

There is substantially more literature that suggests that antidepressants are only about equal to placebo in treating depression in the short term, and that they could contribute to chronicity and worsen long-term outcomes, but covering each study in detail is beyond the scope of this paper. The evidence presented above is sufficient to support the assertion that there is valid scientific reason to question the efficacy of antidepressants and think critically about the standard psychopharmacological treatment model for many depressed clients.

This paper will now briefly look at anxiolytics, which come under fire not for being ineffective per se (at least over the short term), but for potentially causing significant cognitive impairment and emotional blunting, thereby reducing the effectiveness of psychotherapy, and overall treatment (Murray, 2006; Finn, 2001; Breggin, 2013). Finn (2001) found that benzodiazepines can lead to significant cognitive impairment that results in a client retaining less information delivered as part of a

cognitive therapy program as compared with clients who are not medicated. Breggin (2013) finds that although anxiolytics can reduce short-term anxiety, their use may distract from and interfere with recovery and lead to chronicity. Furthermore, researchers have established that anxiolytics have a short-lived effect, and pose a serious risk for tolerance, interdose rebound, and may worsen anxiety, insomnia, and cause panic disorder symptoms with long term use (Breggin, 2013; Whitaker, 2009).

Broadening the discussion to all classes of psychotropic medication, psychiatrist Peter Breggin explains that on a biochemical level the brain attempts to suppress and even reverse the chemical effects of any psychoactive substance that is introduced into the body, and that this compensatory effect, or tolerance, often increases with the amount of time a patient stays on the medication (Breggin, 2013). And NIMH Director Thomas Insel wrote that "medications may be less effective for the outcomes that matter most to people with serious mental illness: a full return to well-being and a productive place in society" (Insel, 2013).

Safety

Nearly all psychiatric drugs have known side effects. In fact, according to psychiatrist and prominent critic of the current psychiatric paradigm Peter Breggin[11],

[11] Peter Breggin has authored more than 20 books, many of them focused on criticisms of current psychopharmacological treatments and the current, drug-centered psychiatric paradigm. He has served on the NIMH, and on the faculties at Washington School of Psychiatry, Johns Hopkins University, and George Mason University.

every psychiatric drug that has been studied for side effects has "proven to be toxic to neurons or severely disruptive of normal brain function" (Breggin, 2013, p. xxiv). The common assumption is that these side effects are infrequent enough and/or mild enough to be outweighed by the benefits of medication in the majority of cases. Questions about efficacy (discussed above), and whether the supposed benefits have been overstated, could skew this equation. Another factor that could skew this equation is the potential misunderstanding or misrepresentation of the severity and frequency of the side effects. This section of this paper will focus on literature that suggests that potential adverse effects of psychotropic medication are often underestimated by pharmaceutical manufacturers and doctors, and misunderstood by patients.

Murray (2006) points out that any discussion of side effects must begin with the understanding that once a medication has been approved by the FDA, there is no requirement for prescribing physicians, other health care practitioners working with the patient, or manufacturers to report side effects to regulators. In the same paper, Murray goes on to assert that many studies during the approval process simply do not last long enough for some of the most significant side effects to emerge (Murray, 2006).

There are dozens of articles, books and scientific papers that engage in extensive discussion of side effects from many classes of commonly used psychotropic medications, including neuroleptics, antidepressants, anxiolytics, and mood-stabilizers. A full examination of the potential side effects they outline is beyond the scope of this paper, but among the side effects mentioned in the literature for these four classes of drugs are: changes in metabolic functioning that could lead to diabetes, possible declines

in cognitive functioning, a link to a neurocognitive brain disorder known as tardive dyskinesia, parkinsonism, akathisia, dystonic symptoms, memory loss, sexual dysfunction, impotence, blurred vision, blindness, fatal blood clots, seizures, and potential birth defects (when used by a pregnant woman) (Breggin, 2012; Glenmullen, 2006; Harper, 2007; Murray, 2006; Whitaker, 2010). Many of these side effects are not recognized by the mainstream psychology (Murray, 2006; Whitaker, 2010).

Additionally, Murray (2006) cites reports of new or increased psychosis and mania after the introduction of antipsychotic or antidepressant medications, and is highly skeptical of pharmaceutical industry explanations that rather than causing the new symptoms, the medication instead stabilizes the patient to the point that "latent" symptoms can be recognized. Increased risk of suicide, while not technically considered a side effect, has been linked to several of these classes of medication, prompting regulators to require that they be labeled with "black box" warnings.

Breggin (2013) explains that the damaging effects of many psychotropic drugs are sometimes masked by the blunting of emotions or a phenomenon known as intoxication anosognosia, which renders an individual unable to recognize or gauge the adverse mental and behavioral effects of the drug. He goes on to explain that long-term exposure to many psychotropic medications can lead to chronic brain impairment (CBI), which can involve cognitive dysfunction, emotional instability, apathy, indifference, and a severe loss of quality of life that goes unrecognized by the patient (Breggin, 2013).

