Professional Psychology: Research and Practice
2004, Vol. 35, No. 2, 158–163

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0735-7028/04/$12.00 DOI: 10.1037/0735-7028.35.2.158

Professional Issues in Pharmacotherapy for Psychologists

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Much of the critical discussion of prescriptive authority for psychologists has focused on the question of whether this is the right direction for the profession. The authors contend that discourse on prescriptive authority should progress to identification of the challenges that lie ahead for psychology as a prescribing profession, with the goal of anticipating and addressing those challenges as early in the process as possible. The authors identify a number of such potential challenges, including both general issues of professional identity and more practical concerns. In some cases, the authors express their opinions on these matters, but more generally their intention is to spur reasoned discussion of the issues psychologists will face.

In 1995, the American Psychological Association (APA) Council of Representatives formally endorsed the pursuit of prescriptive authority for appropriately trained psychologists. This resolution has sparked a great deal of debate, with strong opinions voiced on both sides (e.g., DeNelsky, 1996; Hayes & Heiby, 1996; Heiby, 2002; Hines, 1997; Norfleet, 2002). Objections have been remarkably similar to those raised over 50 years ago when APA began encouraging the development of training programs in psychotherapy for psychologists (Shakow, 1965; Sward, 1950). The recent enactment of legislation awarding prescriptive authority to psychologists in New Mexico increases the likelihood that the outcome for the current agenda will also mirror that of 50 years ago. In light of these events, the critical analysis of APA's decision should move beyond the question of whether it is the right choice to an evaluation of the professional challenges created by adding prescriptive authority to psychologists' scope of practice.

Fortunately, the experiences of other prescribing professions, as well as psychologists, in response to the development of a therapeutic role, help us identify what some of those challenges will be. The purpose of the present article is to discuss some of the key issues to be addressed. The goal here is not to reach closure on these issues but to begin an internal dialogue about the best means to ensure that we consciously guide the evolving character of psychology as a profession and a discipline.

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ALTHOUGH SOME OF THE AUTHORS of this article are involved in the governance of APA or APA's Division 55 (the American Society for the Advancement of Pharmacotherapy), the opinions expressed here are those of the authors and are not intended to reflect the official position of the association.

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General Issues

Maintaining Our Identity

There is perhaps no objection to prescriptive authority more serious than that it can lead to the loss of our identity as psychologists. The importance of this objection is not necessarily predicated on its being a particularly likely outcome of obtaining prescriptive authority, but rather on its being the most potentially damaging outcome to psychology both as a discipline and a profession. The fear is that psychologists will follow the path of psychiatrists, many of whom have surrendered the psychological approach to the understanding and amelioration of mental disorders for a largely medical approach, resulting in the deterioration of traditional psychotherapy and assessment skills. Such an outcome could hurt the discipline in that it would deepen existing rifts between professional and research psychologists, and it would hurt the profession in that it would reduce rather than expand the variety of treatment options we can offer our patients.

It is essential that psychology learn from psychiatry's error, an error that resulted in large-scale abandonment of psychotherapy as a treatment option and, in many cases, resulted in the restriction of treatment options to medication alone.[1] To avoid this outcome, we recommend that prescriptive authority remain a proficiency for a select few, rather than becoming a basic clinical skill for all, with the bulk of training occurring after completion of doctoral-level training as a psychologist health care provider. In this way, the trainee in pharmacotherapy has already committed at least 5 to 7 years to learning a largely psychosocial model of diagnosis and treatment.

The advanced practice nurse (APN), a term that encompasses nurse practitioners and several other advanced training options in nursing, offers a good model for the appropriate role of the prescriber within psychology. The emergence of the APN as an independent practitioner with some form of prescriptive authority in all 50 states has enhanced the image of nursing among consumers and other health professionals and has created opportunities for nurses that did not previously exist. However, APNs remain a minority among nurses and do not dominate nursing as pharmacologists have come to dominate psychiatry. Nursing defines the identity of the APN rather than the other way around.

Although the threat to professional identity continues to be frequently raised as an objection to prescriptive authority by its opponents (cf. Robiner et al., 2002), there is no evidence to suggest that these fears are likely to become reality unless there are dramatic changes in the manner in which psychologists are prepared as prescribers. The few prescribing psychologists who graduated from the Department of Defense program have demonstrated no change in their fundamental professional identity, even though (as the opponents of prescriptive authority often like to point out) the length of their medical training was substantially longer than that called for in APA's (1996) model curriculum for training psychologists in pharmacotherapy. Those favoring prescriptive authority have consistently argued that a graduate education that maintains our fundamental theoretical orientation as behavioral scientists will be the determining factor in predicting practice preferences (Levant & Sammons, 2002).

