

Psychopharmacology Training in Clinical Psychology: A Renewed Call for Action

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Knowledge of psychopharmacology is essential for a clinical psychologist to practice his/her profession, regardless of whether one desires to become licensed to prescribe psychoactive medications. This commentary reiterates a call made almost 20 years ago for all practitioners to gain and utilize this knowledge. Without psychopharmacology knowledge, one is extremely limited in the ability to interact with medical prescribers and to optimally serve their patients as a valued member of the health care team. © 2011 Wiley Periodicals, Inc. *J Clin Psychol* 67:1–4, 2011.

I have read the article by Muse and McGrath (2010), published in this journal in January 2010, as well as the accompanying rebuttal by Heiby (2010). I, as a physician and psychopharmacologist, strongly support the efforts of specially trained psychologists to seek prescription authority for psychoactive medications. However, no matter one's position on this contentious issue, clinical psychologists in general suffer a critical deficiency in pharmacology knowledge, which impedes their ability to evaluate their patients' cognitive abilities (at minimum), to evaluate medication side effects, and to recommend modification of existing treatments. Worst of all, it impedes optimal and comprehensive care for their patients.

Psychopharmacology deficiencies both in psychology training programs and in post-graduate continuing education have long been noted. In 1993, an Ad Hoc Task Force of the American Psychological Association (Smyer et al., 1993) addressed these deficiencies, stating that for all practicing psychologists, "more formal training in psychopharmacology is needed." This refers to expanded training during predoctoral graduate training and continuing into the years of clinical practice. The Task Force committee recommended three levels of training, from expanded basic psychopharmacology to prescription privileges. Therefore, not only must the issue of prescription privileges be addressed, but more comprehensive psychopharmacology training must be offered to both predoctoral students as well as graduate clinical practitioners.

Speaking as a physician/psychopharmacologist, most professional psychologists with whom I come into contact throughout the country know only minimally about how psychoactive medications affect their patients and compromise their response to psychotherapies. They have minimal knowledge about how medications such as benzodiazepines, lithium, or anticonvulsant "mood stabilizers" affect cognitive abilities and daily functioning. They know little about how dopaminergic agents (e.g., bupropion) affect anxiety. It is my strong feeling that every clinical psychologist needs to be competent in monitoring the side effects of prescribed medications on their patient's behavior and in watching for adverse side effects, even before we enter into discussion of the prescription authority issue.

The majority of psychologists will choose not to become involved as prescribing psychologists, but that is not the primary issue. How can any psychologist practice optimally without knowledge of how psychoactive medicines behaviorally or cognitively affect their patients? Further, how can a professional hope to join a "health care team" without being able to consult with prescribers about medication issues, perhaps offering input into medication efficacy and adverse cognitive and behavioral effects? How can we responsibly avoid instilling

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competence in psychopharmacology, so that psychologists can become adept as side effect monitors as well as consultants involved in medication monitoring, overall treatment planning, patient management, even management of treatment efficacy (or lack thereof), and discontinuation planning? Why have we allowed professional psychologists to “fall off the health care team”? It is time to change our teaching and practice!

As I lecture psychopharmacology, I frequently ask clinical psychologists how they feel they differ from mental health counselors. What unique contributions do psychologists bring to the table? In my view, their strength lies in their unique ability to provide excellence in testing, assessment, and diagnosis. Beyond this, psychologists’ treatment techniques may differ only subtly from that displayed by well-trained counselors. Now psychologists have another unique opportunity of standing out from other mental health professionals: assist the prescriber in developing and monitoring an entire treatment plan for a patient. I feel that all psychologists should be trained and competent to perform the following:

- Perform necessary psychological and cognitive testing and evaluation.
- Complete a patient and family history.
- Request a medical evaluation as may be appropriate.
- Develop a plan of comprehensive therapy with other professionals to set the stage for treatment planning as well as monitoring outcome and side effects.
- Plan for monitoring efficacy of therapeutic interventions for both the short and the long term.
- Educate all about the treatment plan.
- Document assent of the patient and any caregivers.
- Focus on risks and benefits of treatment choices.
- Assist with the development and monitoring of psychotherapeutic and medication trials.
- Plan for ongoing assessment of patient response following initial trials of psychotherapeutic treatments and medications.
- Develop and monitor discontinuation plans and strategies for treatment reinitiation should the patient relapse (Walkup & The American Association of Child and Adolescent Psychiatry, 2009).

To achieve this, knowledge of psychopharmacology is essential. One must read relevant medical literature (and know how to access such literature) and be able to converse with the prescriber. Only with this knowledge can one become a valued member of the treatment team. Clinical psychologists can bring much to the table, even if they choose not to prescribe. With such knowledge, they can be much more effective members of the health care team and can be much more satisfied with their professional work.