Commenting on findings of decreased cognitive and executive functioning associated with neuroleptics, the former editor of the American Journal of Psychiatry, Nancy Andreasen[12], told the New York Times:

> What exactly do these drugs do? They block basal ganglia activity. The prefrontal cortex doesn't get the input it needs and is being shut down by drugs. That reduces psychotic symptoms. It also causes the prefrontal cortex to slowly atrophy. (Dreifus, 2008)

There is also considerable debate about the addictive potential of many of psychiatric drugs. Some, such as benzodiazepines, are widely acknowledged to have high potential for addiction and abuse. But with many others, there is debate over whether complications upon discontinuation of the medication signal a return of the patient's original pathology, or are in fact symptoms of withdrawal (what the psychiatric community refers to as "discontinuation syndrome"). However, there is substantial literature supporting the argument that psychiatric drug withdrawal is a real and dangerous phenomenon (Breggin, 2012; Glenmullen, 2006; Harper, 2007).

Breggin (2013) asserts that because the brain adapts to any psychoactive substance that is introduced into the body, "the abrupt withdrawal from any psychiatric drug can produce distressing and dangerous withdrawal reaction" (p. xxii). Among the effects listed by those who have studied psychiatric drug withdrawal or developed an expertise around working with clients who have chosen to discontinue use of

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[12] Nancy Andreasen is a neuroscientist and neuropsychiatrist. She served as editor-in-chief of the American Journal of Psychiatry for 13 years, stepping down in 2006. She has received numerous awards for her work, including the National Medal of Science. She currently holds a psychiatry chair at the University of Iowa's Carver College of Medicine.

psychotropic medication are severe depression, mania, psychosis, violence, and suicidality (Breggin 2013, Harper & Austin, 2007; Whitaker, 2011; Glenmullen, 2006). Paradoxically, for some individuals the decrease in cognitive deficits when medication is reduced or discontinued can sometimes serve to make them more aware of their mental deficits, leading to anxiety and despair (Breggin, 2013). However, it is sometimes difficult to distinguish between withdrawal effects and direct long-term toxic effects of the drug (Breggin, 2013).

Overall, the literature on the side effects and addictive potential of psychotropic drugs clearly demonstrates that there are numerous valid reasons to question whether these medications are as safe as many counselors and their clients may believe.

Medication and Rising Rates of Mental Illness

Journalist Robert Whitaker (see footnote 6) has devoted three books and dozens of articles to investigating whether increasing rates of psychopharmacological medication use in the United Sates are causing, rather than being caused by, increasing rates of mental illness. While acknowledging that psychiatric drugs are often effective in the short term and help many people stabilize, in an article in the spring, 2005, issue of Ethical and Human Psychology and Psychiatry, Whitaker concludes that:

> Over the past 50 years, there has been an astonishing increase in severe mental illness in the United States. The percentage of Americans disabled by mental illness has increased fivefold since 1955, when Thorazine -- remembered today as psychiatry's first "wonder" drug -- was introduced into the market. The number of Americans disabled by mental illness has nearly doubled since 1987, when Prozac

> -- the first in a second generation of wonder drugs for mental illness -- was introduced. There are now nearly six million Americans disabled by mental illness, and this number increases by more than 400 people each day. A review of the scientific literature reveals that it is our drug-based paradigm of care that is fueling this epidemic. The drugs increase the likelihood that a person will become chronically ill, and induce new and more severe psychiatric symptoms in a significant percentage of patients. (p. 23)

In reviewing Whitakers claims, the former editor-in-chief of the New England Journal of Medicine, Marcia Angell[13], writes that, "The evidence [Whitaker] marshals for his theory varies in quality," but concludes that, "Nevertheless, his evidence is suggestive, if not conclusive" (Angell, 2011). In the same article, Angell sites data showing even larger increases in mental health disability rates than those Whitaker referenced (her data was slightly more up to date), including a 35-fold increase since 1987 in children diagnosed with mental health disabilities. She goes on to raise a number of questions:

> What is going on here? Is the prevalence of mental illness really that high and still climbing?... And what about the drugs that are now the mainstay of treatment? Do they work? If they do, shouldn't we expect the prevalence of mental illness to be declining, not rising? (Angell, 2011)

Again, rather than attempt to provide answers to the questions raised by Angell, Whitaker, and others in this section of the literature review, this paper argues that it is

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[13] Marcia Angell is medical doctor and served as the editor-in-chief at the New England Journal of Medicine from 1999-2000. She was the first woman to serve in that position. She is currently a senior lecturer at Harvard Medical School. She has written extensively on medical ethics, and has authored four books. She is also a fellow on the Committee for the Scientific Investigation of Claims of the Paranormal and an outspoken critic of medical quackery and the promotion of alternative medicine.

appropriate for professional counselors, counselors in training and counselor educators to be asking the same questions.

Review of the Literature Part III: Counseling and Psychotropic Medication

Section I of this literature review cited statistics that made it clear that psychotropic medications are some of the most commonly used drugs in the United States and around the world, and that most counselors must expect that some of their clients will be taking one or more of these medications. Section II of this literature review established that there are valid scientific questions regarding the safety and efficacy of these medications, and a legitimate controversy about their impact on individuals and communities. Yet two important questions remain: Do counselors have a professional role in the discussion about psychotropic medication? And is it appropriate for the controversy over psychotropic medication to impact their work with clients?

