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ABSTRACT

This study explored how social workers in private practice view the role of psychotropic medications in treatment and handle psychopharmacological issues in practice. It specifically focused on social workers' perspectives on the helpfulness of psychotropic medications and the nature of their communication with prescribing providers. Split treatment has become the standard arrangement for providing both psychotherapy and psychopharmacotherapy to mental health clients, yet there is limited research on issues that social workers encounter in split treatment relationships and how they view them. Fifty-six independently licensed social workers who provided psychotherapy in private practice completed a mixed method survey that asked them to share demographic information about their practices, their perspectives on the helpfulness of psychotropic medications and prescribing providers for their clients, and the nature and frequency of their communication with prescribing providers. The findings indicate that overall, social workers in private practice find psychotropic medications and prescribing providers to be helpful for their clients, but there is a fair amount of variation depending on the type of mental illness being treated and the type of prescribing provider in the split treatment relationship. The findings also indicate that communication between social workers and prescribing providers is insufficient, and is affected by a multitude of barriers that arise in split treatment relationships.

**SOCIAL WORKERS IN PRIVATE PRACTICE AND
PSYCHOTROPIC MEDICATIONS**

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2012

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CHAPTER I

Introduction

The purpose of this study is to explore the relationships that private practice social workers have with psychotropic medications when practicing psychotherapy, specifically looking at their own perspectives on psychotropic medications in practice and the nature of their professional relationships with prescribers of psychotropic medications. This study was conducted with the goal of filling the Smith College School for Social Work masters thesis requirement for the masters in social work (MSW) degree program. It is based on a mixed method survey tool that was disseminated to participants via the internet or a mailed paper copy. In order to have taken part in the study, participants were required to be independently licensed clinical social workers who were providing psychotherapy in private practice to adult clients.

Much of my desire to research this topic came from my work as a first year social work intern where I was placed on an inpatient psychiatric unit at a teaching hospital in New England for seven months. There, it was often my responsibility to coordinate care between outpatient therapists and prescribing providers for patients who were discharging from the unit. Many patients did not have outpatient providers who could prescribe psychiatric medication, and it was often very difficult to find prescribers who focused on mental health care, such as psychiatrists and psychiatric nurse practitioners. Patients often had to be discharged with the agreement that their primary care practitioners would monitor their responses to their psychotropic medication regimens. Some primary care providers were comfortable with this, but others were often very

hesitant, especially if the patients were being discharged on medications that were more complicated to manage. I was also responsible for making sure that patients had follow up psychotherapy services with licensed providers who were often social workers. These providers were also often worried about their clients not having adequate help with psychotropic medications. It seemed very rare that we could discharge psychiatric inpatients into the care of psychotherapists and psychotropic medication providers who had consistent professional relationships with each other. There were a few occasions where some of my patients had outpatient psychiatrists and outpatient therapists who did not agree on how best to treat their clients. They had been providing treatment with no discussion or real awareness of each other's reasoning and motives, seeming as if they were almost treating different clients. The treatment arrangement appeared as though it could easily become iatrogenic. Some examples of what I saw included a therapist who neglected to bring the psychiatric nurse practitioner into the loop in order to discuss the role of medications in a client's recent suicidal crisis; or, a psychiatrist who was not willing to consider feedback from the clinical social worker which contradicted her diagnosis of bipolar affective disorder and subsequent decision to place the client on lithium.

In thinking about the possibility of becoming a clinical social worker and psychotherapist, I wanted to find out more about how licensed clinical social workers in the world of outpatient psychotherapy were perceiving and handling dilemmas related to psychotropic medications, since it seemed like the system of providing split-treatment for mental-health clients had many weaknesses. After looking into some of the current research that was available, it became apparent to me that there were not many updated studies that looked into the state of the split-treatment system and relationship to clinical social workers. The goal of the following chapter is to provide a review of the literature relevant to the roles of social

workers as psychotherapists when psychotropic medication is part of the treatment process. It also provides a theoretical and empirical foundation for this study. Following the literature review chapter is the methodology on how the study was conducted. It is presented in a way so that this study can be easily replicated or built upon in the future. Finally, the discussion chapter reviews much of the findings, and highlights their implication for social work and mental health practice. It also points out other topics for future study which I uncovered through my work but was not able to investigate through this study.

CHAPTER II

Literature Review

Split Treatment and Professional Responsibilities:

Today, "split treatment" is one of the most predominant forms of service provided to individuals who suffer from mental illness. It is a major reason why social workers in private practice and prescribing provider relationships are important in the effective treatment of mental illnesses. In split treatment, patients generally have two practitioners who are accountable for their mental health needs. First is the psychotherapist, who is often a non-physician, which includes social workers and psychologists. The second individual is a "pharmacotherapist" or prescriber of psychotropic medication (Kahn, 1991).

Balon states that split treatment has both positive and negative aspects. The positive aspects include cost-effectiveness, more time spent with clients by providers, a broader range of talent available to clients, a greater chance for clients to have at least one provider with a similar ethnic background, and more opportunities for providers to offer professional support to each other. Negative aspects include the possibility for "splitting" to occur between clients and providers, greater potential for discrepancies in communication between individuals, intervention decisions made by one provider without considering information from the other provider, confidentiality, legal and clinical responsibility grey areas, and the fact that collaboration time is often not reimbursable (Balon, 2001).

Kahn (1991) states that split treatment must be a "three-way therapeutic alliance in which all share a common "reality" overview of the illness and the treatment plan." Kahn writes some of the most problematic issues in split treatment arise when providers disagree on whether or not to prescribe medication, along with transference and countertransference triangles between the providers and patient. This implies that frequent and effective communication between all providers and the client is necessary for split treatment to be effective

Gutheil and Simon go farther in the discussion of problems that can arise during split treatment by recommending that providers use the "Eight Cs" of collaborative treatment in order to safeguard clients from abandonment and other problems that can arise in split treatment relationships. These are "Clarity, Contract, Communication, Consent, Contact, Comprehensive view, Credentialing, and Consultation". In summary, the "Eight Cs" state that providers should have a clear understanding of each other's responsibilities, and should focus on maintaining regular and cooperative communication with each other. This process can be aided by having written agreements outlining each other's responsibilities and reaching out to other providers for consultation when necessary (2003).

Bentley, Walsh, and Farmer (2005) write that for social workers, the practice of referring clients for medication should be taken "as seriously as they do other aspects of service delivery." They advise that the social worker's responsibilities in the referral process should include establishment and maintenance of collaboration between the social worker and prescribing provider, providing psychoeducation on medications for clients and other supportive individuals involved in their treatment, exploring the meaning of psychotropic medication with clients and their supporters, helping clients to prepare for meetings with prescribing providers and then

following up on the outcome of these meetings, and management of legal and ethical issues related to treatment with medications.

The next two sections in this literature review discuss theories and paradigms that could influence social workers' perspectives and interventions related to practice with psychotropic medications, specifically if and when they choose to refer clients for medication consultation. One point that is argued to be universal no matter what theoretical foundation is used is that the possible consequences of making the choice to not refer a client who might need medication are far worse than referring one who ultimately does not need medication (King & Anderson, 2004; Klerman, 1990; Malcom, 1986). Social workers do not have the proper training to make the decision to prescribe a medication, but they do have responsibility of making sure that clients have access to levels of mental health treatment beyond scope of social work practice. All clinicians must keep this in mind when faced with the decision to refer a client for psychotropic medications. However, this is a topic beyond the scope of this review.

Biopsychosocial and Medical Models:

Concepts pertinent to the study of the social worker's relationship with psychopharmacology include the medical model of treating mental illness. This is the driving force behind psychopharmacology, since it assumes that mental illness can be fixed through biological changes. The biopsychosocial model, or BPS model, of mental illness is what frames most clinical social worker training. A 2010 study on peoples' perceptions of psychiatrists found that social workers value providers who can look beyond the medical model in terms of understanding mental illness (Bhugra, Gupta, Smyth, and Webber, 2010). Although not every psychiatric or social work paper explicitly states and debates theory on the medical vs. the BPS

models, they are both very important for the social worker to consider at the level of practice because each one informs different ways of forming assessments and treating clients. In empirical literature relating to the question of "How do social workers in private practice view the role of psychotropics in treatment and handle psychopharmacological issues in practice?" the significance of the medical models and BPS models are not explicitly discussed. Rather, it seems that there is an implied understanding that these studies are supported by variations of either model. It is important to explore the concepts and theories from both of these models, because they are the primary foundations for psychopharmacological and social work practice. In working to answer the research question in this study, the assumption is that social workers responses will be informed by their views on both of these models.

Social workers who focus on using evidence based practice, or EBP, use the medical model to inform their practice as stated here by Adams, Matto, and Lacroy (2009). "*EVIDENCE-BASED PRACTICE* (EBP) is a term that is now widely used in social work and psychosocial disciplines. Modeled after evidence-based medicine, a state-of-the-art approach where the focus is on finding appropriate treatments (pharmaceutical, medical, and surgical) for a patient's medical conditions". EBP focused social workers may be more willing to encourage their clients to consider psychotropic medications as an adjunct to therapy because of EBP's direct link to evidence-based medicine, or the medical model. Addams, Matto, and Lacroy acknowledge the usefulness of the current shift towards and EBP paradigm and social work, but they also advocate caution in how far this is carried out. They emphasize that using evidence based medicine to develop EBPs answers questions with a very narrow focus, with the goal of producing "right or wrong" answers on how to treat specific diagnoses. They warn that this could generate too much focus on treating symptoms of specific diagnoses without looking at a

more holistic picture of client's environments, strengths, concerns, previous experiences, and their overall need for services (2009).

The approach that they are advocating social workers take in this excerpt is more of BPS approach, because they should not look at just "treating" the diagnosis, but also investigate other factors such as those that are part of the family environment. One of the first health care providers to capture the essence of this and name it the "biopsychosocial model" was the physician, George Engel, which he first summed up in 1977:

To provide a basis for understanding the determinants of disease and arriving at rational treatments and patterns of health care, a medical model must also take into account the patient, the social context in which he lives, and the complementary system devised by society to deal with the disruptive effects of illness, that is, the physician role and the health care system. This requires a biopsychosocial model. (1992, p.324)

Although antiquated, this statement clearly articulates the different levels of approach that the medical model does not take into account in treatment, and it still informs BPS practice in clinical social work and more holistic medicine today. When working on the foundations of the BPS model, a challenge that clinical social workers face with pharmacological issues is how much credit to give the biological perspective versus focusing on the psychological and social angles when assessing and helping clients. This includes the question of how much should clinical social workers try to improve upon psychological and social factors in clients' lives before suggesting that they consider seeing medication prescribers.

