SPECIAL ARTICLE

PSYCHOLOGISTS' RIGHT TO PRESCRIBE — SHOULD PRESCRIBING PRIVILEGES BE GRANTED TO SOUTH AFRICAN PSYCHOLOGISTS?

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Current changes in legislation regarding prescription rights increase the possibility of non-medical practitioners being authorised to prescribe medication. There has been ongoing debate about granting psychologists in South Africa a limited right to prescribe (RTP) psychotropic medication. The main reasons advanced for granting psychologists RTP include the advantage of delivering integrated treatments, with psychologists well placed to offer such treatment, and the shortage of mental health practitioners in South Africa. If psychologists were granted the RTP they would have to undergo extensive training in psychopharmacology. Curricula for such training are currently being prepared with the help of the American Psychological Association. But there is also considerable opposition to psychologists being granted the RTP, both from within psychology and from other quarters. Opposition from outside psychology is based largely on safety considerations relating to lack of relevant training among psychologists. Opposition from within psychology is based on a concern about the loss of the distinctive contribution of psychology to mental health care in South Africa. Various aspects of this debate are examined in this paper.

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Current changes in legislation will allow the possibility of non-medical practitioners having limited right to prescribe (CRTP) medication in South Africa. Psychologists are among the professionals who have considered applying for this right. The Psychological Society of South Africa (PsySSA) has been investigating this matter for some time, and has now firmly decided to recommend that psychologists be granted the RTP.

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South African psychologists are not isolated in their attempts to gain the RTP. In 1991 the American Psychological Association (APA) appointed a task force on pharmacology and in 1995 endorsed a policy supporting the RTP for psychologists.[1] The APA has demonstrated considerable interest in this issue as it has emerged in South Africa, and has offered ongoing support to PsySSA in this regard. Because of the need to modify legislation in each state of the USA independently, the APA sees the RTP issue as one likely to succeed in South Africa far sooner than in the USA. It also believes that South Africa might set an international precedent in this regard. However in the USA some psychologists have already had limited RTP for some time, e.g. in Veterans Administration hospitals and in the US Indian Health Service.[2] Similar issues regarding psychologists' RTP are also under consideration in the UK, although the matter has received considerably less attention there.[3]

As might be expected, this matter has caused considerable controversy both within the psychology profession and elsewhere. In brief, there seem to be three core arguments in favour of granting psychologists the RTP. First, integrated, multidimensional treatment of mental and behavioural conditions is desirable. Given that psychology is a discipline grounded in biological, cognitive and social sciences, psychologists are well placed to offer such integrated treatment. Second, granting psychologists the RTP will help to alleviate the acute shortage of competent mental health practitioners in this country. However, there is also considerable opposition from various sectors to psychologists being granted the RTP. This paper examines some of these arguments and the issues informing this debate from various perspectives.

At the outset it needs to be said that all those advocating the RTP for psychologists, both in South Africa and internationally, acknowledge three important issues. First, prescription of medication would be an additional form of intervention undertaken by some, but certainly not all, psychologists. Second, in order to be granted RTP, psychologists would need to undergo thorough training in psychopharmacology. Third, psychologists would only be granted limited RTP. All of these issues are addressed in this paper.

INTEGRATIVE VIEW OF TREATMENT OF MENTAL HEALTH CONDITIONS

There was a time when debate raged over the biological versus psychological aetiology of psychiatric conditions such as depression, with attempts at single-variable explanations and corresponding single-modality treatments. It is now widely accepted that most behavioural and psychiatric disorders have a multidimensional aetiology; and medication in combination with psychosocial intervention is probably the best intervention for most psychiatric and/or behavioural conditions.[4,5] This is consistent with an emerging

biopsychosocial approach to mental health care;[6] for example several studies have demonstrated the enhanced efficacy of combined antidepressants and cognitive therapy in treating depression.[4]

There has been a growing amount of research on the neurobiology of behavioural and psychiatric disorders since the 1950s, with extensive developments in the field of neuropsychopharmacology.[5] From the start psychologists have played a very active role as researchers in the field of neuropsychopharmacology, in addition to their dedicated psychological and behavioural interests. As developments in neurobiology and neuropsychopharmacology have progressed, it has become apparent that psychologists must train their students and practitioners to understand the role, efficacy and consequences of neuropharmacological products and treatments, and to be aware of their facilitating or retarding effect on other forms of treatment.