The key condition in the previous paragraph is the maintenance of current training models for psychologists, even those who ultimately plan to prescribe. To protect the current identity of psychologists, it is important to clarify the degree to which pharmacotherapy should be incorporated into predoctoral training. Though APA's (1996) model curriculum for training psychologists in preparation for prescriptive authority is entitled *Recommended Postdoctoral Training in Psychopharmacology for Prescription Privileges,* the preamble states

> the same curriculum and practicum experiences could be incorporated into an expanded predoctoral curriculum in programs that so wish. These programs could then accept students who would enter their graduate education with the goal of a professional practice that includes prescription privileges. (p. 1)

We believe that widespread expansion of the standard predoctoral curriculum in this way would be potentially dangerous for the future of the profession. A basic knowledge of pharmacotherapy should be expected of all practitioners but should not comprise a substantial portion of their predoctoral training. For the majority of practitioners, pharmacotherapy is best treated as a proficiency to be mastered subsequent to the integration of basic knowledge, skills, and abilities that make up health care psychology as traditionally practiced. Accordingly, it is our position that training for prescriptive authority should remain a largely postdoctoral endeavor.

Over time, we are likely to find some students who aspire to a career focusing on basic or applied psychopharmacology, potentially justifying the development of curricula that accommodate this interest. However, even in these instances, APA educational policy must be designed to ensure that predoctoral training in psychopharmacology does not occur at the expense of an education in the psychosocial fundamentals that continue to define our field. Furthermore, it is important that such programs remain a relatively small portion of training opportunities in psychology. Doctoral training programs specializing in neuropsychology or health psychology offer a good prototype for the appropriate level of specialization in predoctoral training experiences.

Toward a Psychological Model of Prescribing

One of the desirable outcomes of ensuring that prescribing psychologists maintain their traditional identity as psychologists is the development of a uniquely psychological model of prescribing. The specifics of such a model will have to emerge out of dialogue over psychologists' experiences prescribing to their patients. However, even at this early stage, we can identify three primary principles that should underlie such a model.

First, a psychological model would integrate pharmacotherapy into the existing armamentarium of skills available to the clinician, allowing selection from a variety of treatment options based on the specifics of each case. Medicine in general, and psychiatry to a lesser extent, has failed to meet the needs of individuals with

[1] There are few objective data concerning the degree to which psychiatrists in the United States continue to provide psychotherapy, though a decline in its frequency is universally acknowledged (e.g., Gabbard & Kay, 2001; Luhrmann, 2000). Pincus et al. (1999) found that psychiatrists self-reported providing psychotherapy to 43.1% of 1,228 patients, but Goldman et al. (1998) found that psychiatrists provided psychotherapy in only 12.6% of 1,517 managed care cases involving simultaneous psychotherapy and pharmacotherapy for treatment of depression.

mental disorders because they have rejected all but one modality of treatment. Thus, most patients are prescribed medication without consideration of whether it represents the optimal treatment.

For example, surveys of physicians' practice patterns suggest that almost 100% of patients seen for depression in primary care settings receive a prescription for medication, and very few of these patients seek other forms of treatment, such as psychotherapy (National Depressive and Manic Depressive Association, 2000). Psychiatrists are similar in their use of medication, placing approximately 90% of their patients on psychotropics, with most of the remaining patients apparently seen for psychotherapy alone (Pincus et al., 1999).

This is particularly questionable approach for two reasons. Engel (1977) was the first to make the case that medical disorders can be understood only within a complete biopsychosocial framework. As this model gains credence in psychiatry and society at large (e.g., Satcher, 1999), a largely biomedical approach to the conceptualization of mental disorders seems increasingly difficult to defend (Gabbard & Kay, 2001).

In addition, there is a growing body of evidence that medication is not necessarily the best first-line treatment for at least some mental disorders. For example, a review of drug trials used to support applications to the Food and Drug Administration suggested that medication is no more effective than placebo, at least for milder forms of depression (Khan, Leventhal, & Khan, 2002; Kirsch, Moore, Scoboria, & Nicholls, 2002; Moncrieff, 2001). A recent meta-analytic comparison of complete remission of mild to moderate depression found no difference in efficacy for antidepressants versus psychotherapy, with lower dropout rates for participants in therapy (Casacalenda, Perry, & Looper, 2002). Cognitive–behavioral therapy is increasingly accepted as the treatment of choice for generalized anxiety disorder (Tonks, 2003), while a recent review of treatment options for mental disorders in geriatric populations identified a number of circumstances where psychosocial interventions are equal or superior to pharmacotherapy in terms of effectiveness (Bartels et al., 2002).

