

Counseling Patients on Medication For Adult Psychiatric Disorders

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Upon successful completion of this article, the pharmacist should be able to:

1. Explain the purpose and desired outcome of providing medication counseling to patients who receive psychiatric medication.
2. Identify three key counseling points for patients receiving a new prescription for an antidepressant, antipsychotic, mood stabilizer, anxiolytic, or hypnotic medication.
3. Discuss how to counsel a patient regarding onset of effect and duration of treatment for antidepressant, antipsychotic, and mood stabilizer medication.
4. Discuss how to counsel a patient regarding the more uncomfortable topics of alcohol use, the possibility of increased suicidal ideation with antidepressants and antidepressant-induced sexual dysfunction.
5. Choose preferred terminology to use when counseling a patient about adverse effects of antidepressant, antipsychotic, or mood stabilizer medication.

Upon successful completion of this article, the pharmacy technician should be able to:

1. Explain the purpose and desired outcome of providing medication counseling to patients who receive psychiatric medication.
2. Identify medications used to treat adult psychiatric disorders.
3. Discuss the importance of thorough and ongoing counseling regarding the more uncomfortable topics of alcohol use, the possibility of increased suicidal ideation with antidepressants and antidepressant-induced sexual dysfunction.



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INTRODUCTION

Since the Omnibus Budget Reconciliation Act of 1990 (OBRA '90) became widely implemented in 1993, and most states enacted laws or regulations requiring medication counseling to ensure safe medication use and effective outcomes by the late 1990s, pharmacists have a responsibility to counsel patients about their medication. Successful medication counseling requires both a sufficient knowledge base and the skills to effectively communicate and discuss relevant information with patients. While most pharmacists are competent and comfortable discussing most classes of drugs, counseling on medication for psychiatric disorders is often a less comfortable task. The goal of this article is to present the most pertinent information for medication used to treat adult psychiatric disorders that is necessary for effective patient counseling, as well as how to best communicate that information; that is, what to say and how to say it. The focus of this article is patient medication counseling that would more typically occur in a community pharmacy rather than an acute care hospital or clinic setting.

It is beyond the scope of this article to review the therapeutics of each class of drugs for psychiatric disorders. Instead, this article will offer tips on how to decide which therapeutic information is most important to include in counseling, and how to communicate that information most effectively.

PURPOSE OF PATIENT COUNSELING

Although most states have laws and regulations that mandate pharmacists to provide or at least offer medication counseling on new prescriptions, there is a higher purpose than merely fulfilling a legal responsibility. Patient counseling is the primary way a pharmacist may positively influence a patient's drug therapy outcome. Effective medication counseling can improve patients' adherence to drug therapy, increase patients' understanding of their symptoms and drug therapy, help set appropriate treatment expectations, avoid the more dangerous possibilities of drug-drug interactions and concomitant use of alcohol and driving concerns, and advise regarding the less common but more serious adverse effects.

Today's world is much different than when the original laws and regulations mandating medication counseling were written. In the 1990s, the primary purpose of medication counseling was to provide information about a patient's drug therapy. Patients today, however, have access to an overabundance of information about their medication from websites, direct-to-consumer advertising of newer drugs by pharmaceutical companies, blogs, and social media that often includes misinformation, leading to confusion and/or fear. Most pharmacies today provide written medication information sheets with most prescriptions, leading patients to wonder which of the listed 83 possible side effects they should worry about. Today's purpose of medication counseling is no longer to merely

provide drug information to patients. It should be to prioritize what information is most important, correct misinformation, and answer patients' questions and concerns.

DO PHARMACISTS ACTUALLY PROVIDE MEDICATION COUNSELING?

Currently, 19 states require face-to-face counseling by pharmacists, while the rest require only an offer to counsel. There is a substantial literature, both in the 1990s and more recently, that has explored whether pharmacists actually counsel patients consistent with state laws and regulations. A review article of early surveys published by APhA in 2004 found that only 33-42 percent of patients recall being counseled by a pharmacist on a new prescription. Observational surveys found that 54-74 percent of patients received counseling by a pharmacist, and studies using covert "shoppers" found 40-94 percent (mean 63 percent) received counseling by a pharmacist. A study using hidden cameras and patient actors in 100 pharmacies located in Georgia, Florida, and New York/New Jersey in 2007 found only 27 percent were counseled or offered counseling. The same study was first conducted in the mid-1990s, finding 61 percent were counseled, meaning there has been a significant decrease in the frequency of counseling from the 1990s to 2007. In 2011, shoppers in 365 community pharmacies in 41 different states presented new prescriptions for lisinopril and metformin. In the states with more strict oral counseling laws, 57 percent received counseling. In the states with weaker counseling laws, only 33 percent received medication information from anyone in the pharmacy. These studies suggest that many patients do not receive counseling from their pharmacists, with evidence that the frequency of counseling has decreased over the 20 years that pharmacist counseling has been mandated by law and regulation.

In the past 10 years, the Food and Drug Administration has become increasingly concerned about patients' need for information about their drugs. Of greatest concern are drugs with serious adverse effects and when patient adherence is essential to a drug's effectiveness. The 2007 FDA Amendments Act called for risk evaluation and mitigation strategies (REMS) to ensure that the benefit of using certain drugs outweighs the risk and one commonly used element to assure safe use is a Medication Guide (MedGuide). In 2011, the FDA mandated MedGuides for some drugs, and that drug list now numbers more than 240 drugs that have written medication guides for patients.

A 2012 study of these MedGuides evaluated the readability and comprehension of MedGuides in 450 adults. Only 50 percent of these adults correctly read and understood the MedGuides, and the study noted that the average length of 185 MedGuides available in 2012 was more than 1,900 words. The authors concluded that the MedGuides offer little value to patients, being too complex and difficult to understand.

The fact that some pharmacists are not counseling pa-

Look up and print MedGuides from:

<http://www.fda.gov/Drugs/DrugSafety/ucm085729.htm>
or
<http://dailymed.nlm.nih.gov/dailymed/index.cfm>

Table 1. What is This Medicine for?

Antidepressant Drugs
Poor: "This antidepressant ..." (multiple uses beyond depression) Better: "This medicine has many uses, what did your doctor tell you about it?"
Mood Stabilizers
Poor: "This drug is for your bipolar disorder." "This drug is for your manic-depressive disorder." Better: "This medicine will help stabilize your mood, and can reduce the frequency of big changes in your mood."
Antipsychotic Drugs
Poor: "This drug is for your schizophrenia." Better: "This medicine can help with your thinking – some people find it helpful to reduce fearful thoughts or to think more clearly, or to relax and sleep better."

tients, and that the FDA now mandates MedGuides for many drugs, leaves several lingering questions. Do mandated MedGuides suggest that the FDA believes pharmacist counseling is inadequate? Are some pharmacists abdicating their verbal patient counseling responsibility to now merely providing written materials? Is there a need to revise the 15-20 year old patient counseling laws and regulations to better reflect today's realities that patients no longer need just medication information, but instead would be better served by helping them interpret all the drug information they often have?