Treatment Techniques:

Talk-therapy treatment techniques that clinical social workers use in private practice such as Psychodynamic or Cognitive Behavioral Therapy (CBT) also can inform their relationships

with psychopharmacology. From a historical perspective, Roose describes psychodynamic psychotherapy as standing in opposition to the treatment of mental illness with psychotropic medications, because its etiology was based on unconscious conflict, not neurobiological processes. This line of separation eased as the efficacy of medication in treating schizophrenia and some affective disorders became a reality (1998). Even though psychodynamic psychotherapy is commonly used alongside pharmacotherapy today, its historic foundations still inform the way that clinical social workers working from a psychodynamic perspective see their clients' problems. As a result, they may be less apt to incorporate the topic of psychotropic medications in dialog with their clients. Another factor is that many clinicians use a combination of treatment techniques based on their own preferences, the needs of their clients, and their clients' preferences. In these situations, clinical social workers' interventions may vary based on the situation and the theories that they incorporate from different techniques.

CBT is a therapeutic treatment technique that has often been viewed as a compliment to psychotropic treatment of mental illness, because they both have similar antidepressant and anxiolytic effects. The goal of CBT is to help clients recognize and change distorted thought patterns, which in turn has a positive affect on their emotions. Recent research is now finding that the combining both therapies are not necessarily advantageous as opposed to CBT or pharmacotherapy alone when treating specific anxiety disorders (Davis et al., 2006). Research on the treatment of such disorders may even suggest that in some cases it might be most effective to stick with only one of these treatment techniques, depending on the type of anxiety disorder a person is struggling with. In the case of using CBT to achieve extinction of a particular response to stress, the use of psychotropic medications to treat symptoms might prevent this from happening. On the other hand, there is new research highlighting medications that are designed

to enhance the effects of evidence-based psychotherapy such as CBT. These medications do not cover up symptoms; instead they work on neurological pathways that create the distorted thoughts that CBT also addresses (Davis et al., 2006). As a result of this history and new research, CBT social workers could have varying approaches and views on the role of psychotropic medications in psychotherapy, which is what the research question "How do social workers in private practice view the role of psychotropics in treatment and handle psychopharmacological issues in practice?" intends to explore, along with the approaches and views of social workers using other types of treatment including psychodynamic, family systems, eclectic, etc.

Empirical Findings on Social Workers' Perspectives:

Currently, empirically supported information on how social workers perceive the role of psychotropic medications in the treatment of people who suffer from mental health issues is limited. With regards to this subject, there are a few studies that are specific to working with younger client populations. The Moses and Kirk (2006) quantitative study that was a mail survey based on sampling from a random group of NASW social workers who worked with adolescents. This study concluded that overall, social workers feel that psychopharmacological treatment for adolescents is more beneficial than detrimental, although many of the respondents highlighted common concerns with this type of treatment. The second study by Moses (2008) on adolescents investigated the topic of social workers perspectives on psychopharmacological treatment of adolescents with more specificity than the first, as it considered the different types of psychotropic medications clients were prescribed, psychological factors concerning client readiness, willingness, support for taking psychotropics, along with the social workers personal attitudes towards the use of these medications. It illustrated that the perspectives that social

workers have on the topic of adolescent psychopharmacology are complex, and cannot be summarized by the “all or nothing” categories of “helpful or harmful”. It found that social workers who are better informed about the effects of psychotropic medication tended to view it as more helpful for their clients, resulting in higher levels of client self-esteem, self efficacy, sense of normalcy, etc. The study also suggested that social workers differentiate between the effects that medication has on target symptoms (such as behavior and mood) and the “meta effects” of medication, such as hopes, fears, and the meaning ascribed to taking medication. The study recommended that this latter finding could be further explored by in depth-qualitative interviewing. This suggests that if a study's questions are too limiting, it also will not be able to effectively capture and summarize the themes that it is supposed to explore.

Content and Methods of Empirical Surveys:

A great deal of the literature studying clinicians relationships with psychopharmacology is biased by gathering data from predominantly white, well educated clinicians who are members of NASW, such as some of the studies Moses and Walsh. An example being Walsh's 2003 study called “Ethical Dilemmas of Practicing Social Workers Around Psychiatric Medications”. A reason for this is gathering data from clinicians is much less risky from an ethical standpoint than gathering it from patients, and using the NASW for recruiting a sample simplifies the process. The problem with this is it excludes social workers who are not members of NASW, which may unintentionally exclude social workers with smaller financial resources since NASW's member fees are quite significant. It is important to consider how the NASW member pool differs from the overall population of social workers in the US, and how it could affect the data from Walsh' studies.

In the Walsh Study, one of the major research questions regarding the topic of psychopharmacology was “What specific ethical dilemmas do social workers face and how bothersome are they?” Survey categories for ethical dilemmas were generated by feedback from focus groups at the beginning of the study. The pre-determined ethical dilemmas were listed on the mailed surveys, and respondents were asked to list how frequently they encountered each dilemma and numerically scale how bothersome it was. There was also an open-answer section for respondents to describe and rate “other” ethical dilemmas that were not addressed in the survey questionnaire.

Another mixed method study investigated how competent social workers felt within their roles and activities concerning psychotropic medication issues by asking quantitative questions. A qualitative section in this study also investigated how social workers thought that they could be successful and what they desired to change regarding their practice with clients and other providers on the subject of psychotropic medications (Bentley, Walsh, & Farmer, 2005). Some of the topics that social workers felt most competent with include discussion of clients' feelings and regarding medications, monitoring compliance, encouraging clients to take medication, preparing clients to speak with physicians, making referrals to prescribers, communicating about medication compliance to prescribers, and helping families contact physicians. Social workers felt the least competent with assessing the severity of side effects, suggesting that physicians change a medication, providing clients information on how medications work, facilitating psychoeducation groups on medication, and ensuring that client's medication blood levels are checked when needed. Some of the activities in this study looked at are more likely to be conducted by social workers in case management roles, including helping clients fill their pillboxes, delivering medications, and transporting clients to physician's appointments. The use

of the term "physician" to signify prescribers is also confusing because many clients get their medication from primary care practitioners and non-physician prescribers such as nurse practitioners and physicians' assistants.

All of these studies do not limit the participants to only social workers in private practice because most previous research appears to have mixed agency based social workers with private practice social workers. In private practice, they may be more isolated from other practitioners, specifically those who are prescribers, so they might encounter different issues or dilemmas than the groups of respondents that all of these studies have used. So, the goal of this study is to specifically target the experiences of this more isolated group.

Empirical Findings on What Happens in Practice Involving Split-Treatment:

There is dearth of research on what social workers are actually doing in terms of handling issues of psychopharmacology in their day to day work, since most of the research focuses more on their perspectives on how things are or how they would like them to be. Some information on this topic can be found in the quantitative section of Bentley, Walsh, and Farmer study 2005, which investigated how frequently social workers engage in activities connected to the use of psychotropic medications by their clients in a "typical month". The data is presented by the percentage of respondents who specified that they engaged in specific activities "very frequently". Over 70% of respondents said that they frequently make referrals to physicians for medication consultation, and discuss with clients "feelings about taking medication" and the "desired combined effects of medication and psychosocial interventions", but only 46% consult with physicians very frequently regarding the effectiveness of client's medications. A potential problem with this study is the questions regarding frequency of engaging in activities were subjective. Instead of asking for quantitative answers on how frequently respondents engaged in

each activity, possible answers were subjective such as “often” or “very frequently”.

Respondents’ answers could have varied greatly depending on their own perceptions of how frequently they engaged in the activities that this study investigated.

There are a few studies that cover this topic focusing on the more general population of psychotherapists, some of which include social workers. The Hansen-Grant and Riba study from 1995 is an earlier study that examined communication between psychiatric resident physicians and psychotherapists over a five-month period. Data was gathered from quantitative surveys filled out by 13 psychiatric residents and patient charts. The surveys asked residents about the frequency and types of communication that they had with psychotherapists. The study concluded that communication between psychiatric residents and therapists was not adequate, due to it being irregular, infrequent, and inconsistently documented. Being over fifteen years old and based on a very limited and small sample, it would be very worthwhile to look again at some of the questions that this study aimed to answer.

Another study that looks at the relationship between psychopharmacology and psychotherapy practice is the Springer and Harris study (2010) that examined licensed Marriage and Family Therapists' (MFTs) attitudes towards this subject and how they would act in a hypothetical situation. This study used a randomized sample of 322 respondents who were blind to the study's purpose. All participants were asked to read a clinical vignette, then give their impressions on diagnosis and what direction to proceed in with treatment. The goal was to look at which clinicians would refer the client in the vignette for medication consultation. A three part mixed-method questionnaire was used that included open-ended questions about participants’ beliefs, demographic questions, and a Likert-scaled quantitative section that asked more specific questions about participants’ beliefs and attitudes. Only 35.7% of the participants said that they

would refer the client in the vignette for a psychiatric medication consultation, even though the researchers designed the vignette to appear as though a consultation was probably indicated based on current evidence based literature. Twenty-six percent of the clinician respondents failed to explicitly diagnose the client in the vignette with major depression, even though it was determined through focus groups during the design phase that the vignette clearly portrayed a client suffering from symptoms specific to major depression. While using a vignette is a creative way to approach clinicians' attitudes and beliefs, this study did not account for all variables that could have affected participants' responses. One thing that the study should have explored more is the assessment and decision-making that the respondents used before determining their diagnostic impressions and whether or not to refer for medication, since the responses to the brief clinical vignette did not capture this. Respondents might have followed the belief that a preemptive diagnosis or referral could be stigmatizing without further exploration or rapport building.

The Avena and Kalman study (2010) explored the topic of communication between psychotherapists and psychopharmacologists. A total of 53 non-prescribing psychotherapists were recruited through a Cornell University listserv and snowball sampling. They were mailed a brief quantitative questionnaire that questions about respondents caseloads, work experience, and the frequency at which they communicate with their clients' psychotropic medication prescribers. The study questions used in this questionnaire were very specific to just communication with prescribers, and did not leave room for respondents to elaborate on their experiences and perspectives since they were purely quantitative. This study found that of the 434 patients on psychotropic medication, for 22% of these cases there was no communication between therapist and prescriber. The statistical significance of the findings from this study is unclear and not

mentioned in the results section, so it appears that it was primarily a descriptive study. The goals of my study go beyond this by looking for statistically significant relationships between social worker communication and other descriptive variables.

Study Goals Based on the Literature

Ultimately, the goal of this study is to begin to build on the research of social worker's relationships with psychopharmacology because this is an area where there is a lack of empirical data. Since it also is an area that seems to lack a significant research base, studying this subject might open up new avenues of discussion. Based on this review of the literature, there are no studies that investigate the relationships between clinical social workers' own perspectives on medication, their related interventions in treatment, and the frequency and quality of their communication with providers who prescribe psychotropic medications. This study aims to investigate some of the relationships between all of these topics in the realm of split-treatment psychotherapy practice. Since there is a general lack of empirical literature in this area, there is also a need for this study to be more exploratory in nature, since there is a possibility many situations that arise in treatment have not yet been discovered by current research.