In contrast, preliminary evidence suggests that psychologists who are given authority for medication management use pharmacotherapy for a much smaller percentage of their patients (J. L. Sexton, personal communication, August 4, 2000; Wiggins & Cummings, 1998). Psychologists who are comfortable with both psychosocial and biological approaches will be in a much better position than primarily medical professionals to determine whether to prescribe on the basis of the literature and the individual rather than the biases of training. Within a biopsychosocial framework, mental disorders should be treated as multifactorially determined, and medication should generally serve an adjunctive role in a multimodal treatment plan.

Second, a psychological model would treat prescribing as a collaborative activity. A number of studies have demonstrated that a large proportion of individuals who are prescribed psychoactive medications terminate use of the medications prematurely (e.g., Mojtabai et al., 2002; Pampallona, Bollini, & Tibaldi, 2002). Given that medication is not always necessary or palliative, the decision to terminate medication can be reasonable if the patient accurately perceives the medication as ineffective or chooses to pursue other alternatives. Unfortunately, patients often feel uncomfortable sharing such concerns with physicians and terminate the use of medication unilaterally. This phenomenon reflects the well-documented failures in communication between prescribers and patients in medical practice (e.g., Lawton-Smith, 2002).

In contrast, a psychological, collaborative approach would be based on the mutual development of a contract between prescriber and patient, including a review of medication and its alternatives; different medication options; a discussion of side effects to the extent considered appropriate for the individual; information about the latency to reach effective dosage level; an evaluation of obstacles to participation, including motivation for the intervention; and a plan for ongoing monitoring of progress, side effects, obstacles, and compliance. In particular, a collaborative model would allow for the possibility that the decision to terminate medication would be a joint decision and might be an affirmative step rather than resistance to treatment.

A psychological model of prescribing attempts to place patients in the role of primary decision makers. The psychologist serves as a consultant and provider of expert knowledge who educates and assists patients in determining the treatment plan best suited to their circumstances. In particular, the risks and benefits of appropriate treatment options must be communicated effectively to the patient. Thus, the provision of accurate and complete informed consent is a cornerstone of the psychological model of prescribing (Sammons, 2001).

Third, a psychological model of prescribing would take into consideration the potential psychological meanings of medication. The term *meaning* is intended here to encompass the various potential formulations for understanding how the person would interpret the act of taking medication, including cognitive schemata, interpersonal templates, object relations, or wishes and fantasies. Fears associated with the use of medication and reactions to authoritarian or caretaking figures must be considered in determining how to interact with the patient over medication issues.

A key error in the medical practice of pharmacotherapy is the treatment of prescribing as an impersonal act. This error directly impacts compliance rates, negative reactions, and the effectiveness of medication. Prescribing psychotropic agents is an inherently interpersonal act, one that can be improved by a psychosocial approach to the event. Ultimately, the best predictor of satisfactory outcome is likely to be patient choice, the patient's willingness to participate in the treatment offered. Because patient choice is potentially influenced by a variety of personal, economic, familial, and cultural factors, it is incumbent on providers to be aware of the influence of these factors in guiding patient decisions regarding the most appropriate treatment.

The Particulars of Practice

Considerations for Nonprescribing Psychologists

Even though few psychologists in the United States are currently permitted to prescribe in their role as psychologists (though some do so through dual licensure), professional issues of some importance concerning pharmacotherapy already affect psychologists. The more inclusive of the issues to be discussed here is the legal status of consulting with patients and other professionals concerning medication management. Anecdotally, many clinicians report that they are often asked by other professionals to provide advice concerning appropriate biological treatment for a patient or that clinicians approach other professionals with concerns of their

own (see VandenBos & Williams, 2000). Such reports are frequently accompanied by an admission that psychologists feel uncomfortable with this role given their limited training in psychopharmacology but that the exigencies of the situation force the role on them.

Given the frequency of this practice, it is not surprising that licensing boards in a number of jurisdictions have explicitly identified consultation with other professionals about pharmacotherapy as part of the scope of practice for psychologists. These jurisdictions include California (where a consultative role in medication management is explicitly stated in the scope of practice for psychologists), the District of Columbia, Florida, Louisiana (with restrictions), Massachusetts, Missouri, Oklahoma, and Pennsylvania. In most cases the boards have chosen to note in some way that final responsibility for medication decisions rests with the other professional. Individuals in other jurisdictions who regularly find themselves engaging in such consultations should consider requesting such a statement from their board as a means of assuring themselves that they are acting within their scope of practice.