GENERAL PRINCIPLES

Case 1 gives an example of a typical encounter of a pharmacist providing medication counseling on a new prescription for paroxetine. This example illustrates that effective patient counseling not only requires knowledge of the drug but also the skills of how to communicate the important information. Every fact that is provided to J.S. is correct information, but there are many things wrong with how the information is provided.

Effective patient counseling is best done as a dialogue with the patient, not a one-way monologue of merely reciting facts. The patient should be engaged in the discussion, and their concerns or questions need to be addressed. Patients are more likely to recall a discussion that addresses their concerns or questions, but are less likely to recall a litany of facts presented to them. As discussed earlier, many patients have access to, and have already researched information about

Case 1

J.S., a 38-year-old male, presents a new prescription at his local pharmacy for paroxetine 20 mg #30; take one at bedtime, 3 refills. The pharmacist determines that J.S. has never taken paroxetine in the past. The pharmacist says:
"Here is your Paxil prescription. Take one at bedtime. This antidepressant might cause GI upset and sexual problems, and don't drink alcohol with it. This drug can make you sleepy so be careful when driving."

The content of the counseling is correct information, but how the information is presented is far from ideal:

- Nothing positive is communicated, it's only adverse effects, and a warning not to drink.
- An assumption is made that the paroxetine is for depression, but paroxetine has many other indications.
- Be careful with terminology. For example, "GI upset" may need further explanation for some patients.
- The blunt statement about sexual problems will likely scare the patient.
- Discuss consequences of alcohol use instead of the absolute "don't drink."
- The monologue to a passive patient allows no opportunity to discuss concerns or questions.

Case 1 Redone

"What did your doctor tell you about this new medicine?"

Once the pharmacist establishes that it is for depression:
"Be patient, it may take several weeks for paroxetine to work."
"Take it at bedtime; it might make you sleepy, which will help you sleep better."

"Take it with food to reduce the risk of upset stomach."

"Some people notice a change in sexual function. If you notice any change, let your doctor know since it can be treated."

"It is best not to drink alcohol with paroxetine. Both have sedative effects that can be additive. Your paroxetine is to help improve your mood, and alcohol often has the opposite effect on your mood."

"If you experience any problems with this medicine, contact your doctor or me, but it is best to never change the dose or discontinue the drug on your own."

"Do you have any questions?"

their new medication. These patients do not need more facts about their drug, but instead they need help interpreting those facts, and their concerns or confusion need to be addressed. Table 2 details general counseling principles that are relevant

regardless of which drug or drug class is being discussed.

Another general principle is to consider the sequence of the counseling discussion. In Case 1, nothing positive is communicated to J.S. about his paroxetine. Only the negative aspects of paroxetine are presented—adverse effects and an instruction to not drink alcohol. A more effective approach would be to first provide some positive information about the drug before discussing more negative aspects such as adverse effects. Sometimes potential adverse effects can be presented in a positive way. Sedation from paroxetine can be presented as a beneficial effect that may improve J.S.'s sleep, since he will take it a bedtime. No adverse effect should be mentioned without also adding what the patient should do if it occurs.

Both the patient's culture and age must also be considered when counseling, especially with medication used for psychiatric disorders. It is beyond the scope of this article, but many cultures view psychiatric disorders differently. Psychotic disorders such as schizophrenia are often not discussed or are hidden, while depression is often viewed as a personality flaw or weakness rather than something that can be treated medically. Denial of psychiatric disorders by the patient and family members is common for psychiatric disorders, making counseling about a medication to treat such a disorder more challenging.

Even more important than cultural differences can be generational differences. There has been much more acceptance and more open discussion of psychiatric disorders in the last 10-20 years, so patients in their 20s and 30s are more likely to be accepting of medication treatment options for psychiatric disorders. But patients in their 70s and 80s are more likely to be guarded or may deny their psychiatric disorder. A general recommendation about counseling about medication for psychiatric disorders is to focus on the symptoms of their diagnosis, instead of the diagnosis itself, especially among older adults. While an older adult will be more likely to deny that they have a diagnosis of depression and thus object to an antidepressant, they will be more accepting of a medication that will help their troublesome symptoms like sleep difficulty, difficulty concentrating, and fatigue. Table 1 provides specific examples of how best to discuss symptoms instead of diagnosis when counseling about psychiatric medication.

Another important consideration that should influence the content of patient counseling is if a new prescription is a substitution for an initial drug that is being discontinued due to lack of efficacy or adverse effects, or if it is the first time the patient has been given a drug in that class. If paroxetine is being given after another antidepressant caused intolerable side effects, then the counseling content must be different. The most important content will be stressing the differences, and advantages, of paroxetine compared to the first antidepressant. The patient will likely have concerns that this second antidepressant might cause the same problems as the first drug, so he will need some reassurance that paroxetine is different.

Table 2. General Counseling Principles

- Engage the patient in the discussion; avoid a monologue.
- Address any patient concerns or questions.
- Start with positive aspects of the drug before discussing negatives.
- Never mention an adverse effect unless the patient is also provided instructions about what to do if the adverse effect occurs.
- Use terminology that the patient can understand.
- Educate instead of merely telling the patient what to do.
- Adjust counseling to individual patient needs – such as age, culture, and literacy.

Table 3. Possible Content Areas Of Patient Counseling

- Name [trademark, generic or other descriptive name(s)]
- Intended use and expected action
- Route, dosage form, dosage and administration schedule
- Special directions for preparation
- Special directions for administration
- Precautions to be observed during administration
- Common side effects that may be encountered, including their avoidance and the action required if they occur
- Techniques for self-monitoring of drug therapy
- Proper storage
- Prescription refill information
- Potential drug-drug or drug-food interactions
- Other therapeutic contraindications
- Action to be taken in the event of a missed dose
- Any other info peculiar to the specific patient or drug

Table 2 summarizes these general counseling principles.

There are three major types of patient counseling, listed here in increasing order of effectiveness. Information transfer is the pharmacist providing a monologue of factual information to a passive patient. Medication education is a more collaborative learning experience with a goal to increase a patient's knowledge. Medication counseling is when the pharmacist provides guidance designed to increase the problem-solving skills of the patient. Given those definitions, a pharmacist will provide the most value with a blend of medication information and medication counseling while information transfer alone is of least value for the patient. The patient's perspective must be considered when initiating patient counseling.

Table 3 is a comprehensive list of possible content areas of what a pharmacist might provide a patient when counseling. It is usually not possible to cover all possible drug information in the very limited time pharmacists have in a typical community pharmacy setting. This time pressure often results in a rapid monologue of information given to the patient with no dialogue or time for a patient's questions or concerns to be

addressed. How can a pharmacist best utilize the 1-2 minutes available to counsel a patient? To encourage counseling as a dialogue, the Indian Health Service's counseling model recommends that three key questions be asked when a patient receives a new prescription. "What did your doctor tell you the medicine was for?" "How did the doctor tell you to take it?" and "What did the doctor tell you to expect?" This approach allows the pharmacist to quickly assess what the patient already knows, and determine if the patient has any concerns or questions. Most studies of the value of pharmacist counseling indicate that patients often remember little about the factual information provided, but the highest recall and value is when the pharmacist answers a patient's questions or concerns. Along with the three questions listed previously, a necessary question in any counseling session is "Do you have any questions about your medicine?"

