
Psychopharmacology Training and Canadian Counsellors: Are We Getting What We Want and Need?

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ABSTRACT

The psychopharmacology training experiences and attitudes of Canadian counsellors were the focus of our national Internet-based survey. This study was part of a larger investigation on Canadian counsellors' attitudes, practices, and training experiences related to clients on antidepressants. Results of the current study indicate Canadian counsellors vary considerably in type and amount of psychopharmacology training received. A majority of participants reported that they did not receive this type of training in graduate school, though a strong majority advocated for such training to be mandatory in graduate school. Limitations of this research and directions for future research are provided.

RÉSUMÉ

Les expériences de formation en psychopharmacologie et les attitudes des conseillers canadiens étaient le point focal de notre sondage national par Internet. Cette étude faisait partie d'une plus grande enquête sur les attitudes des conseillers canadiens, leurs pratiques et leurs expériences de formation en matière de clients sous antidépresseurs. Les résultats de la présente étude indiquent que le type et la quantité de formations reçues en psychopharmacologie varient considérablement d'un conseiller à l'autre. Une majorité de participants ont indiqué n'avoir jamais reçu ce type de formation dans leur programme d'études supérieures bien que la majorité affirme qu'une telle formation est obligatoire dans ce genre de programme. Les limites de cette recherche et les orientations des prochaines sont fournies.

Health Canada (2002) indicates that 20% of Canadians will experience mental illness directly in their lifetime. As such, the actual or potential use of psychotropic drugs in Canada is significant. According to Beck and Weishaar (2005), approximately 7% of Canadians take at least one type of psychotropic medication, with the prevalence rate for women (9.5%) almost twice that of men (5.0%). To put this in perspective, in the year 2005 "psychotherapeutics" (antidepressants, mood stabilizers, and antipsychotic medications) were the second most frequently dispensed medications at Canadian pharmacies (IMS Health Canada, 2006a). The increased trend of antidepressant medication use by Canadians is particularly noteworthy. In 2004, 22.5 million prescriptions for antidepressants were dispensed in Canada, representing an increase of approximately 55% in the number of prescriptions filled annually since 2000 (IMS Health Canada, 2006b). In total, it has been estimated that 5% of the Canadian population takes antidepressants at any given time (Patten, 2004), making these the most popular psychotropic drugs.

Given the large numbers of prescriptions being filled for psychotropic medication, it is likely that many Canadian counsellors work with clients taking this

type of medication. This certainly seems to be the case in the United States, where 89% of counsellors associated with the American Mental Health Counseling Association (AMHCA) reported that they worked with clients taking psychotropic medication (Scovel, Christensen, & England, 2002). However, fewer than 20% of these same counsellors reported that they were required to take psychopharmacology training as a part of their master's and/or doctoral level training. Up to now, similar data on the extent and type of psychopharmacology training Canadian counsellors have received have not been elucidated through research. Given the large number of prescriptions being filled for psychotropic medications within Canada, research into the psychopharmacology training experiences and attitudes of Canadian counsellors is timely and necessary.

Our research focused on the extent and type of psychopharmacology training Canadian counsellors have received and the attitudes they hold toward this type of training. The purpose of this article is to report these preliminary findings from an Internet-based survey. We begin by contextualizing the issue and providing a rationale for such research. Through asserting relevant sections within the Canadian Psychological Association's (CPA) Code of Ethics (2000) and the Canadian Counselling Association's (CCA) Code of Ethics (1999), we highlight the need for inquiry into psychopharmacology training experiences of counsellors. It is worth noting that we are not advocating the use of psychopharmacological medications by clients or for the right of psychologists and/or counsellors to prescribe these medications (for a review of the prescription privileges debate see Resnick & Norcross, 2002; St. Pierre & Melnyk, 2004; Westra, Eastwood, Bouffard, & Gerritsen, 2006). Our focus is solely on understanding the training Canadian counsellors receive and their attitudes and reported needs in this significant area.