CHAPTER III

Methodology

This is a cross-sectional, mixed-method, descriptive and exploratory study that addresses the question of "How do social workers in private practice view the role of psychotropics in treatment and handle psychopharmacological issues in practice?" As a result, its goal is not to investigate causality, only description and exploration of the issues within this topic are of interest. The study is mixed-method because the survey can provide both quantifiable data, while also allowing for responses that provided greater depth and variation within the open-ended questions. Having more exploratory open-ended questions was further reinforced by the reality that there is not a great deal of current research on the topic of social workers' relationships with psychopharmacology and previously validated assessment tools.

Sample:

Inclusion criteria required that participants were licensed to independently practice as clinical social workers at a master's level. They also had to provide psychotherapy within a private practice format as opposed to working within a larger human services or mental health agency. The last criterion was that they must work with individual clients over the age of 18. This was a nonprobability convenience sample. Since this sample was generated for a mixed-method study and elements from the population do not have an equal chance of selection, it is not representative of the general population. Instead, the goal was to undertake an exploration of the experiences and perspectives of this group of respondents.

The initial sampling frame was all clinicians on the MBHP website. The MBHP website was selected as a starting point for recruitment in an effort to obtain a more diverse sample that works with more economically marginalized populations, since MBHP is made up of providers who provide mental health care for those who cannot afford private insurance. Many MBHP providers provide services to individuals with private insurance as well. If an individual who I contacted was interested in participating in the study, I asked for his or her email to send a link to the internet survey, or a physical mailing address to send a paper copy of the survey. I contacted all of the licensed clinical social workers on the MBHP website who listed working phone numbers. The total was 222. Approximately ten percent of the MBHP providers expressed interest in participating, so I had to expand the scope of my sampling in order to reach the goal of 50 participants. As a result, I contacted 225 New England providers through the Psychology Today provider website were also contacted using their publicly available phone numbers and email addresses. A snowball sampling method was also used in order to generate a larger sample. For the snowball sample, participants who had already volunteered to help complete the survey were asked to generate other contacts. Using Psychology Today and snowball sampling expanded the geographic region from which the original sample was to be derived, and also expanded the sample social workers who were not MBHP members. The disadvantage of the sampling methods used in this study is that this sample is not representative of the general population of social workers in private practice. The strength is that the MBHP providers who cover underserved populations were given the opportunity to participate. This sample is mostly restricted by geographic location within New England and individuals and associates of those who were not MBHP or Psychology Today providers were excluded.

Data Collection:

A paper list of participant candidates was generated during the recruitment phase through the MBHP and Psychology Today websites and participant referrals through the snowball sampling method. This list was used to keep track of how and when each candidate was contacted and invited to participate. This list remained secured in a locked file and was only viewed by myself. It was destroyed after data collection was completed.

Most of the data was collected via an anonymous internet-based survey with the SurveyMonkey platform. SurveyMonkey was selected over other internet survey platforms because it is the preferred internet survey tool at the Smith College School for Social Work due to the anonymity safeguards that it provides by disguising the IP addresses of participants. Participants were also given the option of completing a paper-based survey as an alternative to the internet survey. The paper-based survey included the same informed consent and questions as the internet survey. It was mailed to participants with a self-addressed stamped return envelope. A total of 12 surveys were completed by pen and paper.

Participants were instructed to not include their return addresses with completed surveys in order to preserve anonymity. SurveyMonkey and paper-based surveys also did not ask for any identifying information. For return addresses that were accidentally included, I removed and destroyed all identifying information such as names or agency names from return envelopes for the paper-based surveys. Informed consent forms were removed from paper-based surveys and kept in a separate location. I entered the the data from each completed paper-based survey into SurveyMonkey. Written responses to qualitative questions were transcribed word-for-word. At this point all of the data was stored within SurveyMonkey, therefore it was anonymous through the use of SurveyMonkey's anonymity safeguards. My research advisor, Jennifer Perloff was given access to quantitative data in the form of a SurveyMonkey excel file and the qualitative

data from open-ended questions after I removed all identifying information. Complete copies of the IRB application and informed consent form are included in the appendix section at the end of this report.

The main data collection instrument for this study was a survey of my own design, which was created to gather qualitative data, quantitative data, and some demographic data on each of the participants. Some of the survey tools covered in the literature review section of this paper served as informal foundations for this survey tool, with this survey going into more depth regarding the frequency and nature of provider communication. “Section A”, the demographic section, asked participants to specify their age, sex, race, years practicing psychotherapy, treatment modalities used, practice setting, caseload, primary issues of focus, and percent of clients currently taking psychotropic medications. For demographic questions where it was not feasible for me to list all possible answers, the option of “other” was provided as an answer choice, along with a space for participants to specify what their response was. Following the demographic data, the survey had two separate sections of questions. The first section, “section B”, inquired about social worker’s working relationships with prescribing providers, while the next section, “section C”, specifically addressed social workers’ perspectives on the use and helpfulness of psychotropic medications. A complete copy of the survey instrument is included in appendix D of this report.

Qualitative questions were all open-ended so as to give participants the change to elaborate into some depth about their perspectives and experiences. In order to account for possible omissions that could affect the results of qualitative data, the “Is there anything else?” question was included at the end of sections B and C. Sections B and C each contained qualitative questions, with a total of six for the entire survey. Quantitative questions were present

in all sections in multiple-choice format. For quantitative questions addressing “helpfulness”, Likert scales were used with possible responses being “strongly agree, agree, disagree, strongly disagree, and not sure”. Multiple choice questions in section B asked participants to specify how many of each type of prescribing provider they communicated with, the frequency of this communication, and social workers’ perspectives on the relative helpfulness of different types of prescribing providers. Section C asked participants to specify how helpful they felt psychiatric medications were for different diagnoses of mental illness.

The main risks of participation in this study were emotional stress as a result of answering the survey questions and the possibility of breach of confidentiality. Some of the survey questions asked participants to describe their beliefs and subjective experiences regarding the provision of psychotherapy and working with other mental professionals, which some participants may have found stressful. Participants had the option of discontinuing the survey at any time in order to minimize this risk. To address the issue of confidentiality, participants were not asked for identifying information on any of the actual surveys (both mailed and internet). Participants were not provided with referral information for support services since they were all licensed mental health professionals.

Analysis:

Once all of my data was gathered and ready for analysis, open coding was used to categorize the qualitative data for themes that were analyzed at a greater depth. All qualitative data was collected and recorded as written text in Excel spreadsheets. Common themes were then analyzed using frequency distribution. When initially pulling for themes from the qualitative data, open coding was appropriate for this study because I did not have a clear picture of what themes I will find in the responses, so being able to create new categories for themes as I

went along was necessary. Data was grouped in such a way that it could be linked back to its original context in the written responses in order to allow for re-examination. Responses were read multiple times in order to maximize quantitative data yield.

In the quantitative data section, correlation of Likert-scale responses with each other and/or other demographic data was also used to shed light on ideas for hypotheses on how respondents' perspectives, behaviors, and demographics might relate. This was accomplished by using simple descriptive statistics and Spearman correlations, by comparing grouping variables from the demographics or Likert-scale topics with other test variables from Likert-scale topics. A relationship was considered statistically significant if the p value was lesser than or equal to 0.05. One example included clinicians' frequency of communication with psychiatrists and their perspectives on the "helpfulness" of psychotropic medications with clients with serious mental illness. Weaknesses with this type of analysis include the possibility of a sample that is too small to generate statistically significant relationships, the subjectivity and variation of responses that occurs with Likert scales, and the fact that the diversity of the sample will be skewed by recruitment methods. Since my total sample is fairly small (56) and limited by snowball sampling, generalizable quantitative correlations could not be made between respondent demographics and their responses. The goal of both the qualitative and quantitative data analysis was to expand the knowledge base of the kinds of experiences that social workers in private practice encounter with respect to medication issues.

My own personal bias regarding psychotropic medication could have affected the results of this study, since it is a topic that I have some strong personal opinions about. Since I created my own survey, it was very important for me to scrutinize my questions to avoid possible bias. In order to account for possible omissions that could affect the results, I asked a few of my

student peers and two clinical research professionals for feedback on my survey. Having the “Is there anything else?” question as the last qualitative question was also designed to help to account for possible omissions resulting from the other questions.

CHAPTER IV

Findings

This chapter summarizes the findings from a mixed method survey (Appendix D) that was designed to explore clinical social workers perspectives on the helpfulness of psychotropic medications, major issues that they encounter in practice when discussing psychotropic medications with their clients, and the nature of their communication with prescribing providers of psychotropic medications. This first part of this chapter will present the quantitative demographic data retrieved from the study, followed by quantitative and qualitative data from Section A and B of the survey. Lastly, the chapter will cover correlational findings based on 14 variables created from quantitative data.

Descriptive Findings:

Respondent Demographics. There were 66 total responses to the internet and paper based survey tools in this study, but the data from only 56 was used. 10 respondents were excluded from the study because they did not meet exclusion criteria requirements or did not complete any survey questions beyond the initial screening questions. Of the sample of 56 official respondents, the average age was 58.9 years, with the youngest respondent being 34 years old and the oldest being 79 years old. Fifty-eight point nine percent identified their sex as female and 41.1% identified their sex as male, which is a diverse sample in terms of sexual identity, considering that the majority of clinicians who were contacted during the recruitment phase were female. The sample was not diverse in terms of racial identity, with 100% of the

respondents identifying as white. Fifty-five of the respondents listed the number of years they had practiced psychotherapy, with a response average of 26.4 years, the least being 4 years and the most being 48 years. Fifty-six of the respondents specified the setting of their practice, with 14.3% in rural areas, 41.1% in suburban areas, and 44.6% in urban areas.

Table 1

Demographics of the Respondents

Age	Average	59.8 years
	Minimum	34.0 years
	Maximum	79.0 years
Sexual Identity	Female	58.9%
	Male	41.1%
Racial Identity	White	100.0%
Setting of Practice	Rural	14.3%
	Suburban	41.1%
	Urban	44.6%
Years Practicing Psychotherapy	Average	26.4 years
	Minimum	4.0 years
	Maximum	48.0 years

The treatment techniques used by respondents are listed below on Table 2. Out of the 56 respondents, they most frequently listed cognitive behavioral therapy (89.3%), psychodynamic (69.6%), and then eclectic (55.4%) as treatment techniques used in practice. In addition to the three most frequently used techniques, respondents specified quite a variety of other techniques that they use in practice, including coaching (25.0%), dialectical behavior therapy (26.8%), eye movement desensitization and reprocessing (26.8%), family systems (14.8%), humanistic

(35.7%), mindfulness based cognitive therapy (46.4%) and psychoanalytic (19.9%). Treatment techniques that were specified by less than 10% of the respondents are not included in the results on Table 2. In this section, most respondents listed three or more techniques, suggesting that most of the respondents were “eclectic” to some extent.