KEY COUNSELING POINTS BY DRUG CLASS

Antidepressant Drugs

Indications for Psychiatric Disorders

Antidepressants are indicated for a number of psychiatric disorders in addition to treatment of major depression. No assumption should be made that a patient is being treated for depression when they present a prescription for sertraline or paroxetine. Both the SSRIs (selective serotonin reuptake inhibitors – such as fluoxetine, sertraline, paroxetine) and SNRIs (serotonin-norepinephrine reuptake inhibitors – such as venlafaxine, duloxetine) have indications for treatment of a variety of anxiety disorders. For many patients, the drug treatment of choice for panic disorder, generalized anxiety disorder, and obsessive-compulsive disorder will be SSRIs or SNRIs. Thus as mentioned previously, an important starting point in counseling about antidepressants is to first ask "What did your doctor tell you the medicine was for?" Furthermore, some antidepressants are also used for other FDA-approved indications and some off-label therapy; examples include duloxetine for fibromyalgia, bupropion for smoking cessation, fluoxetine for premenstrual dysphoric disorder, and paroxetine for premature ejaculation. Effective patient counseling requires knowing why the antidepressant is being prescribed.

Onset of Effect

When antidepressants are being used to treat a major depressive disorder, the onset of effect is slow. Successful treatment of depressed mood, lack of interest, hopelessness, and suicidal ideation often requires a month or more before the patient notices improvement in these symptoms. The physical symptoms of a depressive episode, however, can show improvement within the first 1-2 weeks. The patient will notice an improvement in sleep, energy, and appetite well before the mood improves. This information is important for the patient to understand. Because adverse effects can begin within the first few days of treatment, some patients will feel

worse before they feel better. It is thus not surprising that after several weeks patients may discontinue their antidepressant because they are experiencing adverse effects but see no improvement in their depressed mood and hopelessness. Patients must be counseled that these drugs do take some time to become effective. Additionally, if they experience an improvement in sleep or energy in the first few weeks, it is a sign that the drug is starting to work and the other symptoms should also improve with continued treatment.

Duration of Treatment

For treatment of major depression, all patients should remain on antidepressant therapy for at least 6-12 months, longer than the 1-2 months when improvement in symptoms should occur. It is tempting for a patient to discontinue their antidepressant after several months when they experience improved symptoms and believe they no longer need the antidepressant. But treatment guidelines suggest that there is a high risk of relapse and return of depressive symptoms if treatment is not continued for 6-12 months. When a patient experiences their first depressive episode, approximately 20 percent will never experience another depression in their lifetime. For those patients, only 6-12 months of antidepressant treatment is indicated. At the other end of the spectrum, there are patients who experience frequent recurrent depressive episodes. Treatment guidelines suggest that if a patient experiences three or more depressive episodes within a five-year period, lifelong maintenance treatment is indicated. The notable exception is when patients experience their first major depressive episode after age 60. For those patients, lifelong maintenance antidepressant treatment is recommended since their risk of relapse upon discontinuation is much greater than for younger patients. Unlike many other drugs, the dose for maintenance therapy should be the same as the acute dose, not lower, as the risk of relapse is increased.

There is no need for pharmacists to offer advice to patients about how long they should take an antidepressant, usually because the pharmacist does not know enough about the patient's history. Those questions about duration of treatment should be referred to their prescriber. However, it is important for the pharmacist to advise that antidepressants are best continued for months, even after their depressive symptoms have been successfully treated, due to the risk of relapse if discontinued as soon as their symptoms improve. Patients need to understand the concept that the antidepressant is used not only for treating acute symptoms, but also to prevent the return of those symptoms.

Common Adverse effects

The expectable common adverse effects among antidepressant drugs differ greatly. Table 4 lists the relative differences among antidepressant drugs adverse effects. Thus counseling about adverse effects must be drug-specific. As can be seen,

Table 4. Relative Adverse Effect Differences—Antidepressant Drugs

	Sedation	Activation Insomnia	AC	GI	Sexual Dysfunction
TCA					
Amitriptyline	H	L	H	L	H
SSRIs					
Citalopram	L	L	0	H	H
Fluoxetine	L	H	0	H	H
Paroxetine	M	L	M	H	H
Sertraline	L	L	0	H	H
SNRIs					
Duloxetine	M	L	L	H	M
Venlafaxine	L	M	0	H	H
OTHER					
Bupropion	L	H	0	L	0
Mirtazapine*	H	0	L	L	L
Vilazodone	L	H	0	H	M

Scale: 0 = no effect; L = low; M = moderate; H = high

AC = anticholinergic effects; GI = nausea, diarrhea

*Sedation is inversely related to dose; can also increase appetite

there are antidepressants that are very sedating, others that are activating, and many others without prominent sedation or activation effects. These differences dictate whether morning dosing or bedtime dosing should be recommended. Significant differences also exist in regard to gastrointestinal effects, most commonly nausea, as well as sexual dysfunction. These adverse effect differences often drive the decision about which drug will be selected for a patient. The adverse effects identified as more likely in Table 4 should be discussed with the patient. For example, with bupropion the potential activating effects mean the drug should not be taken later in the day or evening, but there is no need to discuss nausea or sexual dysfunction. In contrast, with mirtazapine the potential for sedation means the drug is best taken at bedtime. And with sertraline, activation or sedation is not expected but discussion should focus on nausea and sexual dysfunction.

Sexual dysfunction associated with antidepressants is typically an uncomfortable topic for both the patient and the pharmacist. But since adverse sexual effects from antidepressants represent the most common reason for patients skipping doses or stopping their antidepressants, it is a needed component of counseling. Furthermore, all antidepressants

with prominent serotonin agonist effects (SSRIs and SNRIs) are associated with at least a 30 percent likelihood of delayed ejaculation in men, and anorgasmia in men and women. As seen in Case 1, merely indicating that an antidepressant may cause sexual problems is not effective counseling. Instead, it is more advisable to indicate that the antidepressant may be associated with changes in sexual function. If changes in sexual function occur, the patient should be counseled not to self-discontinue treatment but to discuss with their prescriber since it can be treated. While a bit vague, changes in sexual function is a comfortable starting point for discussion. Some patients will then be comfortable asking more follow up questions, and the pharmacist must be ready with more specific information. Stressing that patients should report a change in sexual function is important, since patients often may have pre-existing sexual difficulties that are not attributable to the drug. Today, many patients are aware of the potential for antidepressants causing sexual dysfunction, and often have misinformation. Decreased libido is a common symptom of depression, and antidepressants may in fact increase libido when the depression is successfully treated. The more common SSRI and SNRI drug-induced effect is delayed ejacula-

tion and anorgasmia, occurring in up to 30 percent of patients. Bupropion, mirtazapine, and trazodone represent antidepressants least likely to negatively affect sexual function (Table 4).