On the other hand, if one occasionally feels left off the treatment team, this may result from the fact that treatment for mental health disorders continues to be focused largely on medication therapies. This situation has been driven by large pharmaceutical houses, by media advertising, by widespread economic incentives, and by physician reluctance to acknowledge nonmedication contributions (Carlat, 2010). This has allowed nonprescribing mental health personnel to be devalued for their “nonmedical” contributions. We are in a desperate shortage of trained psychiatrists at all levels from child and adolescent psychiatrists to geriatric psychiatrists. Certainly, manpower shortages, economic conflicts, stresses, and realities have led many psychiatrists away from thorough assessment, diagnoses, and nonmedication therapies to the widespread practice of being medication managers. Currently, about 85% of prescriptions for psychoactive medications are written by nonpsychiatrists, including general practitioners and mental health nurse practitioners with modest training in mental health diagnosing or psychosocial interventions.

Nowhere else in medicine (with the possible exception of treating infectious diseases) has reliance been so heavily placed on medication as a sole therapy for illness. For example, few physicians treating diabetes, hypertension, heart disease, or chronic pain would rely only on medication; they routinely refer their patients to dietitians, nutritionists, and physical therapists, receiving frequent feedback and functioning as a “team.” Desperately needed is a new standard for mental health care where a prescriber works as a member of a team with a

psychologist trained in assessment, diagnosis, treatment planning, discontinuation planning, and long-term outcome evaluation of a patient.

However, to be a member of such a health care team, the nonprescribing psychologist needs to understand not only the disease itself, its assessment, and diagnosis, but also psychopharmacology, at least to a minimum of being a monitor for side effects, for incomplete responsiveness, and for recommendation of alternative approaches that might better fit the need profile of an individual patient.

How might this be accomplished? Quite simply, it first involves at least a basic understanding of how psychoactive medications work, including their pharmacokinetics and their side effects (as advocated by the 1993 Task Force). Also, the medical prescriber has to be open to collaboration with the knowledgeable psychologist. I feel strongly that such acceptance can be earned through knowledge of pharmacology.

In other words, this knowledge must be gained and put into practice. This begins with a mandate to develop a medication record for each patient and a review and update of this record on each patient visit. Included with this record should be knowledge of the most common side effects for which one is continually to be on the lookout. This would include the various names by which a drug is called and adverse medication effects on sexual functioning, cognition, body weight, anxiety, and treatment compliance.

Next, one must develop a technique with which he/she remains in communication with the prescriber regarding collaborative issues as well as any treatment issues that might emerge during collaborative care (see Julien, Advokat, & Comaty, 2011, p. 678). Certainly, other nonprescribing personnel provide feedback to prescribers. Ideally, as mental health care teams develop, one may express concerns to other members of the team such that therapies might be modified to better fit individual's needs, thus improving compliance and reducing side effect burdens.

In my interactions with thousands of psychologists, only a minority routinely access relevant medical literature to answer even the simplest medication questions. Prescribers routinely access this literature, and that knowledge guides therapy. To be a member of the health care team requires similar ability and routine use. Such access is free and easily accessible at www.pubmed.gov.

For example, a recent article in the journal *Pediatrics* (U.S. Preventive Services Task Force, 2009) calls for widespread screening of adolescents for major depressive disorder, provided, however, *only when systems are available for accurate assessment and follow-up care*. What a call to action!! However, I have rarely found a nonprescribing professional who has read this article, let alone integrated the recommendations into practice. The American Psychological Association should spearhead such efforts.

Am I being harshly critical (as an outsider to the profession)? I think not. I love and respect my psychologist colleagues. I am married to a (now retired) neuropsychologist. I sponsor psychopharmacology seminars as well as a study group for psychologists, and I advocate for prescription privileges.

I, therefore, urge the professional psychological associations and graduate school educators to integrate psychopharmacology into curriculums and trainings much more completely than they do now. I urge a new energy into implementing the recommendations of the 1993 Ad Hoc Task Force. I ask the American Psychological Association to guide their members to relevant medical literature and to urge and guide their members to become knowledgeable about psychopharmacology, thus becoming collaborative and respected members of the health care team. It has become incredibly clear to me that optimal treatment of mental health disorders involves a combination of pharmacological and psychological therapies. Without basic and current awareness of psychopharmacology, the nonprescribing psychologist is deprived of the opportunity to participate as a fully integrated member of the health care team and, more important, such lack of knowledge deprives our patients of optimal care.

It is time to mobilize and use our psychologists with advanced training in psychopharmacology; these practitioners are a ready pool of knowledgeable persons who can lead and inspire their colleagues so that we can change the world one patient and one colleague at a time. These psychologists can raise the awareness of their colleagues, offer medication consultations, and attend grand rounds and case conferences at professional schools. They can

offer continuing education courses through their respective local and state societies. In essence, they can contribute to graduate-level psychopharmacology education as well as their postgraduate colleagues. The opportunity is great and the time is now!

Yes, we can blame others for our problems. However, we must look into expanding our own professional knowledge and abilities. One way of accomplishing this is to integrate knowledge of our patients' medications into being a part of overall patient management. The issue of prescription privileges for specially trained psychologists affects a few and will remain controversial. The overall deficiency in psychopharmacology knowledge deprives our patients of optimal and collaborative care.

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