

be verbally cut down by a professor with a conflicting opinion. I also know a few graduate students who were expected to work for their mentor or assistantship, far beyond their original agreement and who felt there was nothing that could be done about it. This leads me to think there isn't a clear distinction for what type of treatment should be expected from professors or an understanding of what behavior should be expected of us.

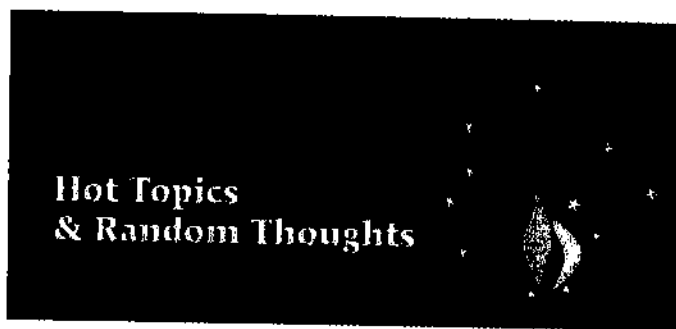
Issues of how to behave toward professors and expectations for our own treatment are common quandaries for many graduate students. Shifting from undergraduate to graduate means we are committing to a career and graduate school is intended to function as a professional training ground. However, it seems at times as though we are treated less as professionals than as indentured servants. It is my position that we are to be considered junior colleagues and treated accordingly. This position is not an entitlement however; it's a privilege.

With privilege comes responsibility. So, what are our responsibilities as junior colleagues? Really, there's only one: showing respect for our higher-ranking colleagues. They've come to their positions through hard work, which included servitude to their superiors earlier on. The respect due them was earned before we arrived and the respect we give now is the same we should come to expect when we're peer colleagues.

There are myriad ways we can show such respect. Coming to class prepared, asking thoughtful questions, contributing to discussions, knowing and practicing ethical principles, and staying within projected timelines for achievement milestones, are just a few behaviors that acknowledge our professors' legitimate authority and show we're ready to become professionals. Another is dressing suitably whenever we teach or represent our departments, which shows we care about what we do.

As junior colleagues we are assuming a moderated stature of similarity. So, we may be on friendlier terms with our teachers than we were as undergraduates. In general, the use of titles and last names conveys a sense of respect, while the use of first names denotes similitude and solidarity. Still there are times when "Doctor" is the always the appropriate term to use, such as introductions, when in the presence of undergraduates or clients, or in attending official meetings or presentations.

Thus, we come to students' expectations for professors. These encompass many aspects of behavior and attitude. In exchange for our respect and hard work, we've justifiable privileges due us. We expect to be treated with respect and not to be disparaged at any time, especially in class. We expect sincere guidance from senior colleagues so we are truly prepared to enter the workplace upon graduation. Accordingly, we expect our mentors to devote a reasonable portion of their time to our individual development. We expect our personal lives to be acknowledged and appreciated. Thus, we expect our time commitments to be honored and not to be abused with extraordinary demands. We expect our contributions to research or other projects to be duly recognized and officially noted. We expect occasional outward demonstrations of appreciation for us as people. We expect, in short, the same treatment we should give to our future junior colleagues. At least, those are my expectations. ♣



Reconsidering Prescription Privileges for Psychologists

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On March 10, 2001, the New Mexico House of Representatives passed a bill that would give qualified psychologists the ability to prescribe psychotropic medications (Herndon, 2001). Although the bill ran out of time and was not voted on by the New Mexico Senate, these recent developments have once again brought to the forefront the debate over granting prescription privileges (RxP) to psychologists. The APA officially endorsed the fight for RxP in 1995, and APAGS soon followed suit. Nevertheless, the issue of whether psychologists should be able to prescribe medications continues to deeply divide the membership of APA and APAGS as well. In this brief article, we will highlight some of the reasons why so many current and future psychologists think that the fight for RxP is leading the organization in exactly the wrong direction.

Proponents of RxP frequently promote the idea that members are firmly in favor of the position. For example, they cite APA survey data from 1990 indicating that 70% of clinicians and 64% of non-clinicians support the idea (see Williams, 2000). However, a proper survey of membership opinion has never been undertaken by APA, and some of the limited data available on this issue has raised serious questions. For example, a recent survey by the Pennsylvania Psychological Association (2001) of its members indicated that 55.9% felt that RxP should be "very low" or "low" in priority, as opposed to only 21% who felt that it should be a "high" or "very high" priority. Members ranked RxP eighth out of nine legislative priorities. It should be noted that APAGS officially endorsed the position favoring RxP without conducting any formal polling. Although some may strongly support the idea of RxP, it is clear that for other members the quest for RxP is not a pressing concern. If one considers that APA has already spent over \$800,000 fighting for RxP, serious scrutiny of the RxP position is long overdue.