Counsellors and Client Medication Taking

The idea that psychopharmacology training for counsellors is needed can only be advanced if it can be established that counsellors have responsibilities related to their clients' taking of psychotropic medications. In fact, numerous researchers have asserted that, at least when it comes to antidepressants, counsellors have a legitimate and important role to play in all facets of medication use by clients (e.g., Hollon, Thase, & Markowitz, 2002; King & Anderson, 2004). Littrell and Ashford (1995) claimed that this role may be a legally mandated one. In defense of their assertion, these authors cited the case of a mental health facility that the courts deemed liable for "improper treatment" for not providing informed consent consisting of sufficient information with respect to alternate psychopharmacological treatments. In brief, the courts found the treatment facility liable. Such American case law findings may have relevance for counsellors working in Canada although no Canadian cases have arisen to date. However, the codes of ethics that govern counsellor behaviour suggest that counsellors have certain responsibilities when treating clients on psychotropic medications.

Section I.24 of the *Canadian Code of Ethics for Psychologists* indicates that in order to obtain informed consent for treatment, clients must be made aware of

alternative treatments (CPA, 2000). Presumably this includes explaining the known benefits and challenges of medication use to clients. Informed consent notwithstanding, there is a more general role for counsellors to play in providing clients with psychotropic medication information. As much as 80% of all psychotropic medications are prescribed by general physicians (Pincus et al., 1998). However, according to a British study conducted by Garfield, Francis, and Smith (2004), the information needs of a significant number of individuals were unmet at the time of being prescribed antidepressant medication by a general practitioner. Consistent with this perspective, researchers have found that only 9.5% of patients “mostly agree” with the statement “my doctor has explained properly about antidepressants, their action and side-effects” (Demyttenaere et al., 2004). Furthermore, if questions about medication do arise during “split-treatment” (separately, but simultaneously, treating clients with both therapy and medication), it is likely the non-prescribing party (i.e., the counsellor) the client will turn to for answers (Himle, 2001; Scovel et al., 2002). These findings, among other things, also bring into question whether or not medical practitioners routinely obtain a client’s informed consent before beginning a treatment regime with psychotropic medication.

The CCA’s *Code of Ethics*, section A.3, calls on counsellors to refer their clients to other professionals if they are unable to meet the needs of those clients (CCA, 1999). Conceivably, this would include the duty to refer certain clients for a medical evaluation to determine if treatment with psychotropic medication was warranted. On a similar note, the *Code of Ethics and Standards of Practice of the American Counseling Association* (ACA), section A.4, encourages counsellors to seek from clients permission to consult with other mental health professionals concurrently involved in their care (ACA, 1995). When working with clients already on psychotropic medication, this would include seeking permission to consult with prescribing physicians and/or psychiatrists in an effort to better coordinate client care.

If a client is already on psychotropic medication or is going to start taking this type of medication whilst seeing a counsellor, researchers have suggested other roles counsellors may assume in relation to this form of treatment. For example, Paradise and Kirby (2005) asserted that low motivation, negative side effects, and high costs associated with taking antidepressant medication can lead to non-adherence and a host of negative outcomes attributed to the premature discontinuation of antidepressants. In fact, the median adherence rate for antidepressant medication has been estimated to be around 40% (Demyttenaere et al., 2004), whereas a 50% medication adherence rate is generally observed across all chronic illness categories (Byrne, Deane, Lambert, & Coombs, 2004). This suggests that counsellors may have a role to play in supporting clients’ adherence to medication treatment (e.g., monitoring side effects) and/or helping those clients wanting to discontinue treatment to do so safely (e.g., referring clients to medical professionals, discussing gradual discontinuation). With all of the above in mind, it should be noted that counselling, too, has its risks for

clients (see Dineen, 2001), though a complete discussion of this issue is beyond the scope of this article.

Finally, Wissow (2004) noted that whether or not a prescription will be filled and/or consumed is significantly related to the meaning an individual ascribes to the act of being given a prescription. It seems reasonable to assume that clients may feel a need to discuss the meaning of their medication-taking. At least one study suggests that prescribing physicians may not be providing clients with this opportunity. Demyttenaere and colleagues (2004) reported 1.1% of patients “mostly agree” with the statement, “My doctor listens properly to what I think about antidepressants” and 0% of patients “mostly agree” with the statement, “I receive sufficient psychological support and encouragement from my doctor.” These findings suggest that clients may have unmet needs related to the meaning of their medication-taking and counsellors may have a related role to play when working with these clients.