Table 2
Treatment Techniques of the Respondents

Treatment Technique	Percent of respondents who use technique (n=56)
Coaching	25.0%
Cognitive Behavioral Therapy (CBT)	89.3%
Dialectical Behavior Therapy (DBT)	26.8%
Eye Movement Desensitization and Reprocessing (EMDR)	26.8%
Eclectic	55.4%
Family Systems	14.8%
Humanistic	35.7%
Mindfulness Based Cognitive Therapy (MBCT)	46.4%
Psychoanalytic	17.9%
Psychodynamic	69.6%

Looking at caseload demographics listed below on Table 3, Respondents had an average caseload size of 42 clients, with the smallest caseload being 6 clients and the largest caseload

being 150 clients. Forty-seven respondents listed the three most prominent issues of focus with their clients. Of these 47 respondents, 89.4% reported that depression was a major issue of focus in treatment with clients, followed by anxiety at 74.5% and relationships at 47.7%. Only one respondent (2.1%) listed psychosis as a major issue of focus, this being the least prominent issue among the respondents. There was a fair amount of variation within the question that addressed percentage of caseload taking psychotropic medications. The majority of respondents (50.9%) stated that approximately 26%-50% of their caseload is on psychotropic medications. This was followed by 36.4% of respondents stated that 51%-75% of the caseload is on medication, 7.3% stated that 76%-100% of their caseload is on medication, and the least number of respondents (5.5%) stated that less than 25% of their caseload is on medication. Other issues that were listed by less than 10% of respondents are aging, disability, grieving, personality disorders, psychosis, relationships, sexual/gender identity, spirituality and “other”.

Table 3

Caseload Demographics

Number of psychotherapy clients in caseload n= 54	Average	42.33
	Minimum	6.00
	Maximum	150.00

Major issues of focus in caseload n=47	Addiction/Substance Abuse	(11) 23.4%
	Aging	(2) 4.3%
	Anxiety	(35) 74.5%

	Depression	(42) 89.4%
	Disability	(1) 2.1%
	Grieving	(3) 6.4%
	Personality Disorders	(3) 6.4%
	Psychosis	(1) 2.1%
	Relationships	(22) 46.7%
	Sexual/Gender Identity	(2) 4.3%
	Spirituality	(2) 4.3%
	Trauma	(16) 34.0%
	Other	(4) 8.5%
Percent of caseload taking psychotropic medications n=53	Less than 25%	(3) 5.5%
	26%-50%	(28) 50.9%
	51%-75%	(20) 36.4%
	76%-100%	(4) 7.3%

Main descriptive findings. The descriptive findings came from section A and section B of the survey, which addressed the respondents working relationships with prescribing providers and then their own perspectives regarding psychotropic medications, respectively.

Provider communication: Quantitative findings. The quantitative data on working with providers of psychotropic medications is listed below in Table 4. For the survey question that asked participants to specify the “helpfulness” of different types of providers, 68.6% of respondents specified that they agreed that psychiatrists are helpful, and 64.7 % specified the

same with regard to primary care doctors. Only 3.9% of respondents disagreed that psychiatrists are helpful, whereas 11.8% disagreed or strongly disagreed with the helpfulness of primary care doctors. For the category of psychiatric nurse practitioners and psychiatric physician’s assistants, the majority of respondents (48.8%) specified that they strongly agreed that these types of providers are helpful, while a total of 6% either disagreed or strongly disagreed. For primary care nurse practitioners and physician’s assistants, the majority of respondents (42.9%) specified that they were not sure of the helpfulness of these types of providers, 47.0% agreed or strongly agreed that they are helpful, and 11.9% disagreed or strongly disagreed that they are helpful. These results are based on the types of practitioners that the respondents worked with in practice, so the sample size varied between each of these statistics.

The second section of Table 4 shows the results from respondents who communicate with the corresponding prescribing providers at least once a month. These results give a different picture from the above results, showing that psychiatric nurse practitioners physicians assistants are rated more favorably than the other types of providers, with 12 out of 21 respondents (57.1%) selecting strongly agree for helpfulness in this category. For the category of primary care nurse practitioners and physicians, the majority of respondents (7 or 53.9%) listed that they disagree with the helpfulness of these providers. The majority of responses did not change for psychiatrists and primary care doctors, since 64.7% of respondents for each type of provider stated that they agree that they are helpful.

Table 4

Working with Providers of Psychotropic Medications- Helpfulness

Helpfulness of providers regarding psychotropic medications	Type of provider	Strongly agree	Agree	Disagree	Strongly disagree	Not sure

	Psychiatrists n=51	(13) 25.5%	(35) 68.6%	(2) 3.9%	(0) 0.0%	(1) 2.0%
	Primary Care Doctors n=51	(9) 17.6%	(33) 64.7%	(3) 5.9%	(3) 5.9%	(3) 5.9%
	Psychiatric Nurse Practitioners or Psychiatric Physicians Assistants (psychiatric) n=50	(24) 48.0%	(18) 36.0%	(2) 4.0%	(1) 2.0%	(5) 10.0%
	Nurse Practitioners or Physicians Assistants (primary care) n=42	(4) 9.5%	(15) 37.5%	(3) 7.1%	(2) 4.8%	(18) 42.9%

Helpfulness of providers when respondents communicate with them greater than or equal to 1x per month	Type of provider	Strongly agree	Agree	Disagree	Strongly disagree	Not sure
	Psychiatrists n=17	(6) 35.3%	(11) 64.7%	(0) 0.0%	(0) 0.0%	(0) 0.0%
	Primary Care Doctors n=17	(5) 29.4%	(11) 64.7%	(0) 0.0%	(0) 0.0%	(1) 5.9%
	Psychiatric Nurse Practitioners or	(12) 57.1%	(8) 38.1%	(1) 4.8%	(0) 0.0%	(0) 0.0%

	Psychiatric Physicians Assistants (psychiatric) n=21					
	Nurse Practitioners or Physicians Assistants (primary care) n=13	(3) 23.1%	(3) 23.1%	(7) 53.9%	(0) 0.0%	(0) 0.0%

Table 5 lists findings from questions that addressed the frequency of respondents' communication with prescribing providers. When looking at the frequency of communication with specific providers, the majority of respondents specified that they communicate less than once a month with each type of prescribing provider, ranging from 40%-60%. Within all of the different prescribing provider categories, the lowest number of respondents specified that they communicate more than once a week (only one respondent per category, 1.9%-2.9%). The last two sections of this table look at communication frequency depending on the "severity" of mental illness. The majority of clinicians specified that they communicate on average of one time every three months with prescribing providers of clients who have "mild to moderate mental illness" (37.7%) and "more serious mental illness" (44.9%). In general, respondents tended to communicate more frequently regarding clients with more serious mental illness compared to communication regarding clients with mild to moderate forms of mental illness.

Table 5

Working with Providers of Psychotropic Medications- Frequency of Communication

Frequency of communication with different types of		More than once a week	Once a week	Once a month	Less than once a month	Not at all
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providers						
	Psychiatrists n=52	1.9% (1)	7.7% (4)	25.0% (13)	55.8% (29)	9.6% (5)
	Primary Care Doctors n=50	2.0% (1)	6.0% (3)	18.0% (9)	60.0% (30)	14.0% (7)
	Psychiatric Nurse Practitioners or Psychiatric Physicians Assistants (psychiatric) n=50	2.0% (1)	6.0% (3)	34.0% (17)	40.0% (20)	18.0% (9)
	Nurse Practitioners or Physicians Assistants (primary care) n=35	2.9% (1)	2.9% (1)	2.9% (1)	57.1% (20)	34.3% (12)

Table 6

Working with Providers of Psychotropic Medications- Frequency of Communication

Average frequency of communication with prescribing providers for clients with mild to moderate mental illness n=51	More than 1x per week	(0) 0.0%
	1x per week	(1) 2.0%
	1x per month	(8) 15.7%
	1x every three months	(19) 37.7%
	1x a year or less	(23) 45.1%
Average frequency of communication with prescribing providers for clients with serious mental illness n=52	More than 1x per week	(0) 0.0%
	1x per week	(4) 8.2%

	1x per month	(12) 24.5%
	1x every three months	(22) 44.9%
	1x a year or less	(11) 22.5%

Provider communication: Qualitative findings.

Provider inaccessibility. In the open response questions of the survey Section A, the most common issue was that prescribing providers are not accessible for communication about cases, which 29 out of 56 or 51.7% of the respondents wrote about. This may include a lack of regular responses to voicemail messages, or statements that prescribing providers are “too busy”. A typical response that came from one of the respondents regarding this issue is that “prescribers rarely contact me or respond to written requests for information”. Another respondent stated, “The most common issue in dealing with a client's prescriber is the ability to actually talk to them. Coordinating care with a PCP who is hard to get a hold of, is screened by a nurse, and is often (meeting) with a patient like I am.” This response also touches on second most common issue that respondents wrote about, which is that it is difficult to find time to communicate with prescribing providers. This was often due to scheduling conflicts since providers cannot communicate with each other when meeting with clients. The theme of “not having enough time” was present 11 out of 56 or 19.6% of the responses.

Four respondents wrote about the supply of prescribing providers not being adequate, specifically providers who focus on psychiatric medications such as psychiatrists and psychiatric nurse practitioners. A comment that illustrates this from a social worker describing a group of approximately 10-15 clients from her caseload taking psychotropic medications; “Only one of my patients sees a psychiatrist for meds. There are hardly any in this area and those that are do not want to simply prescribe.”

Conflicting views. Eight of the respondents (14.3%) described generally having conflicting views with the types of treatment provided by prescribers. Actual respondent statements pertaining to this theme include “I would like to see the medical profession take more of an interest in therapy which does not use psychotropics”, “On a number of occasions, there have been problems with lack of responsiveness to the acuity of situations regarding suicidal ideation.” and “(I) Sometimes feel that psychiatric providers do not explain enough to clients or listen to clients' complaints with respect to the meds they are on.” Respondents also wrote about not agreeing about the types of medication prescribed to their clients. Three respondents wrote specifically about the issue that prescribing providers are too focused on formulating clients’ cases using biological perspectives and often disregard the psychological and social factors contributing to clients’ mental illnesses, such as “ignorance of intrapersonal and interpersonal issues of client”. The theme of polypharmacy or being prescribed too much of certain types of medication was mentioned by two respondents.

Relationships with specific types of prescribing providers. Two of the respondents reported that psychiatric nurse practitioners were particularly helpful. One even stated that that they are “Godsend”. Another respondent wrote about relationships with Obstetrician-Gynecologists, describing their role in prescribing psychotropic medications as helpful; “I receive many referrals from Ob-Gyns v. PCPs. The Ob-Gyns tend to be more tuned in to their patients; also, the nature of the reasons for patients' visits to Ob-Gyns is often emotionally charged (pregnancy, miscarriage, menopause, infertility, disease, etc.), so those doctors end up doing a lot of prescribing for mild to moderate conditions, esp. depression, anxiety, post-partum, etc.”