The second activity in which current involvement in pharmacotherapy has professional implications for psychologists has to do with participation in practicums related to training in pharmacotherapy in anticipation of prescriptive authority at some point in the future. In some cases, patient consultations are occurring outside the context of an ongoing therapeutic relationship, with psychologists evaluating patients referred to them for the sole purpose of providing a treatment recommendation to a supervising prescribing professional. Psychologists involved in such practicums should examine closely the definition of scope of practice in their jurisdiction, as well as any statements provided by the licensing board concerning consultations on medication, to determine whether such actions are permissible within their jurisdiction.

Considerations for Prescribing Psychologists

If, as we recommend, pharmacotherapy remains an advanced proficiency for psychologists rather than a basic skill, the circumstances will exist in which patients in ongoing care with other professionals will be referred for medication evaluation only. Many such referrals will come from psychologists or other mental health practitioners who have not received prescriptive authority, though some will also come from physicians managing medical conditions. Under such circumstances, economic pressures will be brought to bear on psychologists to adopt the brief (15 min or less) medical consult. Indeed, some (e.g., Luhrmann, 2000) consider economic factors, such as the growth of managed care, the most important contributors to the decline of the biopsychosocial model in psychiatry. It is impossible at this point to evaluate whether prescriptive practice will substantially impact malpractice rates (this has not been the case with APNs), but if this were to happen it could increase the pressure on prescribing psychologists to shorten consultation sessions.

We believe it would be counterproductive for psychologists to accept the brief model of consultation currently dominant in much of psychiatric practice, as it precludes the psychological approach to prescribing discussed earlier in this article. Psychologists accepting such referrals should recognize that their responsibilities as a prescriber exceed what is possible in a 15-min evaluation. First, they must evaluate the patient in light of current evidence on the conditions under which medication is likely to be helpful. Second, they must adopt the collaborative model described previously, which requires evaluation of the patient's feelings about medication as an option, educating the patient about the medication, and developing and implementing a plan for feedback from the patient and monitoring of the patient to evaluate effectiveness and side effects.

We recognize that with prescriptive authority, it is likely some psychologists with expertise in the psychopharmacological treatment of mental conditions will devote a substantial amount of their practice to consultative services to other professionals. We believe this is an acceptable role for psychologists, in the same way that many psychological assessors serve primarily a consultative role to other professionals. However, it is important that such consultations should always include an evaluation of whether psychological treatments are being adequately considered. Furthermore, like the APN in nursing, psychologists who specialize in the conduct of brief medication evaluations for other professionals must remain a relatively small proportion of practicing psychologists.

In summary, psychologists who prescribe must avoid the traditional authoritarian role adopted by many medical professionals. In keeping with a collaborative, integrative model of psychotherapy and pharmacotherapy, prescribing therapists must give responsibility to patients for the decision of whether to include medication in their course of treatment. To fulfill this role adequately, psychologists must remain faithful to their psychosocial roots. Accordingly, it would be counterproductive, perhaps even destructive to the ethos of the profession, for psychologists to develop practices that are largely devoted to medication evaluation.

Interactions With the Pharmaceutical Industry

A common argument against prescriptive authority for psychologists is that our field will be as susceptible to influence from the pharmaceutical industry as the medical profession. Medicine is increasingly troubled by these influences. In recent years, concerns have been raised over the degree to which gifts from drug representatives influence medication decisions (Wazana, 2000), the extent to which continuing education is funded by the industry (Ross, Lurie, & Wolfe, 2000), and the degree to which research contracts restrict the dissemination and interpretation of findings (Bodenheimer, 2000; Choudhry, Stelfox, & Detsky, 2002; Davidoff et al., 2001). For example, Davidoff et al. (2001) criticized agreements that forbid the publication of findings without the permission of the funder. Unfortunately, given the economics of research, they concluded that any attempt to prohibit such contracts is likely to fail, though they did not address the possibility of legislative restrictions to research-funding contracts.

We hope that psychologists' training in the critical analysis of research and psychological models of mental disorders will enhance their resistance to the influence of the pharmaceutical industry compared with other mental health professionals. Psychologists also have the benefit of learning from the prior experiences of other prescribing professions. However, we believe it will require the development of professional guidelines for interactions with the pharmaceutical industry to control the risk of undue influence.