Counsellors and Psychopharmacology Training

Ponterotto (1985) advocated for counsellors to become more knowledgeable about psychopharmacology to enhance communication with prescribing physicians and to overcome physician resistance to counsellor involvement in the medication-taking of clients. King and Anderson (2004) have gone so far as to state that “counselors cannot provide comprehensive treatment planning, ensure client well-being, and minimize professional liability without proper training in psychopharmacology” (p. 329). Researchers have also asserted that without psychopharmacology training, counsellors may not be able to recognize drug-related side effects, may erroneously attribute those effects to social and/or intrapsychic influences, and may not be willing or able to make informed decisions on when to refer clients for medical evaluation (Foxhall, 2001; Litman, 2005). The American Psychological Association (APA) added its voice to this matter over a decade ago when they recommended that all psychologists in training should receive at least basic education in clinical psychopharmacology (APA Board of Educational Affairs, 1995). It should also be noted that the APA advocates for the right of properly trained psychologists to prescribe psychotropic medication (Heiby, Anderson, & DeLeon, 2004).

Although it is unlikely that the recommendations noted above are universally accepted, there is a case to be made for counsellors to receive at least basic training in psychopharmacology. What remains unclear is whether or not Canadian counsellors currently receive and/or want this type of training. Again, research from other countries may offer indications. Over 92% of AMHCA counsellors indicated that basic training in psychopharmacology is needed to accurately refer clients in need of psychotropic medication (Scovel et al., 2002). A survey involving American school psychologists from the National Association of School Psychologists indicated that one in four of their clients were treated with psychotropic medications (Carlson, Demaray, & Hunter-Oehmke, 2006). These psychologists reported an “overwhelming need” for basic training in child psychopharmacol-

ogy. Likewise, Dunivin and Southwell (2000) reviewed three surveys that addressed the attitudes of psychology students, interns, and directors of training toward prescription privileges and psychopharmacology training and concluded that “[p]sychologists in the training pipeline want more education and training in psychopharmacology” (p. 611). General receptivity to psychopharmacology training is further evident from a recent study involving psychologists and clinical psychology graduate students. In this survey, 55% to 72% of respondents favoured or showed interest in psychologists obtaining prescriptive authority (Grandin & Blackmore, 2006).

To fuel the debate, Tulkin and Stock (2004) advanced that when it comes to educating clinical psychologists, basic training in psychopharmacology should occur at the predoctoral level and advanced training at the postdoctoral level. Tulkin and Stock concluded that it is unethical for training programs not to include a basic level of psychopharmacology knowledge in their curriculums. Dunivin and Southwell (2000) concurred, stating that “we are firmly convinced that focused psychopharmacology education is essential at the predoctoral and internship level to establish a knowledge base and conceptual foundation for future learning and effective psychological practice in the 21st century” (p. 611). However, some counsellor educators contested that there is no room within basic counselling curriculum for more training and that adding psychopharmacology training would necessitate elimination of more fundamental psychology coursework (McGrath et al., 2004).

It is beyond the scope of this article to delve into the pedagogical implications of psychopharmacology training in counsellor education. Nevertheless, given the background in extant psychopharmacology research related to needs of psychologists and counsellors, the reality is that no data currently exist on the psychopharmacology training experiences or attitudes that Canadian counsellors hold in regards to this issue.

METHODS

Participants

A convenience sample of 83 Canadian counsellors completed the survey. Participants were recruited from across Canada using a variety of means (see below). The inclusion criteria required participants to (a) be Canadian citizens, (b) be over the age of 18, and (c) hold a graduate degree (master’s or higher) in counselling or a counselling-related field (e.g., social work, clinical psychology). Participants from every Canadian province completed the survey. They ranged in age from 26 to 63 years old ($M = 44.57$, $SD = 10.63$) and were 75% female ($n = 60$) and 25% male ($n = 20$). Three participants did not report their gender. The reported postgraduate counselling experience of participants ranged from a low of 6 months to a high of 35 years. Participants most frequently reported seeing 25 or more depressed clients in the past 12 months. Other salient demographic characteristics of participants are presented in Table 1.