This part of the literature review will provide evidence from the literature that the answer to both these questions is "yes." It will begin by looking at literature that discusses how the medical model and the increasing prevalence of psychopharmacological treatments for mental health disorders have impacted the practice of counseling and influenced the field as a whole. It will also include an examination of relevant parts the American Counseling Association's (ACA's) Code of Ethics and other ACA counseling competencies that should serve as guides to counselors in their work with clients as it pertains to psychotropic medication.

Counseling and The Medical Model

Despite the significant questions that have been raised about psychiatric medication and the medical model as it pertains to mental health treatment, a substantial body of counseling literature suggests that counselors have nevertheless been traditionally expected to "buy in" to many aspects of standard psychiatric treatment protocols. The Council for Accreditation of Counseling and Related Educational Programs (CACREP) standards specify that core skills for counselors in training include learning how to conduct medical referrals (CACREP, 2015), and surveys of psychotherapists confirm that a significant number of these referrals are for potential psychopharmacological treatments (K. J. Bentley, Walsh, & Farmer, 2005). "Medication compliance" is a term that is often used among mental health practitioners, including counselors, with the implication being that one of the duties of counselors and other psychotherapists is to encourage their clients to stay on prescribed medication (Breggin, 2013) – or, as one scholar put it, serving as a "physician assistant, supporting recommendations of medical use" (K. Bentley & Walsh, 2013). Medication compliance is also often referenced as a protective factor when assessing for suicide risk (Gonzalez-Pinto et al., 2006). Taken at face value, it is reasonable and appropriate to expect counselors to perform the above-mentioned duties; even prominent critics of today's psychiatric practices agree that there are cases when use of psychotropic medication is called for (Whitaker, 2011; Breggin, 2013), and research demonstrates that altering or quitting a medication regime without medical supervision can have dramatic negative consequences (Breggin, 2013). However, in a broader sense, one consequence

of this aspect of the work of a counselor is that it has encouraged counselors to implicitly or explicitly endorse the current psychiatric paradigm, and encourage the popular belief that psychiatry overall has made great strides in the treatment mental illness over the past 50 years (Murray, 2006; Breggin, 2013; Whitaker, 2011).

A significant number of commentators have voiced concerns about how the medical model paradigm impacts counselors and other helping professionals. In a December 2011 article in the Journal of Sociology and Social Welfare, Gomory, Wong, Cohen and Lacasse discuss the impact on clinical social workers:

> [T]he biomedical industrial complex has ensnared social work within a foreign conceptual and practice model that distracts clinical social workers from the special assistance that they can provide for people with mental distress and misbehavior … We urge social work and other helping professions to exercise intellectual independence from the reigning paternalistic drug-centered biomedical ideology in mental health and to rededicate themselves to the supportive, educative, and problem-solving methods unique to their disciplines. (p. 135)

Writing in the October 2006 issue of the Journal of Mental Health Counseling, Thomas L. Murray Jr. takes the argument a step further. He states that more than just potentially distracting counselors from the core tenets of their profession, "associating with and imposing particular assumptions about the biological etiology of mental disorders on clients" (p. 330) could in fact be damaging to counseling clients. He explains that instilling the belief in a client that he or she has a disease of the mind is in direct opposition to counseling's foundational principles that involve confirming in clients that

their pain is real, understandable, and they are not broken or in need of fixing. Murray goes on to say:

> It is through that connection to humanity that counselors promote the healing power of relationships and walk with their clients out of their darkness. Reclaiming this healing power that is so closely tied to our heritage and rejecting the medicalization of the counseling profession is paramount for the future of counseling to remain true to its founding principles. (Murray, 2006, p. 331)

In the same paper, Murray calls for more "discourse concerning the problems associated with psychotropic medications and the adoption of psychopharmacology practices as part of the professional counselor agenda" (p. 309).

There is, therefore, a strong basis in the literature to conclude that the movement towards the medical model in counseling and the lack of discourse about the potential negative effects of psychopharmacological medications may be a disservice to counseling clients and the counseling profession as a whole.

The Role of the Counselor

Having established that there is valid scientific basis for counselors to question the overall safety and efficacy of some psychotropic treatment regimes (see Part II of this literature review), and having established that uncritically endorsing or embracing the medical model could be a disservice to counseling clients and the profession as a whole (see preceding section), we turn now to the question of what is appropriate for a

counselor to do when working with clients who are on psychotropic medication, or considering taking it.

Ethical Codes

While there is no mention of psychotropic medication in the ACA's Code of Ethics (ACA, 2014), the code specifies in section C.2.a that counselors must practice "within the boundaries of their competence." As referenced above, there are some who believe this means that counselors should, in all cases, defer to prescribers when it comes to psychotropic medication, without conducting their own independent evaluations of the suitability and potential consequences of the pharmaceutical treatment. However, this interpretation has been challenged by many, among them psychiatrist Peter Breggin, who writes: "Therapists can no longer assume that a prescription, once written, should be continuously taken by the patient and that their professional role is limited to encouraging or monitoring compliance" (Breggin, 2013, p.3). Further examination of the ACA code of ethics and other literature about the profession of counseling reveals that there is substantial justification, and even a mandate, for counselors to explore all aspects of the issue of psychotropic medication with clients when it is relevant to their treatment.