Before one even considers if psychologists *should* seek RxP, it is important to understand the potential problems with APA's current proposal for attaining this goal. Few opponents of RxP argue that psychologists are incapable of being trained to prescribe safely; but arguments do arise over what would be required to assure safe prescribing. Those who argue against RxP point to the major discrepancies between the training program developed by the Department of Defense and the one currently promoted by APA. The intensity of the Psychopharmacology Demonstration Project (PDP) (Alpert, et al., 2000), which concluded that psychologists could be

trained to prescribe safely, far exceeded the program currently supported by APA. For example, APA's proposal includes less than half the required contact hours as compared to the PDP (300 vs. 712 hours, respectively). In addition, the PDP required a one-year, full-time practicum, while APA's plan requires that only 100 diverse patients be seen, estimated to be analogous to a 4-month practicum (Bush, 2001). Therefore, serious questions exist as to whether APA's proposal is adequate for training psychologists to obtain RxP.

Even if an adequate training program could be devised, the time and cost commitment of such an endeavor would be overwhelming for many psychologists. The minimal training program promoted by APA would cost an estimated extra \$5,000 to \$20,000 per student, as well as a two-year sacrifice of no income due to continued training. If training programs are limited to the post-doctoral years, this would add an extra two years of training and \$20,000 to \$30,000, dramatically increasing student debt (Bush, 2001). Is such a program feasible, and if so, would it be worth the extra time and money?

Other serious questions also remain. Will gaining RxP be detrimental to the advancement and utilization of psychosocial treatments? Will malpractice premiums go up for all psychologists? Will the push for RxP further widen the scientist-practitioner gap? Will pursuing this goal be damaging to our relations with organized psychiatry and medicine, who are sure to vigorously oppose RxP for psychologists? Will other mental health professionals (e.g., social workers) also attempt to gain RxP, thereby decreasing the benefits that psychologists would obtain? For those who are interested in learning more about these issues, more extensive information against seeking RxP can be found by reading Bush (2001) or by visiting the following Web site: www.cognitivetherapy.com/camp.

The most reasonable way to receive adequate training to prescribe medications would be for licensed psychologists to attend a nurse practitioner (NP) program, as opposed to the plan endorsed by APA (Bush, 2001). This way, one could receive the adequate medical training required to prescribe medication, instead of simply relying on "crash courses" in psychopharmacology from distance learning programs, as some have suggested. Currently, 50 states allow NPs to have RxP to various degrees. For example, some NPs can prescribe independently, while others can prescribe with physician involvement (Pearson, 1999). Furthermore, we can look to law psychology to supply the model for how to practice in multiple professions. Psychologists who are interested in practicing law are required to obtain a Ph.D./Psy.D. as well as their J.D. A NP degree would provide a fair compromise, since it does not require the comprehensive training involved for a medical degree, yet provides the training necessary to prescribe safely based out of already established and accredited programs. In fact, several psychologists have already obtained the ability to prescribe by taking this route.

We think that it is time for APAGS to reassess its official position in favor of RxP. Williams (2001) listed obtaining feedback from members through online surveys as one of the new top priorities of APAGS. We call on APAGS to set an example that we hope eventually will be followed by APA, and to conduct a proper poll to determine objectively member opinion on this important topic. Even though RxP may be directly applicable to only a portion of future psychologists, this endeavor has implications for all members. We thank the leadership of APAGS for publishing this article, and hope that it will be the first step in ongoing discussion of RxP from both sides of the debate.

References available on request by contacting apags@apa.org



Advancing the Profession: A Prescription for Success

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In graduate school, we embark upon a lifelong course of professional development. New to the field, however, students are often unaware of the relevant professional issues that are shaping our collective future. To loosely paraphrase John Lennon, "the profession is what happens while we are busy studying for exams." The heavy workload, high stress, and limited finances that accompany graduate education often create a sort of tunnel vision that leaves students feeling isolated and disconnected from both the outside world and the larger professional community. As a group that is quite literally the future of psychology, it is essential that we take the time to understand current professional issues and work to actively shape our chosen profession.

One of the more controversial and often revisited topics is that of granting psychologists the authority to prescribe psychotropic medication. The mere mention of a psychologist holding a prescription pad brings affect-laden opposition not only from psychiatrists, but also from some factions within our own ranks. Arguments that prescribing psychologists would be "dangerous," that those who want to prescribe should simply go to medical school, and that we would somehow lose our professional identity and become "junior psychiatrists" make headlines, while the facts are swept silently under the rug.

The statement that expanding psychology's scope of practice would place clients at undue risk is far from a novel argument. Most of us are too young to remember, but until the 1970s, psychiatrists argued that allowing psychologists to provide outpatient psychotherapy without physician supervision was unsafe. Similar arguments have been made in attempts to block psychologists from treating clients in hospital settings and from pursuing training in psychoanalysis. Would prescribing psychologists be dangerous? Let's look at the facts.

Four independent evaluations of a United States Department of Defense (DoD) pilot program con-