Auxiliary labels and the usual counseling regarding alcohol use, as seen in Case 1 is "Do not drink with this medication." Such an instruction to patients may offend those who do not drink. For those who drink, such a mandatory warning will more likely result in non-adherence to the antidepressant since patients may conclude that every time they drink, they must skip their drug. As presented in Case 1 redone, it is preferable to instead focus on the consequences of drinking with the antidepressant, discussing additive effects and alcohol's negative effect on mood.

Discussing Special Warnings About Antidepressants

Some patients will express concern if they read that suicide risk can be increased with antidepressants. Package inserts and medication guides for all antidepressants indicate this increased risk. Pertinent information that must be communicated while counseling about antidepressants is that in the first few weeks of treatment, their doctor should be contacted if any increase in thoughts about suicide occurs. Patients can be reassured that evidence of an increase in thoughts of suicide was seen only in teens and young adults, and the first nine days of treatment were of greatest concern. There is no evidence that antidepressants pharmacologically increase thoughts of suicide. Instead, several different factors contribute to the potential of increased thoughts of suicide in the first weeks of treatment. Antidepressants often require a month or more to exert any benefit on mood, hopelessness, and suicidal thoughts, while patients can more quickly experience relief of their lethargy and decreased energy so that some patients may become more energized yet still be very depressed and suicidal. Additionally, up to one-third of patients will not respond to their first antidepressant, leading to the potential for depressive symptoms continuing to worsen. While warnings of the risk of increased suicidal thoughts are included for all antidepressants, it is also true that most patients' suicidal thoughts will improve with successful treatment of their depression.

The other special warning is needed when male patients receive trazodone. Priapism is defined as a sustained, painful erection lasting more than four hours, and it is a urological emergency. Nearly 80 percent of all cases of drug-induced priapism occur with trazodone. It is not dose-related and may occur with doses of 50 mg or 100 mg, and even with single doses. If not treated quickly, stasis of blood in the penis leads to deoxygenation and tissue damage, the need for surgical intervention, and can lead to permanent erectile dysfunction. Though a very rare adverse event, all male patients given trazodone should be warned about this adverse effect. A possible statement might be: "Although RARE, this drug may cause changes in erections. If you experience a prolonged

Table 5. Key Counseling Points: Antidepressants

- Slow onset of effect: mood symptoms (depressed mood, lack of interest, hopelessness) may take 3-6 weeks but sleep and energy often improve sooner
- Treatment should continue for at least 6-12 months regardless of how soon the symptoms improve
- Antidepressants are not addictive, they are not simulants
- Mention common expectable adverse effects AND what to do if they occur
- Advise regarding use of alcohol

or painful erection, call your doctor or go to emergency room for treatment." Such a statement communicates that this is a rare, very unlikely, but serious adverse effect that requires immediate action.

Treatment Guidelines Versus Actual Use Patterns

Despite clearly established treatment guidelines that define 6-12 months as an adequate duration of antidepressant treatment for depression, studies of actual use patterns of antidepressants reveal significant non-adherence with these guidelines. Studies in primary care settings show that for treatment of major depression, 30 percent of patients have discontinued their antidepressant after only one month, and at least half of patients are no longer taking their antidepressant after 3-6 months instead of remaining on treatment for the recommended 6-12 months. The most common reasons for early discontinuation include adverse effects and the belief that treatment is no longer needed since symptoms have improved. Patients must understand the delay in onset of effect, and understand the risk of relapse if they discontinue treatment too soon. If counseling about adverse effects includes suggestions about what to do if an adverse effect occurs, then the patient will have other options instead of merely discontinuing treatment on their own. In older patients, antidepressant non-adherence has been shown to occur in more than 60 percent of patients. Of note, there are even more reasons for non-adherence in an older adult. These include adverse effects, fear of adverse effects, cost, cognitive impairment, denial of a depressive illness, stigma associated with use of antidepressants, and simply a lack of transportation to obtain refills. When non-adherence is detected, the reason for non-adherence must first be identified and then corrected if possible. Table 5 summarizes the five key areas of antidepressant counseling.

Mood Stabilizers (Lithium, Valproate)

Indications

Bipolar disorder is characterized by episodes of mood swings of both mania and depression. The two best established medications indicated for bipolar disorder are lithium and valproate. Carbamazepine and lamotrigine are generally

considered alternative options if lithium or valproate cannot be used, though their use for bipolar disorder has decreased as many of the atypical antipsychotics now have FDA approval and have become more commonly used for bipolar disorder. Counseling for the atypical antipsychotic drugs is covered in the antipsychotic drug section that follows. Both lithium and valproate have efficacy in the acute treatment of manic episodes, as well as efficacy as maintenance treatment to reduce the frequency of subsequent episodes of mania and depression. Lithium is more effective for treatment and prevention of manic episodes, while lamotrigine is somewhat more effective for bipolar depression.

Duration of Treatment

The natural course of bipolar disorder is characterized by distinct episodes of both manic and depressive episodes, often with periods of normal mood between episodes. There is no way to predict the frequency of episodes; some patients may experience an episode every 5-6 years, while others may experience episodes every year. Acute episodes of mania or depression can be successfully treated, but of even greater importance is continued maintenance treatment to prevent future episodes. Many patients logically think that they can discontinue drug therapy once their acute manic or depressive episode is successfully treated. A key counseling point is that these drugs are also used to prevent future episodes even when the symptoms are gone. Once a diagnosis of bipolar disorder is established, lifelong maintenance treatment with a mood stabilizer is indicated. Bipolar patients experiencing a depressive episode may often be given an antidepressant drug, but it must always be accompanied by a mood stabilizer. Use of an antidepressant alone in a bipolar depression runs the risk of switching the patient into a manic episode.

Common Adverse Effects

While the list of potential adverse effects with lithium is long, many patients experience relatively few adverse effects if their blood levels are adequately monitored and adjusted. The most common adverse effects with lithium include nausea and diarrhea, a fine hand tremor, and increased thirst and urination. If the lithium blood levels are too high, the nausea and diarrhea may worsen, and central nervous systems symptoms such as lethargy, slurred speech, and ataxia may occur. With long-term use, lithium may be associated with hypothyroidism, weight gain, and aggravation of pre-existing dermatological conditions such as acne or psoriasis. Valproate has similar common initial adverse effects of nausea and diarrhea. Less common adverse effects include sedation and ataxia, tremor, transient hair loss, and weight gain. It is important to stress in counseling that these adverse effects can be managed, they should be discussed with their prescriber, and the use of blood level monitoring allows dosage optimization with a lower risk of adverse effects.

Table 6. Key Counseling Points: Mood Stabilizers

- Focus on symptoms, not the diagnosis.
- The primary benefit of maintenance therapy is reducing the frequency of future episodes of either mania or depression.
- Use of drug blood level monitoring allows optimal dosing to maximize benefit and minimize the risk of adverse effects.
- Explain that these medications are useful to prevent return of symptoms, not just treatment of acute symptoms.