Bearing in mind the ethical guideline mentioned above, which makes it clear that counselors must explain the limitations of their educational and professional expertise when they are talking to clients about psychotropic medication, the ACA Code of Ethics (2014) also provides a framework that leaves considerable room for counselors to address

this issues with clients from a variety of perspectives. Section A.1.a of the code states that, "The primary responsibility of counselors is to respect the dignity and promote the welfare of clients." The code also specifies in section A.7.a that it is appropriate for counselors to engage in advocacy to address issues that could interfere with growth and development of clients. These two points can guide counselors to engage in discussions aimed at educating clients on psychotropic medication, and to help them assess or reassess its potential benefits and drawbacks. These points in the code of ethics also make it clear that it falls within the prevue of counseling for the clinician, when appropriate, to engage in advocacy counseling as well as direct advocacy regarding the issue of psychotropic medication. Section C.2.f of the code also directs counselors to stay informed and up to date on "current scientific and professional information in their fields of activity," and states that counselors must not engage in practices when "substantial evidence" suggests those practices could be harmful to the client. Taken together, and bearing in mind the questions raised earlier in this paper about the safety and efficacy of psychotropic medications, these points should be carefully considered by counselors when they make medical referrals for the purpose of possibly helping the client to gain access to such medication, or engage in efforts designed to encourage clients to "comply" with psychopharmacological treatment. And finally, section A.2.a of the code dealing with informed consent states that counselors must provide clients with adequate information about the counseling process in order to allow them to exercise their freedom to choose whether or not stay in the counseling relationship. Given the evidence that the use of psychotropic medication can negatively impact the counseling process and counseling outcomes discussed earlier in this paper, it could be argued that discussing

these issues with clients who are on psychotropic medication should be part of the informed consent process.

Advocacy

The ACA Advocacy Competencies (Lewis, Arnold, House, & Toporek, 2002) encourage counselors to identify social, political, economic, and cultural factors that affect the client (Lewis et al., 2002). Given the controversy about the efficacy of psychotropic medication, the potential dangers of this medication, and the economic, political, and cultural issues involved with the research, marketing, and dissemination of information about psychotropic medications, these competencies can guide counselors when working with clients on issues involving psychotropic medication.

In the dimension of empowerment, the advocacy competencies guide counselors to help the individual to recognize external barriers to development, and to train clients in self-advocacy skills, help them develop self-advocacy plans, and help them to implement these plans (Lewis et al., 2002). When considered in the context of the controversy around psychotropic medication, these competencies can be seen as guiding counselors to engage in discussions with clients that encourage them think critically about these medications and to advocate for themselves when interacting with a prescriber.

In the dimension of direct advocacy for the client, among the steps counselors are encouraged take are development of a plan of action for confronting external barriers to

client development, identification of potential allies for confronting these barriers, and execution of the plan (Lewis et al., 2002). Again, considering the issues raised about psychotropic drugs in this paper and elsewhere, this competency can be seen as guiding a counselor to attempt to determine whether a relevant psychopharmacological treatment or relationship with a prescriber might be a barrier to client development, and if so, to work with family members, medical providers, and other individuals to confront this issue.

When counselors identify systemic barriers to a client's development or well being, the advocacy competencies encourage counselors to work on "altering the status quo" (Lewis et al., 2002). This competency can be seen as guiding counselors to join the broader discussion about the psychiatric paradigm and the medical model when it comes to treating mental health concerns. Writing about advocacy in counseling, Ratts, Lewis, and Toporek (2010) argue that counselors are ideally trained to be "change agents" (p.4). They go on to encourage counselors to be bold in their advocacy efforts, stating that counselors often need to "step outside of the rigid and often unyielding boundaries placed on them by professional organizations as well as certification and accreditation bodies" (Ratts, Lewis and Toporek, 2010, p.3).

Multicultural Considerations

ACA's Multi-Cultural and Social Justice Competencies direct counselors develop knowledge and acquire skills to analyze how "historical events and current issues shape the worldview, cultural background, values, beliefs, biases and experiences of privileged

and marginalized clients" (Ratts, et al, 2015). A 2013 analysis from the General Accounting Office (GAO) on data from the Department of Health and Human Services (HHS) on the use of psychotropic medication among children indicates that lower socio-economic status is positively associated with higher rates of psychotropic medication use. According to the GAO, 4.8 percent of privately insured children nationwide are on psychotropic medication, compared to 6.2 percent of non-institutionalized children on Medicaid. Further, the Medicaid children were nearly three times as likely as privately insured children to be on antipsychotic medication. The GAO analysis also found that about 18 percent of children in foster care were prescribed psychotropic medication. In 2012, the National Survey of Child and Adolescent Wellbeing found that among the foster care children, the rate of psychotropic medication use among those in non-relative parent care, group homes, or residential treatment centers was about 30 percent – more than 6 times the rate of privately insured children -- with about 13 percent of those children on three or more psychotropic drugs. While there are likely a variety of reasons for the differences in psychotropic medication use among these groups of children, it seems clear that it is likely that privilege and socio-economic status play roles in whether or not a child is prescribed psychotropic medication. And given the multi-cultural and social justice related responsibilities of counselors cited above, it is important that counselors are aware of these statistics, and take action to try to understand the reasons for them, as well as their implications for clients and communities.