Table 1.
Demographic Characteristics of Participants

Characteristic	<i>n</i>	%
Highest degree held		
M.S.W.	3	3.57
M.A.	26	30.95
M.C.	3	3.57
M.Ed	19	22.62
Ed.D.	4	4.76
Psy.D.	2	2.38
Ph.D.	19	22.62
Other	8	9.52
Primary theoretical orientation		
Cognitive-behavioural	29	34.94
Psychoanalytical	3	3.61
Humanistic	6	7.23
Feminist	7	8.43
Family systems	2	2.41
Brief therapy	4	4.82
Eclectic	24	28.92
Other	8	9.64
Principal place of practice		
University or college campus	17	21.25
Community agency	13	16.25
Private practice	27	33.75
Hospital	7	8.75
Other	16	20.00

Measures

The instrument used for this research was a 21-item online survey that was part of a larger survey entitled "Clients on Antidepressants: A Survey of Canadian Counsellors' Attitudes, Practices, and Training." The survey comprised a variety of questions including Likert-type, multiple-choice, and open-ended questions. For example, to investigate training experiences, participants were asked, "During your graduate schooling did you receive any formal training in psychopharmacology?" Attitudinal questions in the survey included Likert-formatted items, for example: "Training in psychopharmacology should be offered in graduate-level counselling programs" (1–*Strongly Agree* to 5–*Strongly Disagree*). Construction of the survey (e.g., design, type, and length) was guided by the recommendations set forth by authorities in the field of survey design (e.g., Fowler, 2002; Kelley, Clark, Brown, & Sitzia, 2003; Punch, 2003). As conducting surveys on the Internet introduces some unique challenges not seen with traditional surveys (e.g., security of data), construction of the survey was also guided by recommendations set forth by

authorities in the field of Web-based survey design (e.g., Carini, Hayek, Kuh, Kennedy, & Ouimet, 2003; Daley, McDermott, McCormack, & Kittleson, 2003; Granello & Wheaton, 2004; Nesbary, 2000; Riva, Teruzzi, & Anollir, 2003; Saxon, Garrett, Gilroy, & Cairns, 2003; Sills & Song, 2002). In addition, pre-existing surveys were used to aid in the construction of the proposed survey. For example, surveys designed to measure types of attitudes provided examples of question types (e.g., Luscher, Corbin, Bernat, Calhoun, & McNair, 2002).

Procedure

Recruitment advertisements were placed in the Winter 2006 editions of *Psynopsis* and *Cognica*. *Psynopsis* is a newsletter published by the CPA and is the official newsletter for psychologists in Canada. *Cognica* is a newsletter published by the CCA and has a mandate to reflect the current status of counselling across Canada. Invitations for participation based on recruitment advertisements were also directly e-mailed to faculty and instructors within the Campus Alberta Applied Psychology: Counselling Initiative, a distributed Master's of Counselling program with faculty and instructors residing in provinces across Canada. Using a method closely aligned with Snowball Sampling (Palys, 1992), the content of the e-mail also invited the key informants to distribute the e-mail to Canadian colleagues potentially interested in taking the survey; they in turn were asked to send out the invitation to other colleagues, and so on. Finally, e-mail invitations were posted to listservs of the Alberta division and the national division of the CCA.

The recruitment advertisements and e-mail invitations directed potential participants to the website www.counsellingsurvey.ca and provided them with a password for access to the survey. Those logging into the survey were provided with an overview of the survey and a consent page. If consent was granted by participants, they entered the password and were then presented with survey instructions. After completing the substantive part of the survey, participants were thanked for participating and asked to provide feedback on the experience of taking the survey via an electronic form.