Key Counseling Points for Mood Stabilizers

Table 6 summarizes the key counseling points when discussing mood stabilizers. Patients must understand that these drugs will likely be used for long-term treatment to prevent symptom recurrence, not used just when acute symptoms are present. The term mood stabilizer can be confusing to patients, as these drugs do not modify mood on a day-to-day basis, but will treat and reduce recurrence of episodes of mania or depression that occur over weeks to months. As is true with depression and schizophrenia treatments, it is generally best to focus mood stabilizer counseling on the patient's symptoms instead of diagnosis (Table 1). A focus on the benefits of education for excessive energy and irritability, decreased sleep, and the reducing the risk of negative consequences such as excessive spending, difficulties with social or occupational functioning, and reducing the risk of large swings in mood (either up or down) is preferable to stating that their mood stabilizer is for their bipolar disorder or their mania. Some patients may actually enjoy the feelings of elated mood with a manic episode, and do not want medication to interfere with those symptoms. For these patients it is better to focus on the benefits of medication for decreasing their unwanted symptoms, such as irritability, the need for hospitalization, the depressive episodes, and the legal and financial consequences of their symptoms.

Antipsychotic Drugs

Indications for Psychiatric Disorders

Antipsychotic drugs are indicated for the treatment of psychotic symptoms that are a common component of schizophrenia and bipolar disorders. These symptoms are best considered a disorder of thinking. Examples of the types of symptoms for which antipsychotic drugs can be effective include loose associations (disconnected thoughts), delusions (fixed false beliefs), and hallucinations (hearing voices). Several antipsychotic drugs are also indicated as adjunctive treatment to antidepressants for treatment-resistant depression. Unfortunately, some of these drugs with prominent sedation (such as quetiapine), though not indicated, are inappropriately used for insomnia in the absence of psychotic symptoms. Using an antipsychotic drug to treat insomnia has been compared to using a sledgehammer to nail a small tack into a wall. It can

Table 7. Relative Adverse Effect Differences—Antipsychotic Drugs

	Sedation	EPS	AC	OH	Weight Gain
Aripiprazole	L	L	0	L	L
Clozapine	H	0	H	H	H
Olanzapine	H	L	M	L	H
Quetiapine	H	0	M	M	M
Risperidone	L	M	0	M	M
Ziprasidone	L	L	0	L	0
Haloperidol	0	H	L	L	L

Scale: 0 = no effect; L = low; M = moderate; H = high

EPS = extrapyramidal effects; AC = anticholinergic; OH = orthostatic hypotension

Table 8. Key Counseling Points: Antipsychotic Drugs

- Focus on symptoms, not the diagnosis.
- Several weeks are often needed before these medications exert their beneficial effects on psychotic symptoms.
- Most adverse effects can be managed, allowing continuation of the medication.
- Mention the common expectable adverse effects AND what to do if they occur.
- Explain that these medications are useful to prevent return of symptoms, not just treatment of acute symptoms.

be successful, but there is a great risk of collateral damage given the significant adverse effects associated with extended use of antipsychotic drugs. When counseling patients receiving an antipsychotic drug, it is best to first inquire about what their prescriber told them about the drug. Instead of focusing on their diagnosis, it is usually more comfortable for patients if the focus is on the symptoms of their disorder (Table 1).

Onset of Effect

At least several weeks are required for antipsychotic drugs to reduce the severity of psychotic symptoms. It is important for patients to know these drugs have a slow onset of effect. For most patients, they will often feel worse before they feel better as adverse effects may begin in the first few days of treatment long before any beneficial effects are experienced.

Duration of Treatment

Schizophrenia and bipolar disorders are chronic lifelong disorders that require lifelong treatment. It is usually not the place for the pharmacist to discuss duration of treatment, as those discussions should be referred to the patient's prescriber. But it is quite appropriate for the pharmacist to indicate that these medications are not only used to treat

acute symptoms, but are usually used for months and often years to prevent these symptoms from returning. Patients should not consider discontinuing treatment on their own as long-term medication is also very effective in reducing the risk of symptom return.

Common Adverse Effects

The expectable common adverse effects among the many antipsychotic drugs differ greatly. Thus counseling about adverse effects must be drug-specific. As can be seen in Table 7, there are several antipsychotic drugs that are very sedating, while many have no prominent sedation. Significant differences also exist in regard to extrapyramidal effects, anticholinergic effects, orthostatic hypotension, and weight gain. Anticholinergic effects (dry mouth, blurred near vision, constipation) are rarely serious, but can often be bothersome enough for patients to skip doses or discontinue treatment on their own. For older patients, anticholinergic effects are of much greater concern, as cognitive function and urinary retention are much more serious consequences. For drugs with a greater risk for orthostatic hypotension, patients must be counseled about rising quickly from a sitting or reclining position. Without such counseling, the patient who experiences dizziness when rising will believe the medication is “too strong” and often will either reduce the dose or discontinue treatment on their own. A number of antipsychotic drugs have the potential for significant weight gain. Some patients taking olanzapine or clozapine can experience weight gain of 20, 30, or 40 pounds or more, and the risk of adult-onset diabetes is increased. When counseling about the potential for weight gain, it is best to focus on what the patient will first experience, which is an increased appetite. If the patient notices an increased appetite, additional attention to diet and increased exercise is recommended, and they should inform their prescriber. The adverse effect differences detailed in Table 7 often drive the

Table 9. Key Components Of Sleep Hygiene Counseling

- Set a regular time to sleep and awaken.
- Minimize noise, light, excessive temperatures during sleep time.
- Use bed only for sleeping, not paying bills, technical reading, watching television.

Avoid:

- Daytime naps
- Caffeine 4-6 hours prior to bedtime
- Nicotine, alcohol, large meals, fluids before bedtime
- Exercise 4-6 hours prior to bedtime
- Decongestants, diuretics past mid-afternoon, any activating medication after 6 p.m.

decision about which drug will be selected for a patient. The key counseling points for antipsychotic drugs are detailed in Table 8.

Anti-Anxiety Drugs

Indications

An important distinction is to differentiate the symptom of anxiety from the primary anxiety disorders. The symptom of anxiety has many causes and can vary in severity and duration. Anxiety can be brief when induced by stressful situations, and anxiety can be a secondary consequence of many medical and psychiatric disorders. In these cases, use of a drug to treat the anxiety is often not needed, or very low dose benzodiazepines may be used for 1-2 weeks or on an occasional as-needed basis. In contrast, there are a number of primary anxiety disorders that require a very different approach in drug therapy. Diagnoses of generalized anxiety disorder, panic disorder, social anxiety disorder, post-traumatic stress disorder, and obsessive-compulsive disorder each require unique drug treatment approaches that are beyond the scope of this article. Interestingly, the primary treatment for most anxiety disorders listed above is antidepressants, not benzodiazepines.