A number of studies have also found differential prescription patterns related to ethnicity (Connolly, 2010; Daumit et al., 2003; Lloyd & Moodley, 1992). For instance, research published in the August, 2002, issue of the Journal of Clinical Psychiatry found

that African Americans diagnosed with bipolar disorder were more likely to be prescribed antipsychotics, were prescribed antipsychotics for longer, and were more likely to receive the drugs even in the absence of psychotic symptoms than white patients with similar demographic backgrounds who received the same diagnosis (Fleck, Hendricks, DelBello, & Strakowski, 2002). And, in his 2002 examination of the history of psychiatry titled *Mad In America*, Robert Whitaker says that African Americans are also more likely than whites to be diagnosed and medicated for schizophrenia (Whitaker, 2002). Again, when considered in the context of counseling competencies regarding multiculturalism and social justice, the literature on ethnicity and prescribing practices makes it clear that counselors must be vigilant regarding issues of psychotropic medication when working with clients from marginalized populations.

Counselor Education

The latest CACREP Standards require counselor education programs to provide students with an understanding of the classifications, indications, and contraindications of psychotropic medications for appropriate medical referrals "and consultation" in several specialty areas: addictions counseling, clinical mental health counseling, rehabilitation counseling (CACREP, 2015). The standards also require that students understand how these medications can impact marriages, couples and families (CACREP, 2015). These requirements indicate that it is appropriate for counselors to understand how psychotropic medication can impact a client both positively and negatively, and to act on that knowledge.

Existing Recommendations

Several authors have produced recommendations for counselors who are working with clients who are struggling with psychotropic medication. In 1999, Breggin and Cohen issued a set of guidelines for counselors; while taking care to stress that counselors should not pressure clients to take any particular position, and should warn clients about the dangers of abruptly stopping medication, they also suggest it is appropriate to inform clients about both sides of the debate, recommend consultations and readings from both viewpoints, and share knowledge about potential adverse effects of medication (Breggin & Cohen, 1999). Breggin followed up this work by developing what he calls a person-centered collaborative approach to psychiatric drug withdrawal, and devotes a substantial part of a recent book on the treatment to describing the role of the counselor or therapist (Breggin, 2012). And Murray and Murray (2007) assert that counselors "maintain an ethical obligation to learn about and help their clients understand issues surrounding the prescribing and use of psychotropic medications" (pp. 2-3), suggesting that the first step to addressing these issues is for counselors to examine their own values and beliefs regarding the benefits, risks, and usefulness of this type of medication.

Recommendations

This paper has demonstrated that there is legitimate reason to question the efficacy and safety of a variety of psychotropic medications (literature review Part II). This paper has also demonstrated that it is appropriate for a professional counselor to engage in substantive discussions that go beyond mere medication monitoring about psychotropic medication with clients who are taking this type of medication, or considering taking it (literature review Part III). The following section will present recommendations for professional counselors who are working with such clients, as well as recommendations for counselors in training and counselor educators about preparing future counselors to work with such clients. Finally, this section will also include an examination of how the ACA Advocacy Competencies can be used to work with clients around the issue of psychotropic medication.

General Recommendations

Recommendations for Professional Counselors

1. As outlined in the ACA code of ethics, examine your own attitudes, beliefs, values and biases about psychotropic medication.
2. As outlined in the ACA code of ethics, fully disclose to your client the limits of your education and competence regarding psychotropic medication.

3. As outlined in the ACA code of ethics, in the course of discussing informed consent, cover research on how psychotropic medication use may have either a positive or negative impact psychotherapy outcomes.
4. As outlined in the ACA code of ethics, keep abreast of current research on psychotropic medication, as well as trends in prescribing.
5. Be aware of conflicts of interest that could impact researchers or other sources of information about psychotropic medications; always look into financial disclosures and funding of the sources of information.
6. When a client is on psychotropic medication, be willing to explore that experience with them. Ask about the symptoms they experienced, the diagnosis, and the specialty of the prescriber. Ask about what they were told to expect from the treatment. Ask about their response the medication and side effects. Engage in psycho-education in order to attempt to provide them with a broad perspective on what is and is not known about psychotropic medication.
7. When a client is on psychotropic medication, encourage them to develop a long-term plan in collaboration with the prescriber. How long do they expect to be on the medication? How will they know when it is time to discuss discontinuing the medication?
8. When a client is on psychotropic medication, be willing to share observations and collaborate with the prescriber (with client permission).