Adequacy of prescribing providers. Five respondents stated that prescribing providers who are not psychiatrists or who do not specialize in psychiatric medicine do not have adequate knowledge or experience to prescribe psychotropic medications, including one respondent that made this statement regarding primary care practitioners; “some of whom have little understanding of the benefits of individual antidepressants, meaning it is not unusual to see the patient prescribed "the wrong" or less effective med, or start patients at full doses when titration up would limit side effects that are often temporary. Intense side effects in beginning equals non-compliance and fear of meds.” Two respondents wrote that they are “uncertain” of whether or not their clients’ prescribing providers perform adequately.

Other issues that come up when working with prescribing providers. In section A of this survey, six (10.7%) of the respondents reported that they feel like their input is not respected and/or valued by prescribing providers. The same number of respondents emphasized that teamwork is important in order to provide the best care for clients. Two respondents mentioned having general issues with continuity of care, while two other respondents emphasized that adequate communication does occur when a client is in crisis. When having collaborative discussions about the efficacy of medication, two respondents stated that the general inefficacy of medication is a common theme. Four respondents mentioned that finding adequate medications for clients with substance abuse issues is something that they frequently have to troubleshoot with prescribing providers.

Work with clients and psychotropics: Quantitative findings. The quantitative question from the survey Section B on social workers views of psychotropic medications asked clinicians to specify their level of agreement with the helpfulness of psychotropic medications depending on the type of mental illness symptoms that clients struggle with. Overall, respondents tended to

agree or strongly agree that psychotropic medications are helpful for each of the symptoms. For mild to moderate anxiety, 11.3% strongly agree and 62.3% agree with the helpfulness of psychotropic medications. Nine point four percent disagree and 3.8% strongly disagree with the helpfulness of medications, while 13.2% said they were “not sure”. For severe anxiety, 94.3% either agree or strongly agree with the helpfulness of medications. For mild to moderate depression 75.5% agree or strongly agree with the helpfulness of psychotropic medications, but 94.3% either agree or strongly agree when clients struggle with severe depression. For mood instability, 86.8 of respondents agreed or strongly agree, 3.8% strongly disagree, and 9.4% are not sure with the helpfulness of psychotropic medications. Lastly, for psychotic symptoms 82.7% of respondents agree or strongly agree with the helpfulness of medications and 13.5% are not sure.

Table 7

Social Workers’ Perspectives on Psychotropic Medications

Psychotropic medications are helpful for clients who struggle with...	Strongly agree	Agree	Disagree	Strongly disagree	Not sure
Mild to moderate anxiety n=53	(6) 11.3%	(33) 62.3%	(5) 9.4%	(2) 3.8%	(7) 13.2%
Severe anxiety n=53	(27) 50.9%	(23) 43.4%	(1) 1.9%	(1) 1.9%	(1) 1.9%
Mild to moderate depression n=53	(10) 18.9%	(30) 56.6%	(6) 11.3%	(1) 1.9%	(6) 11.3%
Severe depression n=53	(31) 58.5%	(19) 35.8%	(2) 3.8%	(1) 1.9%	(0) 0.0%
Mood	(22) 41.5%	(24) 45.3%	(0) 0.0%	(2) 3.8%	(5) 9.4%

instability n=53					
Psychotic symptoms n=52	(30) 57.7%	(13) 25.0%	(1) 1.9%	(1) 1.9%	(7) 13.5%

Work with clients and psychotropics: Qualitative findings.

Side effects. The issue that respondents mentioned the most frequently when writing about work with clients is the topic of side effects caused by psychotropic medications. Thirty of the fifty-six respondents (53.5%) mentioned side effects being problematic at some point within the open-ended responses of Section B. Some specific side effects that were mentioned include “fogginess”, “weight gain”, “dry mouth”, inability to cry”, and reduction of “sexual functioning”. Within many of these responses, it was noted that side effects contribute to clients’ fears of starting and/or staying on medications, or complying with medication regimens.

Fears and stigma. The next most frequently reported issues are regarding clients’ fears of being on medication. Fourteen respondents (25.0%) wrote that general “fears” of being on medication are an issue in treatment. The same number of respondents mentioned that dealing with emotional and social stigma or processing the fear of emotional and or social stigma is problematic for clients who are either on medication or considering going on it, respectively. An good example from a respondent regarding this issue is, “The stigma attached to taking these medications is often internalized by clients who then tend to see their need for the medicine as an indication of weakness or defect.” Two respondents also reported that clients’ negative past experiences with psychotropic medications add to their fears of trying them again.

The need for psychoeducation. Providing psychoeducation, helping clients who are misinformed and teaching clients how to advocate for themselves when discussing psychotropic medications in therapy were three different themes present in the survey responses. Six

respondents (10.7%) stated that psychoeducation about psychotropic medication was an important part of their work, which was often about helping clients to understand the positive and negative aspects of medications. Four respondents stated that their clients are often misinformed about medication, such as having the “incorrect information about course of treatment and side effects.” None of the respondents were specific about the sources of misinformation. Another related topic that five respondents wrote about was that many clients place expectations that are too high on their medication, such as wanting it to act quickly or eliminate all negative feelings. Lastly, seven respondents (12.5%) wrote about the importance of clients knowing how to be advocates for themselves when meeting with prescribing providers about psychotropic medications. One provider wrote about this regarding the issue of changes to the medication regimen, “People need to learn that they have to advocate for themselves and know that they must step down carefully when coming off meds. If a new provider wants to abruptly take them off a medication, the client must advocate for him- or herself and not just allow an abrupt change to be made.”

Changing medications and dosages. Change in the medication regimen was another frequently mentioned issue in this section of the survey, specifically about how many clients struggle with their medication types and dosages being changed. Six (10.7%) of the respondents stated that this was an issue that their clients frequently bring up, especially because there are often multiple trials before many clients are on the best medication regimen.

Building rapport. One respondent emphasized special consideration that is necessary when working with clients who struggle with more severe forms of mental illness, “Ironically, it is often the most ill patients that are most opposed to medication. It takes patience and building a rapport along with informing them about the increase in control of their thought and feelings that

will likely come from taking the medications”. He emphasizes the need to build trust in order to help clients who are very resistant to taking medication as a result of their fragile mental states.

Issues with the prescribing provider. Six respondents (10.7%) mentioned that they and their clients struggle with being satisfied by and/or trusting the collaborating prescribing providers. Some of the specific issues mentioned related to this topic include “ Being diagnosed without a comprehensive and collaborative assessment”, “Short sessions with prescribers leave clients feeling unheard”, “resistance of the MD to modify or change the med at the appropriate time”, and “Failure of the prescriber to be invested in the client’s real world struggles.”

Professional boundaries. When some of the respondents encounter situations where they are questioning the prescribing provider’s actions, one of the common dilemmas that they mentioned was overstepping the professional boundaries of their roles as social worker-psychotherapists. A total of nine (16.1%) of the respondents mentioned overstepping professional boundaries as an issue that they struggle with in practice. In one case, a respondent stated “Masters level clinicians can't legally recommend medications, so a fine line is often walked when a patient is not on an appropriate medication, or is over-medicated. The fine line is how not to anger prescribers (most often primary care docs) and still get the point across.” Another statement that shows a more guarded perspective is, “I am very cautious about discussing meds with patients. I am a LICSW and, as such, I feel that more than a suggestion of referral/med check is outside my sphere of professional competence.”

The need for more holistic perspectives and approaches. Seven respondents (12.5%) reported that their clients focus too much on the biological aspects of their treatment, specifically medications. As a result of this, they do not give enough credit to improvements that they have made as a result of hard work in psychotherapy. Or, they may come to psychotherapy as a

formality when they really feel like medication is the only thing that is helping or will help them. Two respondents emphasized the need for more holistic types of treatment that incorporate interventions that are not traditionally a part of psychotherapy. Possibilities include incorporating “meditation”, “breathing techniques”, “nutrition”, and “exercise”.

Other barriers to pharmacotherapy. Two other major barriers to pharmacotherapy that respondents pointed out included clients’ struggles to be compliant with their medication regimens and monetary issues associated with psychotropic medication. Compliance issues that were highlighted by five respondents include, coming off medications (against medical advice) as a result of “a desire for more autonomy”, not “taking meds as prescribed” and struggling with “abstinence from alcohol and other drugs”. Three respondents mentioned that money was an issue, stating that the additional cost of medications to clients and lack of therapist reimbursement for time spent collaborating with prescribing providers prevent clients from getting the best treatment. Two of the respondents reported that health insurance company policies cause some of these issues.

Correlative findings: Fourteen variables were analyzed for statistically significant relationships using the Spearman’s rank correlation coefficient. The variables are: caseload; years practicing psychotherapy; therapy count (total number of therapeutic techniques a respondent uses); percent of caseload on medication; frequency of communication with psychiatrists; frequency of communication with primary care physicians; frequency of communication with psychiatric nurse practitioners and physicians assistants; frequency of communication with primary care nurse practitioners and physicians assistants; frequency of communication with prescribing providers of clients with mild to moderate mental illness; frequency of communication with prescribing providers of clients with serious mental illness; helpfulness of psychiatrists;

helpfulness of primary care doctors; helpfulness of psychiatric nurse practitioners and physicians assistants; and helpfulness of primary care nurse practitioners and physicians assistants. These correlation figures can be found in Table 7.

Looking at the caseload variable, one statistically significant weak correlation was found in relation to respondents' frequency of communication with prescribing providers of clients with serious mental illnesses. This was a negative correlation of about -0.33, so higher caseload numbers corresponded with lower communication frequencies. There were two statistically significant correlations with the age variable, both of which were also negative. These showed relationships between the respondent's age and their perception of how helpful psychiatrists or psychiatric nurse practitioners and physician's assistants are to their clients, with correlations of -0.37 and -0.32, respectively. This means that older respondent age corresponded with perceptions of psychiatrists and psychiatric nurse practitioners/physicians assistants being less helpful. For the percentage of respondent caseload on medications variable, negative statistically significant correlations were found between this variable and helpfulness of psychiatric nurse practitioners/physicians assistants along with communication frequency with primary care nurse practitioners /physicians assistants. The correlations for these were $Rho = -0.32$ and $Rho = -0.39$, respectively.

Statistically significant positive correlations were found between all of the psychiatrist, primary care doctor, and psychiatric nurse practitioner communication frequency variables. The strongest correlation was between psychiatrist and psychiatric nurse practitioner/physicians assistant communication frequency ($Rho = 0.59$), followed by psychiatrist and primary care doctor communication frequency ($Rho = 0.46$), and primary care doctor and psychiatric nurse practitioner/physicians assistant communication frequency ($Rho = 0.36$). There was no

statistically significant correlation between primary care nurse practitioner/physicians and psychiatrist communication frequency. But, there were significant correlations between primary care nurse practitioner/physicians assistant and primary care doctor communication frequency along with primary care nurse practitioner/physicians assistant and psychiatric nurse practitioner/physician assistant communication frequency. Correlation values for these were Rho=0.49 and Rho=0.61, respectively.