Onset of Effect

Sedation is required for the occasional dosing of a drug for the symptom of anxiety, and the onset of effect occurs shortly after drug ingestion. However, sedation is not a required pharmacological effect for an anti-anxiety drug when used to treat a primary anxiety disorder. Antidepressants that have no sedative effect (such as fluoxetine) are effective for many anxiety disorders, and buspirone is an effective treatment for generalized anxiety disorder without any sedative effect. Patients should not expect to “feel” the anxiolytic effect of these drugs.

Buspirone requires several unique counseling points. In addition to not having any sedative effect, buspirone’s onset of effect requires at least 1-3 weeks of continuous use before

symptoms of generalized anxiety disorder improve. Buspirone is not effective if used with as-needed dosing, or if taken as an additional dose when anxious. For patients who have experienced the very rapid effect of benzodiazepines in the past, they may believe buspirone is not effective since there is no subjective feeling of sedation, and no benefit is experienced for several weeks. Thus there is a high risk of self-discontinuation of buspirone unless the patient is properly counseled about its differences compared to benzodiazepines. For panic disorder, benzodiazepines and antidepressants are both effective treatments, but their onset of effect differs greatly. Benzodiazepines such as alprazolam or clonazepam can significantly reduce or eliminate panic attacks within 1-2 weeks, while antidepressants such as paroxetine or sertraline require 2-3 months to become effective. For that reason, a patient with panic disorder experiencing 2-3 panic attacks per week will usually be started simultaneously on a benzodiazepine to quickly extinguish the panic attacks, as well as an antidepressant which will be continued for long-term maintenance.

Duration of Treatment

Unlike the brief use of occasional anxiolytic drugs for situational anxiety, drug treatment of primary anxiety disorders often requires extended treatment time. Because benzodiazepines carry the risk of dependence with long-term use, they are typically used for the short-term treatment of acute symptoms, with antidepressants continued as maintenance therapy to prevent symptom recurrence.

Common Adverse Effects

Benzodiazepines most commonly may cause excessive sedation, dizziness, and impaired ability and judgement when driving a car or other motor vehicle. Anterograde amnesia, more common with the higher potency benzodiazepines such as alprazolam and lorazepam, is characterized by interference with memory after taking the drug. While not sedating, buspirone has a unique set of possible adverse effects, including dizziness, headache, and nervousness. When antidepressants are used for primary anxiety disorders, they may cause an initial worsening of the anxiety symptoms, so usually initial doses are lower than that used for depression.

Key Counseling Points: Anti-Anxiety Drugs

Patients receiving a benzodiazepine for the first time should be counseled that the degree of initial sedation is not predictable. Patients should be cautious about driving during the initial few weeks of treatment or when their dose is adjusted upward. Patients who are concerned about the potential for addiction to benzodiazepines should be reassured that when using the prescribed dose, there is little risk for addiction. The difference between addiction and dependence should be explained. Addiction is the use of excessive doses beyond the therapeutic indication for the drug. Dependence, however,

merely means the body has become used to the drug being present, and after several weeks of continuous use, the drug cannot be abruptly discontinued. The key message about dependence is that patients should not skip doses or self-discontinue treatment, but dose changes must be done slowly and in consultation with their prescriber.

Hypnotic Drugs

Clinically Important Differences

There are currently five benzodiazepines approved for treatment of insomnia in the United States. Triazolam has the shortest elimination half-life, a rapid onset of effect, and the most utility for sleep-onset insomnia, but is more likely to cause rebound insomnia and is not effective to maintain sleep during the night. Temazepam and estazolam have intermediate elimination half-lives and are useful for sleep maintenance. Flurazepam and quazepam have the longest elimination half-lives, useful for sleep maintenance, but have the greatest risk of residual daytime effects. These differences in elimination half-life and duration of effect allow selection of a drug that will be of most benefit for either difficulty getting to sleep or staying sleep.

The three "Z" drugs available in the United States as non-benzodiazepine hypnotics are zolpidem, zaleplon, and eszopiclone. As a class, these drugs have a somewhat lower incidence of memory impairment, daytime sleepiness, respiratory depression, and orthostatic hypotension compared to benzodiazepines. All three drugs are rapidly absorbed and reach peak effect within one hour, but there are significant differences in their duration of effect.

Zolpidem has an intermediate and variable duration of effect of 3-8 hours and is usually not associated with rebound effects upon discontinuation. Eszopiclone has a pharmacokinetic profile similar to that of zolpidem, but with a slightly longer elimination half-life. Eszopiclone should be used only for patients who will spend at least eight hours or more in bed after ingestion. Zaleplon is very different from zolpidem and eszopiclone because it has an ultra-short elimination half-life and duration of effect. This unique profile predicts efficacy for promoting sleep onset, but it is not effective for sleep maintenance. Zaleplon can be used to treat insomnia when it occurs, even during the night or early in the morning rather than at bedtime. Zaleplon is uniquely suited for middle-of-the-night administration and for patients exposed to short sleep opportunities and unpredictable awakenings that require maximal alertness. These differences represent useful information that should form the basis of effective patient counseling about these drugs.

While not FDA-approved for insomnia, several antidepressants with prominent sedative effects are commonly used in patients without clinical depression. Antidepressants have become an attractive alternative to benzodiazepines and Z drugs as they are not scheduled drugs, have lower risk of

abuse and dependence, are available as generics, and have less performance-impairing effects. Despite its very common use, there are few studies that assess the efficacy and safety of trazodone in primary insomnia. Trazodone's safety profile is of more concern for older adults since dizziness and orthostatic hypotension increases the risk for falls and injury, and drowsiness may worsen psychomotor and cognitive impairments.

Doxepin is a tricyclic antidepressant and is the only antidepressant drug approved for treatment of insomnia. Doxepin has demonstrated sustained efficacy for up to 12 weeks. Side effects are comparable to placebo, with no spontaneously reported anticholinergic effects, memory impairment, or substantial next-day residual sedation. Most patients can tolerate the generically available 10 mg doxepin capsules, so the more costly formulation of 6 mg and 3 mg need not be used.

A more recent addition to available hypnotic drugs is tasimelteon, indicated only for Non-24-hour sleep-wake syndrome (Non-24). Non-24 is a serious circadian rhythm disorder that affects the majority of totally blind individuals, estimated to be almost 100,000 individuals in the United States. Patients with Non-24 suffer from periodic daytime somnolence and nighttime insomnia as their circadian rhythms drift in and out of synchrony with the 24-hour day. Tasimelteon can significantly increase nighttime sleep and decrease daytime nap time. Key counseling points unique to this drug include the fact that the 20 mg dose should be taken before bedtime without food at the same time every night, and the dose should be skipped on a night that the drug cannot be taken at the same time as previous nights. Because of individual differences in circadian rhythms, daily use for several weeks or months may be necessary before clinical benefit is realized.