9. Never advise a client not to take psychotropic medication; or to discontinue or cutback on psychotropic medication they are already on.
10. In discussions about starting psychopharmacological treatment, emphasize client choice. Help to educate the client on potential benefits and risks, as well as non-psychopharmacological treatments. Encourage the client to gather information from a variety of different sources and to educate themselves about all sides of the issue.
11. In discussions about discontinuing or cutting back on psychotropic medication emphasize client choice. Be sure the client understands the risks associated with abruptly changing medication dosage and the importance of medical supervision.
12. Develop relationships with prescribers or other medical professionals who can serve as referrals for clients interested in more professional consultation on this issue.
13. Develop relationships with appropriate healthcare professionals who can serve as referrals for clients interested in discontinuing use of psychotropic medications.
14. If a client is open to educating himself/herself on psychotropic medication, refer him/her to readings or other sources of information that will provide a variety of perspectives on the benefits and risks of such medication.
15. When appropriate, use ACA advocacy competencies to frame your work with clients around the issue of psychotropic medication.

Recommendations for Counselors in Training

1. Educate yourself about the issue from a variety of perspectives, including the research on efficacy and safety, the multicultural and social justice implications, and how medication can impact the course and outcome of psychotherapy.
2. Examine your beliefs, attitudes, values and biases regarding this issue.
3. Discuss this issue with faculty in your training program, and advocate for more training on this issue if you feel that there is not adequate information being provided in the curriculum.

Recommendations for Counselor Educators

1. Consider adding curriculum on psychopharmacology to educate students on effects, efficacy, and safety.
2. Consider adding coursework on the multicultural and social justice implications of the controversy surrounding psychotropic medication.
3. Consider adding curriculum that helps students to understand how to work with clients who are on medication from an advocacy perspective.
4. Consider adding coursework that helps students understand how to work with clients who are seeking to go off of medication, and how to refer them to medical professionals who can help with this.
5. Consider adding coursework that allows students to examine how the medical model impacts counselor identity and the counseling profession.

Using the Advocacy Framework

The ACA Advocacy Competencies are divided into six types of advocacy: Empowerment advocacy, direct client advocacy, community collaboration, systems advocacy, advocacy in the public arena, and social/political advocacy. This section of this paper will briefly outline how a counselor could work in each of these areas of advocacy as it relates to possible negative impacts of psychotropic medication on both micro and macro levels. Appendix A will provide a more detailed examination of how a counselor could work with a client around the issue of psychotropic medication within an empowerment advocacy framework.

We will first examine advocacy on the micro, or client-clinician, level. Donna Gibson (2010) writes that there has been a movement in the counseling profession to focus on "factors external to clients that adversely affect the emotional and physical well-being of clients," and she says that addressing these external barriers "is the core purpose of advocacy." Therefore, when a counselor encounters a client who is taking or considering taking psychotropic medication it is appropriate for the counselor to consider whether psychotropic medication is negatively impacting, or could potentially negatively impact, that client's well-being. However, it is important to remember that, unlike a phenomenon that is recognized to have a universally negative impact on clients who are exposed to it (racism, for example), even most critics of psychotropic medication acknowledge that it can be useful for some people at some times. Therefore, the first step in any advocacy effort is to carefully assess and weigh the impact of psychotropic medication in the particular case in question. It is also important that counselors are

cognizant of the fact that in many cases there will be no clear and definitive answer as to whether psychotropic medication is, on balance, helping or hurting a client. Advocacy can still be appropriate in these cases, but the counselor should begin by intervening only on the informed consent and psycho-educational levels (see the general recommendations section above), and be particularly careful to let the client guide the course of any advocacy efforts.

Using the empowerment advocacy competencies, a counselor can work one-on-one with a client with the aim of empowering the client to advocate for himself/herself. Empowerment competencies involve seven steps, including identifying resources, helping a client to recognize ways in which medication may be having a negative impact on him/her, training the client in self-advocacy skills, and developing a plan of action. As mentioned above, Appendix A includes a model of how the ACA's empowerment competencies could be applied when working with a client around the issue of psychotropic medication.

The second level of the APA Advocacy Competencies is client advocacy. When working on this level, a counselor may choose to intervene directly on behalf of the client in order to help him or her receive needed services. This could include, for example, working collaboratively with a prescriber, communicating concerns to a prescriber, or helping a client to locate a medical professional or practitioner who would be able to meet particular client needs around the issue of psychotropic medication.

Levels 3 – 6 of the APA Advocacy Competencies outline ways to address the issue of psychotropic medication on a macro level. This includes working on the

community, systems, public information, and political levels. Again, careful assessment of the impact of psychotropic medication on the clients or community in question should be a first step.

Community collaboration involves counselors offering to assist existing groups who are already working on an issue or concern. In the case of the psychotropic medication issue, this could mean working with a local clinic or agency that is dedicated to providing treatments for mental health disorders that minimize psychotropic treatments, or that assist people who are interested in getting off psychotropic medication. It is also important to keep in mind that community is not just a local construct – that there are regional, national and international communities. Professional communities or communities of mental health patients working to reform the current psychiatric model of care may be particularly relevant to counselors who wish to address the issue of psychotropic medication from a skeptical point of view.