Psychologists involved in funded research should be aware of the guidelines that have been adopted by the International Com-

mittee of Medical Journal Editors (Davidoff et al., 2001) for conflicts of interest created by financial relationships with funding sources. Educational institutions may also wish to consider developing guidelines for faculty who engage in financial relationships with industry (Cho, Shohara, Schissel, & Rennie, 2000). Psychologists involved in medication management should be trained to look for conflict-of-interest statements in any study reporting the outcomes of drug therapy. It is also important to assume that, given that pharmaceutical companies can prohibit the publication of findings suggesting their treatments are inefficacious, the burden of evidence is greater for such treatments than for those not supported by similar funding arrangements (see Kirsch et al., 2002).

In addition, psychologists should consider how to minimize the impact of the pharmaceutical industry on treatment decisions. This may include the development of treatment guidelines by agencies that are independent of the influence of the pharmaceutical industry (see Choudhry et al., 2002) and/or guidelines for interactions with drug representatives. Education about the extent to which economic factors influence the behavior of prescribing professionals should also be a component of both predoctoral and postdoctoral course work in pharmacotherapy. Such education is essential to ensuring that psychologists base their decisions on patient needs rather than presumptions fostered by advertising.

Interactions With Other Professionals

In the struggle to achieve prescriptive authority for psychologists, a particularly welcome experience has been the expression of support from nonpsychiatric physicians. It is likely that primary care physicians will benefit from the greater availability of knowledgeable prescribers of psychotropic medications resulting from awarding psychologists prescriptive authority. However, such interactions will create additional professional challenges.

It will be important to educate physicians concerning the psychological model of prescribing. It is unusual for physicians to think in psychological terms about the decision to prescribe. Despite lack of familiarity, we find that many physicians are open to thinking about the prescriptive process in new ways and are respectful of the ways psychologists address this issue. Increased collaboration with primary care physicians should also be used as the springboard for heightening physician awareness of mental disorders as both primary and secondary issues for their patients (Bray, Enright, & Rogers, 1997), just as physicians should be educating psychologists about the ways that physical issues can impact on mental disorders.

Interactions With Health Care Facilities

The awarding of prescriptive authority will change the role psychologists play in health care facilities. With training in research methodology, assessment and diagnostics, psychotherapy, and pharmacotherapy, the psychologist can potentially play a prominent role in the administration and development of mental health services. Although there is a particularly exciting potential opportunity associated with awarding prescriptive authority to psychologists, as with all other elements of prescriptive authority, it creates new challenges.

Once psychologists achieve greater positions of authority, psychologists may find themselves advocating for increased diversity in the available treatment options. Psychologists will at times be obliged to educate traditional biomedical practitioners in the differences between psychotherapy and behavior therapy versus counseling, the value of psychological assessment, and the use of medication as an adjunctive treatment.

Continuing Training Requirements

The APA Practice Directorate has determined that among the 50 states and the District of Columbia, 42 currently require psychologists to participate in some degree of continuing education (R. Jennings, personal communication, September 20, 2002). At present, though, only one state (Georgia) requires psychologists to receive regular training in psychotropic medications. This is true despite evidence that almost all practicing clinicians report that they regularly engage in medication decision making for their patients (VandenBos & Williams, 2000). We believe that all clinicians should be expected to maintain a minimum level of currency in their knowledge of pharmacotherapy.

For the prescribing psychologist, this obligation is proportionately greater. It would be presumptuous for us to attempt to specify the amount of continuing education that would be appropriate for keeping abreast with developments related to the expanded scope of practice or to try to decide whether this additional training implies the need for modification of existing continuing education requirements because such judgments fall within the purview of the individual state boards. However, we do recommend that state boards address this issue at an early date, perhaps even before enabling legislation is enacted.

Final Thoughts

Fifty years ago, psychology made the transition from a largely academic discipline to one that incorporates a vibrant and growing health care component. The decision to pursue psychotherapy training was made despite uncertainty about the effect it would have on psychology in general, bitter opposition in psychiatry, and disagreement among psychologists themselves. In the end, we think few would disagree that the positive consequences of psychotherapy training—to both the public and psychology—have outweighed the negative.

The decision to pursue prescriptive authority is similarly not without risk. We believe the prescriptive agenda has progressed to the point where there is nothing more to be gained from treating these risks as reasons not to move forward. It is time instead to consider them as challenges to be overcome. This article is intended as the first step in opening a dialogue about the implications of prescriptive authority for psychology and how best to minimize its negative consequences. With the opportunity to learn from both the mistakes and the successes of other professions as they became involved in the practice of pharmacotherapy, we believe psychology has a tremendous opportunity to avoid the mistakes of others while reaping the same benefits for themselves and for the people they serve.

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Received November 26, 2002
Revision received April 15, 2003
Accepted July 16, 2003 ■