A new class of drugs being investigated for insomnia targets the opposite side of the brain's sleep/wake neurobiology by inactivating wakefulness rather than increasing sleepiness. Orexins promote arousal or wakefulness, so antagonism of orexin receptors decreases wakefulness, providing a sleep-enhancing effect. Suvorexant is the first available orexin antagonist. Its more common adverse effects include somnolence, headache, dizziness, and abnormal dreams.

Sedating antihistamines (diphenhydramine and doxylamine) are the most commonly used over-the-counter sleep aids, but tolerance develops quickly and there is no evidence of their efficacy beyond several weeks of continuous use. These drugs are of particular concern in the elderly, since their anticholinergic effects centrally (cognitive impairment) and peripherally (urinary retention, constipation, blurred near vision) can easily outweigh any potential benefit.

Onset of Effect

Hypnotic drugs have a very rapid onset of effect, typically within 30 minutes. Patients should be advised to take their hypnotic drug only when they are ready to get into bed. Deciding to take a shower or going to the kitchen for a late-

night snack after taking their hypnotic drug is not advisable. Patients may awaken several hours later, finding themselves sitting on the toilet or asleep at the kitchen table. Temazepam is the one exception since it has a slower onset of effect of at least one hour.

Duration of Treatment

Most hypnotic drugs have been fully studied in sleep laboratories only for several weeks to several months, thus most are approved only for short-term use.

Common Adverse Effects

Adverse effects of both benzodiazepines and the Z drugs include morning sedation, anterograde amnesia, impaired balance, increased risk of falls and hip fractures, and complex sleep-related behaviors such as sleepwalking and sleep-related eating, driving, and sexual behavior. Most of these effects are dose-related and related to the pharmacokinetic properties associated with the onset and duration of effect of individual agents. Additional concerns include rebound insomnia, withdrawal, and dependence. Abrupt discontinuation of these drugs, especially those with shorter duration of action, may cause rebound insomnia that may last 1-2 days. Rebound insomnia refers to an increase in insomnia symptoms beyond baseline levels. The rebound effect may be minimized by gradual dose reductions over weeks or months. Withdrawal refers to symptoms other than those seen after discontinuation, and may last for several weeks. The potential for abuse of these drugs is increased for individuals with a history of alcohol or other sedative-hypnotic abuse. The risk of abuse or self-escalation of dose is low for patients with no history of substance abuse, and most use their hypnotic drug only to seek a therapeutic benefit. For older adults, benzodiazepines, while effective, pose even greater risks for cognitive and psychomotor impairment with an increased risk of falls. In fact, the Pharmacy Quality Alliance (PQA) has published a pharmacy quality measure that can be used by a pharmacy or payer to track the percentage of patients age 65 and older who have received two or more prescriptions for a benzodiazepine totaling more than 90 days supply.

Since 2007, the FDA has issued a number of warnings about sleep-related complex behaviors, zolpidem dosage reductions in women, and warnings about next-day driving with the use of eszopiclone and the controlled-release formulation of zolpidem. Each of these warnings needs to be incorporated into the counseling of patients who use these drugs.

Key Counseling Points: Hypnotic Drugs

A nonpharmacologic treatment strategy that is a useful part of pharmacist counseling is sleep hygiene. Sleep hygiene measures should be discussed to help identify and eliminate factors that might be interfering with sleep, particularly when patients seek an over-the-counter sleep aid (Table 9). Patients

receiving a hypnotic drug for the first time should be counseled to take it just before bedtime, as the onset of effect with most all hypnotic drugs is within 30 minutes. In the first week of use, patients should determine if there is any residual morning hangover effect that may impair driving. Studies of patients who complain of insomnia indicate that up to 30 percent self-treat with alcohol; patients should be advised to avoid drinking if a hypnotic drug will be used. Elderly patients given hypnotic drugs are of special concern, as the risk of falls and cognitive impairment may outweigh any beneficial effect. If patients believe their current dose is not effective, or the patient wishes to discontinue treatment, counseling must include the advice that any dose adjustment or discontinuation of treatment must be done in consultation with their prescriber.

SUMMARY

Patients who receive medication for psychiatric disorders have a great need for effective medication counseling from their pharmacist. Today's patient is more likely to have access to drug information from websites, blogs, written material provided by pharmacies, and direct-to-consumer advertising on television and magazines. The purpose of medication counseling by pharmacists is no longer to merely provide more drug information, but to assist the patient in prioritizing what information is most important, correct misinformation, and answer patients' questions and concerns. In addition to securing an adequate knowledge base regarding medication for psychiatric disorders, the pharmacist must also develop the skills of being able to comfortably discuss psychiatric symptoms as well as warnings regarding possible adverse effects such as sexual dysfunction and the risk of increased suicidal ideation. Medication counseling can positively impact a patient's treatment outcome and can support treatment adherence. Medication counseling can also be one of the more rewarding and enjoyable responsibilities of a pharmacist. ■

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Editor's Note: For the list of references used in this article, please contact *America's Pharmacist* Managing Editor Chris Linville at 703-838-2680, or at chris.linville@ncpanet.org.

Continuing Education Quiz

Select the correct answer.

1. Which one of the following is true regarding counseling patients about psychiatric medication?
 - a. It is the primary means for pharmacists to improve patient outcomes from their drug therapy.
 - b. The counseling discussion should start with side effects, as this is the most important issue for patients to understand.
 - c. Federal law requires that patient counseling be done for new and refill prescriptions for psychiatric medication.
 - d. It is best not to mention sensitive topics like substance abuse or sexual dysfunction when counseling patients taking antidepressant or antipsychotic drugs.
2. Which one of the following is true regarding medication counseling by pharmacists?
 - a. Studies indicate that the frequency of counseling has increased since the 1990s.
 - b. The FDA MedGuides are an effective method to increase patients' awareness of medication information.
 - c. The majority of states in the U.S. require only an offer to counsel instead of face-to-face counseling.
 - d. Providing a patient an FDA MedGuide can substitute for the requirement to counsel patients on their medication.

(Questions 3-6 relate to GM)

GM, a 67-year-old male, has been taking citalopram 20 mg at bedtime for two weeks for his first major depressive episode. His initial symptoms included depressed mood, anhedonia, psychomotor agitation, insomnia, and difficulty concentrating. His other medication includes atenolol and donepezil. Today he states his sleep has only slightly improved, but his other symptoms have shown no improvement after two weeks. He complains of persistent nausea, occasional diarrhea, and now no longer wants to continue taking citalopram. He asks you what he should do now.