Respondent communication frequency with prescribing providers of clients with mild to moderate mental illness and serious mental illness showed significant positive correlation with respondent communication frequency with psychiatrists, primary care doctors, and psychiatric nurse practitioners. There was no statistically significant correlation between these two variables and primary care nurse practitioner/physicians assistant communication frequency.

Table 8

Correlative Findings

*Bold type indicates statistical significance $p > \text{or} = .05$	Caseload	Years practicing psychotherapy	Percent of caseload on medication	ComFreq: Psychiatrists	ComFreq: Primary care doctors	ComFreq: Psychiatric nurse practitioners and physicians assistants	ComFreq: Primary care nurse practitioners and physicians assistants
Communication frequency (ComFreq): Psychiatrists	Rho=-0.22247 p=0.1205 n=50	Rho=-0.13169 p=0.3570 n=51	Rho=-0.01652 p=0.9084 n=51		Rho=0.46199 p<.0001 n=49	Rho=0.59398 p<.0001 n=50	Rho=0.14887 p=0.3934 n=35
ComFreq: Primary care doctors	Rho=-0.15255 p=0.3006 n=48	Rho=-0.02142 p=0.8839 n=49	Rho=-0.13491 p=0.3554 n=49	Rho=0.46199 p=0.0008 n=49		Rho=0.35913 p=0.0132 n=47	Rho=0.49038 p=0.0032 n=34
ComFreq: Psychiatric nurse practitioners and physicians assistants	Rho=-0.26102 p=0.0731 n=48	Rho=-0.00319 p=0.9826 n=49	Rho=-0.21169 p=0.1442 n=49	Rho=0.59398 p<.0001 n=50	Rho=0.35913 p=0.0132 n=47		Rho=0.60781 p=0.0001 n=35
ComFreq: Primary care nurse practitioners and physicians assistants	Rho=-0.08803 p=0.6151 n=35	Rho=0.14045 p=0.4282 n=34	Rho=-0.38839 p=0.0232 n=34	Rho=0.14887 p=0.3934 n=35	Rho=0.49038 p=0.0032 n=34	Rho=0.60781 p=0.0001 n=35	
ComFreq: Clients	Rho=	Rho=	Rho=	Rho=	Rho=	Rho=	Rho=

with mild-moderate mental illness	-0.29471 p=0.0377 n=50	0.06061 p=0.6759 n=50	-0.03202 p=0.8253 n=50	0.59928 p<.0001 n=48	0.34534 p=0.0187 n=46	0.30305 p=0.0384 n=47	-0.03014 p=0.8656 n=34
ComFreq: Clients with serious mental illness	Rho=-0.32788 p=0.0229 n=48	Rho=0.00563 p=0.9697 n=48	Rho=-0.07858 p=0.5955 n=48	Rho=0.57327 p<.0001 n=47	Rho=0.35830 p=0.0157 n=45	Rho=0.32700 p=0.0265 n=46	Rho=0.03458 p=0.8485 n=33
Helpfulness of (Help): psychiatrists	Rho=-0.18437 p=0.1999 n=50	Rho=-0.36944 p=0.0083 n=50	Rho=-0.04608 p=0.7507 n=50	Rho=0.20285 p=0.1621 n=49	Rho=-0.13776 p=0.3613 n=46	Rho=-0.08473 p=0.5712 n=47	Rho=-0.00695 p=0.9689 n=34
Help: Primary care doctors	Rho=-0.11095 p=0.4430 n=50	Rho=-0.11630 p=0.4212 n=50	Rho=-0.11243 p=0.4370 n=50	Rho=0.16946 p=0.2495 n=48	Rho=0.43399 p=0.0026 n=46	Rho=0.16411 p=0.2758 n=46	Rho=0.24487 p=0.1628 n=34
Help: Psychiatric nurse practitioners and physicians assistants	Rho=-0.01235 p=0.9329 n=49	Rho=-0.32449 p=0.0229 n=49	Rho=-0.11243 p=0.0491 n=49	Rho=0.00108 p=0.9942 n=48	Rho=0.39118 p=0.0079 n=45	Rho=0.33513 p=0.0213 n=47	Rho=0.54790 p=0.0008 n=34
Help: Primary care nurse practitioners and physicians assistants	Rho=0.12485 p=0.4367 n=41	Rho=0.03539 p=0.8261 n=41	Rho=0.09491 p=0.5550 n=41	Rho=-0.20711 p=0.1997 n=40	Rho=0.07132 p=0.6705 n=38	Rho=0.01516 p=0.9270 n=39	Rho=0.65244 p<.0001 n=32

CHAPTER V

Discussion

This study explored the perspectives and experiences regarding psychopharmacological issues of social workers working as private practice psychotherapists. It specifically focused on their own perspectives on the helpfulness of medications for their clients and the nature of their professional relationships with prescribing providers. It used a mixed-method survey comprised of multiple choice and open ended questions (Appendix D) that asked participant social workers to describe their own perspectives on the helpfulness of psychotropic medications, issues that arise when discussing psychotropic medications with their clients, issues that arise when working with prescribers of psychotropic medications in split treatment, and the frequency of their communication with prescribing providers.

The results from this study suggest a few important possibilities. First is that most private practice social workers believe that psychotropic medication is helpful, with the degree of helpfulness varying depending on the nature of the client's mental illness. Second, social workers observe that their clients struggle with a multitude of conflicts affecting their willingness to be treated with psychotropic medications. Third, social workers in private practice find that communication difficulty between prescribing providers frequently has a negative impact on treatment. This includes not being able to communicate frequently enough with prescribing providers, not agreeing with prescribing provider's treatment strategies, and not feeling respected by prescribing providers.

Social Workers Working with Prescribing Providers

Communication frequency. Kahn (1991) emphasizes that an effective split treatment relationship must have productive collaboration and communication between all members. In this study, members consist of the client, the social worker, and the prescribing provider. Despite the importance of effective communication, the results from this study suggest that the nature of communication is not adequate. Both the Hansen-Grant and Riba (1995) and Avena and Kalman (2010) studies investigated the frequency of psychotherapists' communication with prescribing providers, and both concluded that the communication between providers was not frequent enough for adequate treatment, with Avena and Kalman finding that 22% of their respondents did not communicate with prescribing providers at all. In the Bentley, Walsh and Farmer 2005 study, 46% of the respondents listed that they communicate with prescribing physicians "very frequently". Since "very frequently" is a subjective measure of frequency, it is hard to assess. My study also suggests that provider communication is not frequent enough. Forty-five point one percent of respondents stated that when treating clients with mild to moderate mental illness, they communicate with prescribing providers once a year or less. When treating clients with serious mental illness, the majority of respondents (44.9%) stated that they communicate with prescribing providers every three months on average, and 22.5% stated that they communicate with prescribing providers once a year or less.

Some respondents elucidated possible barriers to more frequent communication in the open-ended response sections of the survey. The most frequently mentioned issue was that prescribing providers are hard to reach. Reasons for this include that they have busy schedules and are not able to regularly follow up on phone calls and written requests to share information.

Another possible barrier to communication frequency is the fact that many of the respondents stated that their own schedules were too busy in order to take time out of the workday to contact other providers. One respondent mentioned the lack of reimbursement for time spent outside of psychotherapy sessions is an issue, which could deter social workers from initiating more frequent communication from prescribing providers.

Another possible cause of infrequent and ineffective communication may be a lack of interest in social workers' input on the part of prescribing providers. A significant number of respondents (10.7%) felt like their input was not valued by prescribing providers, which might cause them to put less effort into reaching out. If a significant number of prescribing providers do not value input as these respondents have experienced, the prescribing providers may also be much less likely to communicate frequently with social workers. Disagreement over how to treat clients could also add to this dynamic if it results in shutdown of communication. This is also important to consider because 14.3% of respondents in this study mentioned that disagreement with prescribing providers is a significant issue in practice.

Statistically significant communication frequency correlations. Another significant finding related to the issue of communication frequency is that there was a weak negative correlation between social workers' caseload size and their communication frequency with prescribing providers of clients with serious mental illness. This means that social workers with larger caseload sizes tended to communicate less with prescribing providers regarding clients with serious mental illness. Although this is a weak correlation within a relatively small sample size, the implication of this is very important because it could mean that when social workers have large caseloads, the neediest clients are getting less help and support compared to clients with more mild forms of mental illness.

Positive correlations were found between almost all of the provider-specific communication frequency variables, except for communication frequency with psychiatrists and primary care nurse practitioners/physicians assistants. The statistical significance of the relationship between these two variables was probably affected by the very small sample of respondents who communicate regularly with primary care nurse practitioners and physicians assistants. Given a larger sample, it is possible that a statistically significant relationship may have been found. The trend of significant positive correlations between all of these variables ranges from correlations of $Rho=0.36$ to $Rho=0.61$. Explaining the reasons behind the differences in these variables is beyond the scope of this study, but it appears that if a social worker communicated frequently with one type of prescribing provider, it is likely that she communicated frequently with other providers as well.

Prescribing provider helpfulness. Social workers perceptions of the “helpfulness” of different types of prescribing providers was another variable that this study investigated in order to evaluate the adequacy of split treatment relationships. In the case of respondents who communicated with prescribing providers at least once a month, 57.1% of those who worked with psychiatric nurse practitioners and physicians assistants stated that they “strongly agreed” that these types of providers were helpful and supportive to clients, whereas the majority of respondents working with psychiatrists and primary care doctors stated that they “agreed” with the helpfulness of these providers (64.7% in both cases). In the qualitative response section of the study, two respondents also wrote that they find psychiatric nurse practitioners to be particularly helpful. Primary care nurse practitioners and physicians assistants were perceived to be the least helpful, with the majority of respondents (53.9%) stating that they “disagree” that these types of providers are helpful. To understand the exact reasons behind these findings would

require more exploration, but possible reasons for the non-physician psychiatric providers being more “helpful” could be a result of their training, which might teach them to look at client problems similar to the way that social workers are trained. Since these providers are non-physicians, social workers may view them more as equals and therefore they might seem more approachable. Clients may also view them as more approachable for this reason.

Statistically significant helpfulness correlations. There were weak negative correlations found between respondent age and the perception of helpfulness regarding psychiatrists and psychiatric nurse practitioners and physicians’ assistants, showing that younger participants tended to have more positive views of these prescribing practitioners helpfulness and supportiveness of clients. Determining the possible causes of this phenomena is beyond the scope of this study, but it is still significant if it is a phenomena that occurs on a more widespread level. It would be worth looking into factors that might influence this, including differences in educational background, culture, and attitude that are dependent on the historical timeframes that social workers have practiced in.