Data Handling and Analysis

Data were collected over three months (January 1, 2006 to March 31, 2006). The collected data were downloaded daily from the QuestionPro.com® server as CVS data and transferred to compact disk, which, when not being analyzed, was stored in a locked filing cabinet. The data were imported into and analyzed using the Statistical Package for the Social Sciences (SPSS) software version 14.0. Several measures of central tendency (e.g., mean, median) and variability (e.g., standard deviation, range) were examined for relevance.

RESULTS

Participants reported that over 58% of clients they have treated for depression in the past 12 months took antidepressants at some time during their counselling

treatment. Over half of participants (62.5%, $n = 50$) reported that they did not receive any form of psychopharmacology training during their graduate education. For the 37.5% of participants ($n = 30$) who did receive psychopharmacology training in graduate school, most (23.81%, $n = 10$) reported receiving it as a part of one course. The reported range of this training was between 2 and 100 hours, and the average reported length of this training was 30.67 hours with a standard deviation of 32.45 hours. The median length of training was 15 hours and the mode was 3 hours. In short, the amount of psychopharmacology training survey participants received in graduate school was highly variable.

A majority of participants (65.79%, $n = 50$) reported receiving psychopharmacology training outside of graduate school. For most participants (26.77%, $n = 34$), this training took place at workshops. However, other participants reported receiving psychopharmacology training via seminars (15.75%, $n = 20$), conferences (14.17%, $n = 18$), lectures (13.39%, $n = 17$), and self-study courses (13.39%, $n = 17$). A few participants reported receiving this training as a part of their undergraduate studies, nursing school, and/or internships. In short, the source of psychopharmacology training participants received outside of graduate school was also extremely variable. The amount of this training was also highly variable, with a reported range of between 2 and 100¹ hours. The average reported length of this training was 23.69 hours with a standard deviation of 24.42 hours.

The fact that so many participants reported receiving training in psychopharmacology outside of graduate school indicates that they recognize the need for this type of training. Indeed, 94.93% of participants ($n = 75$) reported that they strongly agree or agree that training in psychopharmacology should be offered in graduate-level counselling programs. In fact, 75% of participants ($n = 60$) strongly agree or agree that this training should be *required* during graduate training. However, fewer than half of the participants (42.5%, $n = 34$) strongly agree or agree that this training is necessary to treat individuals suffering with depression. Similarly, 39.24% of participants ($n = 31$) strongly agree or agree that training in psychopharmacology is necessary to effectively treat most of the issues seen by counsellors.

DISCUSSION

The overall reported psychopharmacology training history of participants was extremely variable. Relatively few participants reported that they received this training in graduate school; those who did indicated that they received very little as it was part of a course. However, the vast majority of participants believe that this training is very important. Evidence of this conviction was underscored by the number of counsellors who sought this training outside of graduate school. However, it is apparent from this study that the preference of Canadian counsellors is to receive psychopharmacology training in graduate school. In fact, an overwhelming majority of counsellors involved in this study advocated that this training be made mandatory in graduate counsellor education. Overall, these results resonate with

findings abroad. In virtually identical proportion to their American colleagues, 92% of whom indicated a desire for basic training in psychopharmacology (Scovel et al., 2002), we found that 94.93% of Canadian counsellors expressed the identical opinion. Likewise, an overwhelming need for basic training in child psychopharmacology was reported by American school psychologists from the National Association of School Psychologists (Carlson et al., 2006).

Given the number of counsellors in this study who stated a need for psychopharmacology training in graduate school, such training could be perceived to be as essential as training in risk assessment or ethics. The powerful nature of antidepressants and other psychopharmacological drugs and the relatively high numbers of clients who utilize them also lends credence to this hypothesis. Nevertheless, fewer than half of the survey participants reported that they believed this sort of training is necessary to treat depression or most other issues seen by counsellors. One possible explanation for this finding is that counsellors involved in this study value education and expanding knowledge in all aspects of treatment but fundamentally accept that effective counselling for depression and other common client concerns is not limited to or exclusively dependent on knowledge of psychopharmacology. Without further study, however, this explanation remains tentative at best.