3. Which one of the following is true regarding GM's citalopram treatment?
 - a. His antidepressant should be switched to different drug since citalopram is not effective.
 - b. He should be asked if he takes the citalopram with food, as nausea can be reduced or managed if taken with food.
 - c. Venlafaxine could be possible alternative choices to reduce the risk of nausea and diarrhea.
 - d. Given his depressive symptoms, bupropion could be a good alternative choice.
4. GM's wife is concerned about his insomnia, and asks if he could take an over-the-counter sleep aid containing diphenhydramine with the citalopram. As you discuss his sleep complaint, which one of the following would be of greatest concern regarding his sleep hygiene routine?
 - a. Eating a large meal with alcohol near bedtime
 - b. Exercising 4-6 hours before bedtime
 - c. Watching television in the evening
 - d. Use of caffeine with lunch
5. What is your advice regarding use of diphenhydramine by GM?
 - a. It can be safely used but only at its lowest dose given his age.
 - b. It is an effective treatment for insomnia as its efficacy has been established in studies for more than two months.
 - c. His use of donepezil suggests some cognitive impairment that could be worsened by diphenhydramine. Do not recommend its use.
 - d. The anticholinergic properties of diphenhydramine could worsen his nausea and diarrhea. Do not recommend its use.
6. His physician decides to switch GM from citalopram to mirtazapine. How do you counsel GM regarding this new antidepressant?
 - a. "Mirtazapine is much less likely to cause nausea or diarrhea compared to citalopram."
 - b. "Take it in the morning as it can cause increased energy and interfere with sleep."
 - c. "Do not drink alcohol if you are taking mirtazapine."
 - d. "Mirtazapine is more effective than citalopram, but it may take one month to work."
7. Which one of the following is true when counseling patients on antipsychotic or mood stabilizer drugs?
 - a. Tie the purpose of the drug to their diagnosis, not just the symptoms that the patient acknowledges.
 - b. Mood stabilizers are best explained as helping with sleep and slowing down thinking.
 - c. It is best not to scare patients by discussing serious or rare side effects.
 - d. Stress that these medications are usually used long-term to prevent return of symptoms, not just to treat acute symptoms.

- 8.** A 22-year-old male with schizophrenia presents you a new prescription for quetiapine. He says he was taking risperidone in the past for his nerves, but had trouble with weight gain and dizziness. His doctor gave him this new drug but didn't tell him anything about it. He asks you if it is different than his previous drug. Your best response would be?
- "Quetiapine is better than risperidone to treat your nerves."
 - "Quetiapine is less likely to cause weight gain than risperidone."
 - "Quetiapine is more sedating than risperidone, so it is best to take it at bedtime."
 - "There are no real differences between these two drugs, but sometimes a patient will do better on a different drug."

(Questions 9-10 relate to SW)

SW, a 38-year-old male with a diagnosis of panic disorder, is taking paroxetine 40 mg at bedtime and clonazepam 1 mg twice daily. He has taken both drugs for eight weeks, and tells you he has experienced no panic attacks for three weeks and now feels more comfortable leaving his apartment to run errands. His only complaint is continuing daytime sedation forcing him to take naps in the afternoon.

- 9.** SW asks if he should still take his medication since his panic attacks are gone. Your best response is?
- "Many patients can stop their clonazepam once the panic attacks are gone, but the paroxetine should be continued longer."
 - "The panic attacks are gone because of the two medications, so they both must be continued."
 - "The dose of both drugs can be decreased to lower maintenance levels since your symptoms are gone."
 - "Any changes in drug therapy must be decided with your prescriber. Do not change the dose or discontinue a drug on your own."
- 10.** SW asks if he can get addicted to the clonazepam. Your best response is?
- "Addiction is only possible if the drug is used more than six months."
 - "If used for a therapeutic reason like your situation, dependence—not addiction—is possible."
 - "As you have taken clonazepam for eight weeks, talk with your doctor soon to get off the drug before you become addicted."
 - "You can try to skip 2-3 days of clonazepam to see if you have any withdrawal effects if you are concerned."

11. The two most important counseling points for a patient receiving a new prescription for buspirone for generalized anxiety disorder are "be patient since this drug may take several weeks to begin working," and "take it at bedtime since it is sedating, which can help you sleep."

- True
- False

12. The FDA safety announcements about zolpidem and eszopiclone that should be part of patient counseling discussions include all but which one of the following?

- Patients should be warned about sleep-related complex behaviors.
- The risk of next morning impairment of activities is greater with the extended-release formulations.
- The recommended dose is now 5 mg for immediate-release tablets for men and women.
- Patients should be warned about driving the day after using extended-release zolpidem.

13. Which one of the following is correct and important to use in counseling regarding tasimelteon and Non-24 disorder?

- Patients with Non-24 suffer from excessive daytime napping and hypersomnia at night.
- Tasimelteon is given as a 20 mg dose in the morning to synchronize circadian rhythm.
- The onset of clinical benefit with tasimelteon often requires weeks to months.
- Tasimelteon is approved for treatment of Non-24 and shift work insomnia.

14. Which one of the following hypnotic drugs has been most associated with causing priapism?

- Trazodone
- Zolpidem
- Quetiapine
- Doxepin

- 15.** A 31-year-old female has been taking paroxetine 20 mg at bedtime for three weeks for a major depressive episode. She is concerned about paroxetine causing sexual side effects. She heard on TV that drugs such as paroxetine can cause sexual problems, and she says her interest in sex (libido) has not been good for several months. She wants to stop the paroxetine, even though her symptoms of depression would be untreated. Which one of the following is true regarding antidepressants and sexual function?
- Antidepressants that decrease serotonin activity are associated with at least a 30 percent likelihood of causing anorgasmia.
 - Decreased interest in sexual activity can be a common symptom of depression, and antidepressants may actually increase libido with successful treatment of the depression.
 - The most common effect of antidepressants on sexual function is erectile dysfunction in men and anorgasmia in women.
 - Bupropion and venlafaxine are least likely to negatively affect sexual function
- 16.** A 37-year-old male librarian has been taking bupropion SR samples from his physician for one week to treat a major depressive episode, and now presents you with a new prescription. He states his doctor didn't tell him about any side effects and wonders if he can drink a glass of red wine with dinner while taking this medication. Your best response is?
- "Since alcohol can worsen depressed mood, it is best not to drink alcohol while you are being treated."
 - "Bupropion plus alcohol can lead to increased sedation and breathing problems."
 - "Alcohol is not a concern with bupropion as there is no sedative effect from bupropion."
 - "One beer would be safer than red wine to minimize the risk of drug interactions."
- 17.** A 21-year-old female with schizophrenia presents you a new prescription for olanzapine 10 mg daily. She asks you what she should know about it as her doctor did not tell her anything except that it will help her relax.
- "It is best to take it in the morning, as bedtime dosing might interfere with sleep."
 - "Be patient as it may take several weeks for it to work."
 - "This drug is likely to cause weight gain and dry mouth."
 - "This drug will help you with your mood swings."
- 18.** When counseling about adverse effects of mood stabilizers, which adverse effects are common with both lithium and valproate?
- Sedation
 - Hypothyroidism
 - Fine hand tremor
 - Weight gain
- 19.** Which one of the following drugs does not carry a warning of possible increased suicidal ideation?
- Lithium
 - Duloxetine
 - Vilazodone
 - Sertraline
- 20.** Which one of the following drugs has the most rapid onset of clinical effect for its indication?
- Olanzapine for schizophrenia
 - Buspirone for generalized anxiety disorder
 - Clonazepam for panic disorder
 - Tasimelteon for Non-24 disorder