The sample for each of these categories is small since a large group from the overall study sample size specified that they communicated with these types of providers less than once a month. But, the differences are significant enough that the topic of other providers’ “helpfulness” would be worth exploring in greater depth to see if this trend is more widespread, and possibly exploring reasons as to why the non-physician psychiatric prescribing providers might be the most helpful in split treatment relationships. Since these questions regarding provider helpfulness are quantitative but subjectively interpreted, they do not address how the respondents perceive the meaning of these concepts. Further research that addresses exactly what social workers perceive to be helpful and supportive could be worthwhile given the opportunity.

This could be beneficial to social work practice because it may uncover some of the issues that trigger a breakdown of split treatment relationships, and reasons why prescribing providers with certain types of training backgrounds might be more helpful than others.

Social Workers' Perspectives on Clients and Psychotropic Medications

Helpfulness of psychotropic medications. It is clear that the majority of social workers in this study believe that psychotropic medications are helpful to adult clients with most forms of mental illness, including anxiety, depression, psychosis, and bipolar affective disorder. This is similar to the results from the 2006 Moses and Kirk and 2008 Moses studies regarding treatment of adolescents, since the general opinion of respondents was that psychotropic medication was more beneficial than harmful when used as treatment for mental illness in this younger population. Despite the mostly positive views of psychotropic medications, the responses from participants in my study and the Moses and Moses and Kirk studies are complex, since their views on the benefits and helpfulness of medication vary greatly depending on many different biopsychosocial factors that affect their clients.

A qualitative question from the survey from this study asked participants to specify their level of agreement with the helpfulness of psychotropic medications depending on the type and severity of mental illness that their clients suffered from. The majority of respondents either agreed or strongly agreed with the helpfulness of psychotropic medications in treatment of mild to moderate anxiety, severe anxiety, mild to moderate depression, severe depression, mood instability and psychosis. The highest levels of agreement with the helpfulness of medications were present for severe anxiety and depression along with psychosis. The illness categories with the most disagreement of the helpfulness of psychotropic medications were mild to moderate depression and mild to moderate anxiety, where a total of 13.2% of respondents either disagreed

or strongly disagreed with the helpfulness of psychotropic medications for each of these two categories.

Responses from qualitative questions may provide insight into the reasons why some respondents disagree or strongly disagree with the helpfulness of psychotropic medications for clients who struggle with less severe forms of depression and anxiety. Over half of the respondents mentioned that the side effects of psychotropic medications are frequently an issue in psychotherapy. Issues with dosage changes and needing multiple medication trials were also issues brought up by clients of some of the respondents. Because of this, side effects and other neurological/physiological issues affecting clients may have a negative influence on how social workers perceive the overall helpfulness of medications.

Other issues from working with clients and psychotropics. Respondents in the open-response sections of the survey mentioned some other issues that they frequently deal with in psychotherapy with clients who are considering or already taking psychotropic medications. First, was that clients' perspectives regarding psychotropic medication were influenced by many different factors in addition to information from mental health providers and actual neurological/physiological effects. "Stigma" was frequently mentioned by respondents (25%), which pertains to the negative cultural stigma around having a mental illness and/or having to take medication for it.

In addition to working with clients on the role of stigma, respondents also spoke about the difficulty of maintaining appropriate professional boundaries while still being able to help clients (16.1%), the importance of providing psychoeducation (10.7%) and helping clients to advocate for themselves (12.5%) regarding psychotropic medication issues. These findings emphasize the need for clinical social worker psychotherapists to have a solid foundation of

knowledge and ability to navigate difficult practice issues regarding the topic of psychotropic medications. They need to be able to provide their clients with basic information about medications since many clients might not have the ability to speak with a prescribing provider when needed. Social workers also need to be comfortable with knowing when a client's needs are out of the scope of social work practice, and should be met with the help of a licensed prescribing provider. Without this foundation, clients will be at risk of abandonment and/or harmful interventions. Currently, social workers can obtain information on psychotropic medication facts and issues from school, trainings, research and colleagues trained in psychopharmacology. In order to provide their clients with the best treatment possible, it is imperative that they actively seek out this information throughout their careers.

Study Limitations

Major limitations of this study include the sample frame and size, the survey tool was a new and unproven instrument, and the survey only focused on the perspectives of social workers. Since the study's sample frame was created using snowball sampling and the frame of MBHP and Psychology Today providers, it is not representative of the larger population. Self-selection bias is also a likely to have affected the results because social workers had the choice to accept or decline participation in the study. What this means is that group of social workers that declined may have responded differently to the survey, which would have created a different set of results. The sample size is also relatively small, also decreasing the likelihood that the results could represent the general population. Even though the survey tool was based somewhat on prior studies, it was still a new and unproven instrument that has not been rigorously tested to eliminate researcher bias. A strong social work perspective also limited the perspectives that respondents shared. Although it was by design, this study did not give prescribing practitioners

and clients a chance to share their own perspectives firsthand. Given the opportunity, it would be worth investigating this in the future.

Implications for Social Work Practice

One of the more disturbing findings from this study is that when treating clients with serious mental illness, social workers communicate less with prescribing providers as the size of their caseloads increases. What this means is that this particular vulnerable population may be getting lower quality treatment than other groups. This issue emphasizes the need to continue research on how socio-cultural and socio-economic factors may affect the quality of psychotherapeutic and psychopharmacological treatment that clients are receiving. Given the opportunity to continue this research, it will be imperative to look into how many other client caseload demographics, such as age, socio-economic status, race, type of health care coverage, and type of psychotherapeutic treatment being received affect the nature and quality of treatment regarding psychopharmacological issues. When looking at caseload demographics, it will also be necessary to take into account how non-client variables such as payers and local healthcare statutes since these variables may influence provider communication separate from client characteristics. It is the duty of social workers to advocate and provide for vulnerable populations, but it is clear that very little is known about the presence or lack of discriminatory treatment in this subject area.

Based on the results from this study and the previous studies mentioned earlier in this chapter, it is becoming clear that there are significant barriers to communication between private practice social workers and prescribing providers. A majority of the respondents in this study highlighted how inaccessible prescribing providers and scheduling conflicts prevent communication from happening as frequently as it should. Furthermore, conflicts that arise

within professional split-treatment relationships can also prevent clients from getting the best treatment. Gutheil and Simon (2003) suggest that social workers create pre-treatment contracts with prescribing providers that outline each provider's roles and responsibilities in treatment. Such contracts may help to maintain regular communication and prevent disagreements between providers that are detrimental to clients. This is another possible area of research where not much is known about how often social workers engage in such arrangements and how helpful they may be to both providers and clients. It is possible that social workers need more education on how to build effective split-treatment relationships.

It also appears that social workers find certain types of prescribing providers to be more helpful for clients than other types, such as psychiatric nurse practitioners and physicians' assistants. This study did not uncover any significant findings as to why this is, but this issue is extremely important because of how 94.5% of respondents in this study reported that more than 25% of their clients were currently taking psychotropic medications. If these statistics are similar to the population at large, this means that almost all social worker psychotherapists in private practice are engaged in some form of split-treatment relationships with prescribing providers. So, if there are types of prescribing providers that make better split-treatment partners than others, social workers could take this information into account when referring clients from medication consultation. This information also might be useful prescribing providers who do not seem as helpful, so that their schedules could be readjusted or their professional training could be reshaped in order to help them focus on more effective collaborative treatment.

A third area for further research is how social worker's preferred treatment techniques affect how they perceive psychotropic medications and how they carry out practice in terms of talking to clients about medications and communication with prescribing providers. This study

did not find any relationships between treatment techniques and these topics, but this does not mean that these relationships do not exist. There was only one quantitative question in this study that asked participants to list the main treatment techniques that they used. An issue with this is that respondents interpreted the meaning of this question in different ways, and were not given the specific opportunity to explain how their treatment techniques inform their practice regarding psychopharmacological issues. In the future, it might be fruitful to have an open-ended question that asks them to discuss this subject. This may develop a better understanding of how psychotherapeutic treatment techniques interface with psychopharmacological treatments.

Based on the information gathered from this study along with previous related research, most social workers view psychotropic medications as an important tool in the treatment of mental illness. But, it also appears that more work needs to be done to strengthen the working relationships between social workers and psychotropic medication providers in order to provide all mental health clients and consumers with the best care. It is the responsibility of the social work profession to continue to push for research progress that bridges the gap between social work and the practice of psychopharmacology.

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APPENDIX A:

Smith HSR Approval Letter



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

February 20, 2012

Rosy Metcalfe

Dear Rosy,

You did a very nice job on the revisions. You are approved and ready to go. Thank you very much.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your research and I look forward to seeing your results.

Sincerely,

A handwritten signature in black ink, appearing to read 'David L. Burton', with a horizontal line underneath.

David L. Burton, M.S.W., Ph.D.
Chair, Human Subjects Review Committee

CC: Jennifer Perloff, Research Advisor

APPENDIX B:

Informed Consent for Paper Survey

Dear Participant,

My name is Rosy Metcalfe and I am a graduate student at Smith College School for Social Work. I am conducting a research project to learn more about social workers perspectives on psychotropic medications and some of the issues that they encounter regarding this topic in private psychotherapy practice. This study will be presented as a thesis and may be used in publications on this topic.

You are being asked to participate in this study if you are able to speak English and are currently a Licensed Independent Clinical Social Worker who provides psychotherapy in part-time or full time private practice to clients over the age of 18. If you choose to participate, I will ask you to fill out a confidential survey. The survey will include some general questions about you and your caseload as well as questions asking you to describe your perceptions, beliefs, and experiences regarding psychotropic medications and the prescribing providers of your clients' psychotropic medications, such as psychiatrists and nurse practitioners. I estimate that the amount of time you will need to complete this survey will be 20-30 minutes.

Participation in this study may bring up feelings regarding your experiences with psychotropic medications as a social worker and your experiences with prescribing providers. Although there will be no financial benefit to you for your participation, my hope is that the knowledge and experiences that you share will be beneficial to the mental health professions and the clients that we serve. You may also benefit from having the opportunity to share your experiences and perspectives, knowing that others will hear about them.

Your confidentiality will be protected in compliance with Federal guidelines. Informed consent forms will be removed from surveys and kept in a separate location. Please do not any identifying information in the paper-based survey.

My Smith thesis research advisor and the Smith data analyst will have access to de-identified data from the surveys. In publications or presentations, data will be presented as a whole. Any quotations or case illustrations will

be carefully disguised to protect the identity of participants. All data from the surveys will be kept in a secure location for a period of three years as per Federal requirements. All data stored electronically will be protected. Should I need these materials beyond the three-year period, they will remain secured and will be destroyed once I no longer need them. Since this study asks you to discuss your practice as a social worker, I caution you to not identify any of your clients.