Advocacy on the systemic, public information, and political levels could mean forming the type of alliance with a community group as described above. These types of advocacy all involve identifying factors in the environment that impinge on clients' development, and attempting to alter the status quo. Examining the approach to psychotropic medication in local health service agencies, and working to change them when appropriate, could be relevant on the systemic level. Advocacy on the public information level could, for example, involve being interviewed on radio or television, or publishing an article in a media outlet, with the aim of helping to inform the public about

concerns regarding psychotropic medication. Finally, on a political level, advocating for changes in laws and regulations would be appropriate.

Appendix A

Empowerment Advocacy Model for Psychotropic Medication

1. Identify strengths and resources of the client in regards to their use of psychotropic medication.

   Does the client have knowledge about these medications, including and understanding of the potential benefits as well as potential negative affects? If not, does the client have access to this kind of information, and the ability to understand that information? Does the client have a support network of individuals who can help monitor the client's responses to the medication? Is the prescriber an objective and reliable resource for information and consultation?

2. Identify the social, political, economic, and cultural factors that affect the client's experience with psychotropic medication.

   Is there family or community pressure involved with the client's use of psychotropic medication? Are there economic issues, such as disability payments, high cost of alternative treatments, or profit incentives for providers and manufacturers, that may impact the client's choice whether or not to use of psychotropic medication? Do the client's sources of information about psychotropic medication present an unbiased perspective on these medications, free from economic or political

pressure? Are there cultural issues involved with the client's use of psychotropic medication, such as lack of alternative treatments or racial influence on diagnosis and prescribing?

3. Recognize the signs indicating that an individual's decision to use psychotropic medication, or his/her response to that medication, reflect responses to systemic or internalized oppression.

   Gibson defines oppression as an external entity imposing "an object, label, role, experience, or set of living conditions that is unwanted, is painful, and detracts from the physical and psychological well-being of the client" (Gibson, 2010). Has a decision about the use of psychotropic medication been imposed on the client in any sense? Is the client's response to the medication unwanted, painful, or detracting from his or her physical or psychological well-being? Did the client make the decision to use the medication with a full understanding of the risks and benefits, and free from social, economic, cultural, or political influence or pressure?

4. At an appropriate developmental level, help the individual identify how psychotropic medication may be affecting his or her development.

   Discuss with the clients the benefits and drawbacks to psychotropic medication use. Help the client to identify how social, cultural, economic

and political factors may play into the prescribing of this medication, and his or her decision to take it. Discuss how this medication may impact other treatment approaches, such as psychotherapy. Discuss long-term outcomes research on the psychotropic medication involved.

5. Train students and clients in self-advocacy skills.

   Help the client learn to advocate for himself/herself with prescribers, other treatment providers, family, friends, and others. This training could include exploring the client's attitudes towards asserting himself/herself about this issue, rehearsing questions, or roll playing how he/she would talk about this issue with a prescriber, family member, significant other, or other relevant individuals. This could also involve helping a client to learn effective ways of obtaining knowledge about psychotropic medication.

6. Help students and clients develop self-advocacy action plans.

   Help client to develop a plan for how he/she will advocate for himself/herself with prescribers, other treatment providers, family, friends or other relevant individuals.

7. Assist students and clients in carrying out action plans.

   Follow up with client about the plan. Review and repeat steps 1-6 when appropriate.

Appendix B

ADVOCACY COMPETENCIES

Lewis, Arnold, House & Toporek

Endorsed by the ACA Governing Council March 20-22, 2003

Client/Student Empowerment

• An advocacy orientation involves not only systems change interventions but also the implementation of empowerment strategies in direct counseling.

• Advocacy-oriented counselors recognize the impact of social, political, economic, and cultural factors on human development.

• They also help their clients and students understand their own lives in context.

This lays the groundwork for self-advocacy.

Empowerment Counselor Competencies

In direct interventions, the counselor is able to:

1. Identify strengths and resources of clients and students.

2. Identify the social, political, economic, and cultural factors that affect the client/student.

3. Recognize the signs indicating that an individual's behaviors and concerns reflect responses to systemic or internalized oppression.

4. At an appropriate development level, help the individual identify the external barriers that affect his or her development.

5. Train students and clients in self-advocacy skills.

6. Help students and clients develop self-advocacy action plans.

7. Assist students and clients in carrying out action plans.

Client/Student Advocacy

• When counselors become aware of external factors that act as barriers to an individual's development, they may choose to respond through advocacy.

• The client/student advocate role is especially significant when individuals or vulnerable groups lack access to needed services.

Client/Student Advocacy Counselor Competencies

In environmental interventions on behalf of clients and students, the counselor is able to:

8. Negotiate relevant services and education systems on behalf of clients and students.

9. Help clients and students gain access to needed resources.

10. Identify barriers to the well-being of individuals and vulnerable groups.

11. Develop an initial plan of action for confronting these barriers.

12. Identify potential allies for confronting the barriers.

13. Carry out the plan of action.

Community Collaboration

• Their ongoing work with people gives counselors a unique awareness of recurring themes.