As it now stands, there are no formal guidelines outlining the psychopharmacology training needs of Canadian counsellors. Given the increased use, marketing, and social acceptance of psychotropic medications (e.g., antidepressants), it is likely that many more of Canadian counsellors' clients will bring with them the spectre of medication use. Likewise, given the serious impact these medications can have on clients' physical, emotional, and psychological functioning, best practice guidelines are urgently needed. Without a sound knowledge base, counsellors may not be in the best position to establish these guidelines, which further underscores the urgent need for inclusion of at least basic psychopharmacology courses as part of counsellors' training if they need not abrogate that responsibility to non-counsellors.

Limitations and Future Research

A small proportion of participants had some medically based education (e.g., nursing undergraduate degrees), which may have inflated the reporting of psychopharmacology training, although minimally given the small number of participants with this background. Also, a technical weakness associated with this exploratory research was that the survey upon which it was based utilized a form of convenience sampling. Furthermore, reliable data on the total number of individuals who provide counselling services to Canadians do not exist (Bryce et al., 2005). As such, participation rates were impossible to calculate. The non-randomness of the methodology also puts the representative nature of the results into question. For example, it is apparent from the demographic data that participants from Alberta were overrepresented in this research. Additionally, given that the survey was Internet-based and that it touched on an often contentious issue (counselling

vis-à-vis medication), there may have been a self-selection bias on either of these counts in terms of participation (i.e., those with Internet access during the running of the survey and/or those who feel strongly about the issue of counselling vis-à-vis medication are overrepresented in the survey). Nevertheless, the overall diversity of the participant pool suggests richness of data and findings.

Given the exploratory nature of the present study, future research possibilities are considerable. For example, there is a need to examine the psychopharmacology training history of Canadian counsellors and their related attitudes in more depth. For instance, it was not clear why a majority of participants thought that psychopharmacology training should be mandatory in graduate education but only a minority of participants thought that this type of training was necessary to treat most issues seen by counsellors. Utilizing qualitative research methods such as individual interviews, case studies, and/or focus groups would provide in-depth data into these significant questions.

It would also be beneficial to examine counsellor education programs in Canada to determine the nature and extent of psychopharmacology training currently offered. For example, counselling curricula and policy documents from programs across Canada could be examined. For those institutions not offering this training at a basic level (which would need to be operationalized), department heads could be interviewed for inquiry about this issue.

The current research suggests there is unmet demand for psychopharmacology training. McGrath et al. (2004) found that this demand is related to limited space within counselling curriculum and the threat to offering fundamental counselling courses if psychopharmacology training was added. Indeed, it is unknown what impacts the perceived unmet demand for psychopharmacology training at present. Perspectives from Canadian counselling faculty and administrators involved in program development would offer valuable insight and contribute to envisioning solutions.

CONCLUSION

Canadian counsellors in this study displayed considerable variability in their psychopharmacology training history. For example, some counsellors had had significant training in this area (e.g., 100+ hours) while others received almost none. Most counsellors indicated that they did not receive any psychopharmacology training in graduate school. However, most reported receiving some psychopharmacology training from other sources, though the source of this training was highly variable (e.g., workshops, seminars, self-study). Counsellors in this study also varied considerably in their attitudes surrounding psychopharmacology training. However, most agreed that this sort of training should be offered in graduate school and, furthermore, that it should be mandatory.

The diversity of experiences and attitudes of counsellors involved in this study may be cause for concern if it means that clients on psychotropic medication are not receiving the best possible care. As stated earlier, some researchers sug-

gest that counsellors have ethical and, perhaps, legal responsibilities to practice in certain ways when it comes to the responsible care of clients on psychotropic medication(s). Furthermore, the codes of ethics that govern Canadian counsellor practice can be interpreted to imply that counsellors across the board need, at minimum, some basic training in how psychotropic drugs can affect individuals and the counselling process. With this in mind, there are clear implications for the psychopharmacology training needs of counsellors. However, best practice guidelines for psychopharmacology training do not exist but are urgently needed.

Note

1. An outlier of 850 hours was removed from the data pool so as not to skew the range or average reported hours of training.

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