Participation in this study is voluntary. You may withdraw from this study at any time during the process of completing the survey and you have the right to refuse any question. If you have any questions about your rights or any aspects of this study, do not hesitate to contact me at **(personal information deleted by Laura H. Wyman, 11/30/12)** or the Chair of the Smith College School for Social Work Human Rights Subjects Review Committee at (413) 585-7974.

BY SIGNING ON THE LINE BELOW AND WRITING THE DATE, YOU INDICATE THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION; THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS; AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Please note: When you mail me the survey using the enclosed self-addressed stamped envelope, PLEASE INCLUDE this consent form and keep the second copy for your records. PLEASE DO NOT include your return address on the envelope.

Signature _____

D a t e _____

Thank you for participating in this study.

Rosy Metcalfe

APPENDIX C:

Informed Consent for Internet Survey

Dear Participant,

My name is Rosy Metcalfe and I am a graduate student at Smith College School for Social Work. I am conducting a research project to learn more about social workers perspectives on psychotropic medications and some of the issues that they encounter regarding this topic in private psychotherapy practice. This study will be presented as a thesis and may be used in publications on this topic.

You are being asked to participate in this study if you are able to speak English and are currently a Licensed Independent Clinical Social Worker who provides psychotherapy in part-time or full time private practice to clients over the age of 18. If you choose to participate, I will ask you to fill out a anonymous survey. The survey will include some general questions about you and your caseload as well as questions asking you to describe your perceptions, beliefs, and experiences regarding psychotropic medications and the prescribing providers of your clients' psychotropic medications, such as psychiatrists and nurse practitioners. I estimate that the amount of time you will need to complete this survey will be 20-30 minutes.

Participation in this study may bring up feelings regarding your experiences with psychotropic medications as a social worker and your experiences with prescribing providers. Although there will be no financial benefit to you for your participation, my hope is that the knowledge and experiences that you share will be beneficial to the mental health professions and the clients that we serve. You may also benefit from having the opportunity to share your experiences and perspectives, knowing that others will hear about them.

Your confidentiality will be protected in compliance with Federal guidelines. Your IP address will remain anonymous though the use of SurveyMonkey. Please do not include your name or any other identifying information in the internet survey.

My Smith thesis research advisor and the Smith data analyst will have access to de-identified data from the surveys. In publications or presentations, data will be presented as a whole. Any quotations or case illustrations will

be carefully disguised to protect the identity of participants. All data from the surveys will be kept in a secure location for a period of three years as per Federal requirements. All data stored electronically will be protected. Should I need these materials beyond the three-year period, they will remain secured and will be destroyed once I no longer need them. Since this study asks you to discuss your practice as a social worker, I caution you to not identify any of your clients.

Participation in this study is voluntary. You may withdraw from this study at any time during the process of completing the survey and you have the right to refuse any question. You may withdraw from this study by logging off of the internet survey or destroying the paper-based survey. Once you have clicked "submit" on the internet survey or mailed your paper-based survey, I will not be able to remove your survey because I will not be able to identify your survey from the other surveys in my study.

If you have any questions about your rights or any aspects of this study, do not hesitate to contact me at **(personal information deleted by Laura H. Wyman, 11/30/12)** or the Chair of the Smith College School for Social Work Human Rights Subjects Review Committee at (413) 585-7974.

BY CHECKING "YES" THE BOX BELOW, YOU INDICATE THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION; THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS; AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY. PLEASE PRINT A COPY OF THIS PAGE FOR YOUR RECORDS.

I AGREE TO PARTICIPATE

YES

NO

APPENDIX D:

Survey

SURVEY

Thank you for participating in my survey on Social Workers in Private Practice and Psychotropic Medications.

Screening Questions-

- 1) Are you currently a Licensed Independent Clinical Social Worker (LICSW)? [Yes/No]
- 2) Do you perform psychotherapy in private practice? [Yes/No]
- 3) Do you work with individual clients over the age of 18? [Yes/No]

*If you answered “Yes” to all three of these questions, please go on to the informed consent on the next page.

**If you answered “No” to any one of these questions, you are not eligible to participate in this study. Thank you for your time and interest.

Note: When answering the questions on this survey, these questions are specific to your work with private practice clients only. Do not answer these questions in terms of work that you may do with clients in other contexts.

General Information-

1) What is your age? -

2) Sex-

Male

Female

Other (Please specify):

3) Race-

Alaska Native

American Indian

Asian

Black or African American

Hispanic or Latino

Multiracial

Native Hawaiian or other Pacific Islander

White

Other (please specify):

4) Years Practicing Psychotherapy, please specify:

5) Treatment Techniques you use (select all that apply)

Coaching

Cognitive Behavioral (CBT)

Dialectical behavior Therapy

EMDR

Eclectic

Humanistic

Mindfulness Based Cognitive Therapy (MBCT)

Psychoanalytic

Psychodynamic

Other (please specify)

6) Setting of practice

Rural

Suburban

Urban

7) Total Caseload of Individual Therapy Clients in your private practice

8) Primary Issues of Focus with Adult Clients (select up to three starting with the most common issue in your practice)

Addiction/Substance Abuse

Aging

Anxiety

Depression

Disability

Grieving

Personality Disorders

Psychosis

Relationships

Sexual/Gender Identity

Spirituality

Trauma

Other (please Specify)

9) Percent of your adult individual caseload who are currently taking psychotropic medications

Less than 25%

26-50%

51-75%

75-100%

Section A: Working with Providers of Psychotropic Medications

1) Types of prescribing practitioners who your clients use for their psychotropic medications. Specify how many of each type of clinician you communicate with and frequently you had contact with each type of practitioner in the last six months.

Psychiatrists ___

More than once a week

Once a week

Once a month

Less than once a month

Not at all

Primary Care Doctors__

More than once a week

Once a week

Once a month

Less than once a month

Not at all

Psychiatric Nurse Practitioners and Psychiatric Physician's Assistants__

More than once a week

Once a week

Once a month

Less than once a month

Not at all

Primary Care Nurses and Physician's Assistants__

More than once a week

Once a week

Once a month

Less than once a month

Not at all

2) With clients that are currently taking psychotropic medications for mild to moderate forms of mental illness, how frequently do you communicate with these clients' prescribing practitioner on average? (Examples include Mild to moderate anxiety and/or depression, adjustment disorders, etc.)

More than once a week

Once a week

Once a month

Once every three months

Once a year

Less than once a year

3) With clients that are currently taking psychotropic medications for more serious forms of mental illness, how frequently do you communicate with these clients' prescribing providers? (Examples include Bipolar Affective Disorder, Psychosis, Major Depression, etc.)

More than once a week

Once a week

Once a month

Once every three months

Once a year

Less than once a year

4) Regarding the issue of psychotropic medications, I find psychotropic medication providers to be helpful and supportive to my clients.

A) Psychiatrists

Strongly Agree, Agree, Disagree, Strongly Disagree, Not Sure

B) Primary Care Doctors

Strongly Agree, Agree, Disagree, Strongly Disagree, Not Sure

C) Psychiatric Nurse Practitioners and Psychiatric Physician's Assistants

Strongly Agree, Agree, Disagree, Strongly Disagree, Not Sure

D) Primary Care Nurses and Physician's Assistants

Strongly Agree, Agree, Disagree, Strongly Disagree, Not Sure

5) Describe the issue that you encounter most frequently when communicating with your clients prescribers of psychotropic medications.

6) Is there anything you would like to add?

Section B: Your perspectives on psychotropic medications

1) Psychotropic medications are helpful for my clients who struggle with...

A) Mild to Moderate Anxiety

Strongly Agree, Agree, Disagree, Strongly Disagree, Not Sure

B) Severe Anxiety

Strongly Agree, Agree, Disagree, Strongly Disagree, Not Sure

C) Mild to Moderate Depression

Strongly Agree, Agree, Disagree, Strongly Disagree, Not Sure

D) Severe Depression

Strongly Agree, Agree, Disagree, Strongly Disagree, Not Sure

E) Mood Instability

Strongly Agree, Agree, Disagree, Strongly Disagree, Not Sure

F) Psychotic Symptoms

Strongly Agree, Agree, Disagree, Strongly Disagree, Not Sure

2) What issue do your clients struggle with most with regarding psychotropic medications? Please describe.

3) What dilemma do you face the most when discussing psychotropic medications with your clients? Please describe.

4) Is there anything you would like to add?

APPENDIX E:

Recruitment Mailing

Dear _____ ,

I am writing to ask for your participation in my study on how social workers in private practice view the role of psychotropic medications in treatment and handle psychopharmacological issues in practice. In my study, I am hoping to collect information from a diverse sample of Licensed Independent Clinical Social Workers in either part-time or full-time private practice to gather a better understanding of how social workers in private practice perceive psychotropic medications, how they handle issues regarding medication with their clients and how they communicate with prescribing practitioners. Participants must be able to speak English, be currently licensed independent clinical social workers and be providing psychotherapy in private practice to adult clients.

For the study, participants will be asked to fill out a confidential survey. If you are interested, you can access the survey anonymously at <https://www.surveymonkey.com/s/6X8MY6K> if you have an internet connection or you can call me at **(personal information deleted by Laura H. Wyman, 11/30/12)** for a printed version which I will mail to with a self-addressed/stamped envelope. If you call me for the printed version, you will not have to give their name, only your mailing address. In addition, please forward this email or my phone number along to any of your own contacts who might be interested in participating in the study or aiding me in the recruitment process. Thank you very much for your support. If you are interested in hearing about my findings when I have completed my study, please contact me. Also, if you have any questions, do not hesitate to get in touch with me.

Sincerely,

Rosy Lea Metcalfe

APPENDIX F:

Recruitment Telephone Greeting

My name is Rosy Metcalfe. I am currently a master's degree student at Smith College School for Social Work. I am contacting to ask for your participation in my study on how social workers in private practice view the role of psychotropic medications in treatment and handle psychopharmacological issues in practice. In my study, I am hoping to collect information from a diverse sample of Licensed Independent Clinical Social Workers in part-time or full-time private practice to gather a better understanding of how you perceive psychotropic medications, how you handle issues regarding medication with their clients and how you communicate with prescribing practitioners. Participants must be currently licensed independent clinical social workers and be providing psychotherapy in private practice to adult clients. For the study, you will be asked to fill out a confidential survey. If you are interested, I can email you the link to my survey website, or I you prefer I not to be emailed, the address for my anonymous survey is <https://www.surveymonkey.com/s/6X8MY6K>.

I can also mail you a printed version, which I will mail to with a self-addressed/stamped envelope. If you call me for the printed version, you will not have to give their name, only your mailing address. In addition, please forward this survey website or my phone number along to any of your own contacts who might be interested in participating in the study or aiding me in the recruitment process.

Thank you very much for your support. If you are interested in hearing about my findings when I have completed my study, please contact me. Also, if you have any questions, do not hesitate to get in touch with me. Thank for your time.