Counselors are often among the first to become aware of specific difficulties in the environment.

• Advocacy-oriented counselors often choose to respond to such challenges by alerting existing organizations that are already working for change and that might have an interest in the issue at hand.

• In these situations, the counselor's primary role is as an ally. Counselors can also be helpful to organizations by making available to them our particular skills: interpersonal relations, communications, training, and research.

Community Collaboration Counselor Competencies

14. Identify environmental factors that impinge upon students' and clients' development.

15. Alert community or school groups with common concerns related to the issue.

16. Develop alliances with groups working for change.

17. Use effective listening skills to gain understanding of the group's goals.

18. Identify the strengths and resources that the group members bring to the process of systemic change.

19. Communicate recognition of and respect for these strengths and resources.

20. Identify and offer the skills that the counselor can bring to the collaboration.

21. Assess the effect of counselor's interaction with the community.

Systems Advocacy

• When counselors identify systemic factors that act as barriers to their students' or clients' development, they often wish that they could change the environment and prevent some of the problems that they see every day.

• Regardless of the specific target of change, the processes for altering the status quo have common qualities. Change is a process that requires vision, persistence, leadership, collaboration, systems analysis, and strong data. In many situations, a counselor is the right person to take leadership.

Systems Advocacy Counselor Competencies

In exerting systems-change leadership at the school or community level, the advocacy-oriented counselor is able to:

22. Identify environmental factors impinging on students' or clients' development

23. Provide and interpret data to show the urgency for change.

24. In collaboration with other stakeholders, develop a vision to guide change.

25. Analyze the sources of political power and social influence within the system.

26. Develop a step-by-step plan for implementing the change process.

27. Develop a plan for dealing with probable responses to change.

28. Recognize and deal with resistance.

29. Assess the effect of counselor's advocacy efforts on the system and constituents.

Public Information

• Across settings, specialties, and theoretical perspectives, professional counselors share knowledge of human development and expertise in communication.

• These qualities make it possible for advocacy-oriented counselors to awaken the general public to macro-systemic issues regarding human dignity.

Public Information Counselor Competencies

In informing the public about the role of environmental factors in human development, the advocacy oriented counselor is able to:

30. Recognize the impact of oppression and other barriers to healthy development.

31. Identify environmental factors that are protective of healthy development.

32. Prepare written and multi-media materials that provide clear explanations of the role of specific environmental factors in human development.

33. Communicate information in ways that are ethical and appropriate for the target population.

34. Disseminate information through a variety of media.

35. Identify and collaborate with other professionals who are involved in disseminating public information.

36. Assess the influence of public information efforts undertaken by the counselor.

Social/Political Advocacy

• Counselors regularly act as change agents in the systems that affect their own students and clients most directly. This experience often leads toward the recognition that some of the concerns they have addressed affected people in a much larger arena.

• When this happens, counselors use their skills to carry out social/political advocacy.

Social/Political Advocacy Counselor Competencies

In influencing public policy in a large, public arena, the advocacy-oriented counselor is able to:

37. Distinguish those problems that can best be resolved through social/political action.

38. Identify the appropriate mechanisms and avenues for addressing these problems.

39. Seek out and join with potential allies.

40. Support existing alliances for change.

41. With allies, prepare convincing data and rationales for change.

42. With allies, lobby legislators and other policy makers.

43. Maintain open dialogue with communities and clients to ensure that the social/political advocacy is consistent with the initial goals.

Appendix C

Educational Resources for Counselors, Educators and Clients

This is a brief selection of resources that can be used as a starting point for practitioners, educators, or clients looking for information about psychotropic medication. Some of the resources listed below include sections with more extensive lists of resources.

Websites:

Mad In America: http://www.madinamerica.com/

This website tracks news and research, has an extensive archive, and provides blogs and discussion resources. It also includes an extensive list of links to sources of educational information, withdrawal resources, and withdrawal communities.

CriticalThinkRx: http://criticalthinkrx.org/

The website of this non-profit organization provides an on-line Continuing Education curriculum for mental health practitioners working with clients around the issue of psychotropic medication. It is particularly geared towards practitioners working with children.

Books:

Anatomy of an Epidemic by Robert Whitaker.

http://www.madinamerica.com/product/62043/

Your Drug May Be Your Problem by Peter Breggin, M.D., and David Cohen, PhD.

http://breggin.com/index.php?option=com_content&task=view&id=17&Itemid=42

Psychiatric Drug Withdrawal: A Guide for Prescribers, Therapists, Patients, and Their Families by Peter Breggin, M.D.

http://breggin.com/index.php?option=com_content&task=view&id=296

Withdrawal Communities:

Recovery Road: http://www.recovery-road.org/

This organization is for people who are affected by withdrawal or dependence on sleeping pills or other tranquilizers, anxiolytics, or antidepressants.

Surviving Antidepressants: http://survivingantidepressants.org/

This is a message board for peer support during or after withdrawal from antidepressants.

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