Given the evidence for the efficacy of such combined treatments and the emergence of a biopsychosocial approach, the value of multidisciplinary teams of psychologists, psychiatrists, and other medical and non-medical disciplines has been stressed.[6] But campaigns and debates over the RTP for psychologists and other non-medical health care providers have led to a reconsideration of certain views on multidisciplinary teams, and to the feasibility of each profession having separate functions.

ADVANTAGES OF PSYCHOLOGISTS GAINING RTP

Attempts by psychologists in various countries to gain the RTP are generally driven by two primary motivations, namely the interests of patients, and the interests of the profession.

Interests of patients

Given the known therapeutic value of combined pharmacological and psychological treatments, it has been suggested[3] that combined treatment be managed by a single professional, as this enables closer monitoring of different aspects of treatment, and greater consistency. It has also been suggested that this is likely to facilitate adherence to the treatment regimen, as the patient is less likely to be caught between two people with possibly conflicting views. On a practical level it is more convenient and cost-effective for the patient to see one professional rather than two or more. This applies even more strongly in the context of primary health care, where treatment should be available at a single site and on one visit. Psychologists having the RTP would, at least in some instances, obviate the need to refer to a medical practitioner, to the patient's advantage.

Psychiatrists, however, might claim that they are as well placed as psychologists to offer integrated treatment. But just as psychologists receive limited training in pharmacology, so most psychiatrists receive limited formal training in psychotherapy or psychological procedures. To offer a truly integrated treatment most psychiatrists would need to undergo further training in psychological and behavioural interventions. In addition the acute shortage of psychiatrists in South Africa also presents a major problem. As there are considerably more registered psychologists in the country, they could make a substantial contribution to the solution of the problem if they were granted the RTP.

In opposition to the argument favouring single-practitioner delivery of treatment, is the argument that separate but parallel treatment of patients by psychologists and medical practitioners/psychiatrists has considerable advantages that would be lost if treatment were to be offered by a single practitioner. These advantages include the development of good, complementary (rather than competitive) interdisciplinary relationships between psychologists and medical practitioners, the development of highly specialised and effective multidisciplinary teams, especially in hospitals, and an opportunity for ongoing education of medical practitioners in psychological issues, and vice versa. If psychologists are granted RTP this may well cost some or all of these advantages, to the long-term disadvantage of both patients and the professions. On a more technical level, some psychotherapists (psychologists or psychiatrists) might argue for the distinct therapeutic advantage of a clear separation between these roles. For example, psychotherapists practising analytic-type therapies may see prescription of medication by themselves as potentially complicating the psychotherapeutic intervention.

It might be argued that being granted the RTP would enable psychologists to deal with some of the less complex cases where medication would be of benefit, freeing psychiatrists to concentrate on those cases requiring more specialised knowledge of psychotropic medications. In this way psychologists would acknowledge the important and specialised role of psychiatrists in the treatment of psychiatric conditions.

Another benefit to patients of psychologists obtaining the RTP, especially in the treatment of behavioural conditions requiring pharmacological treatment (e.g. hyperactivity), is that there might be a distinct advantage to the patient of being monitored by psychologists with expertise in cognitive and behavioural assessment. In addition, certain medications (such as anticonvulsants) may have adverse effects on cognitive functioning, so that systematic assessment of cognitive effects may do a great deal to enhance pharmacological treatment, for example of epilepsy.

Psychologists also play a less direct but central role in the development of many psychotropic medications, namely through the development and implementation of psychometric instruments to evaluate the effectiveness of these medications. RTP psychotropic medicines would give psychologists even more reason to contribute to their development.

INTERESTS OF THE PSYCHOLOGY PROFESSION

Psychologists have also argued that being granted the RTP is consistent with the progressive emergence of psychology as a fully independent profession.[2] In most countries psychologists have developed from being assistants in psychiatric teams in mental hospitals to being fully independent professionals receiving referrals from a variety of sources and offering a broad range of services. Being awarded the RTP would be an important step in legitimising the profession and promoting further professional autonomy.[7]

It is interesting to remember that the psychiatric profession attempted to impede the evolution of professional psychology and psychological practice in other countries.[8] From the 1950s through to the 1970s American psychiatrists argued against psychologists being allowed to perform outpatient psychotherapy without medical referral and supervision; they also opposed psychologists gaining access to specialised psychoanalytic training and their efforts to treat patients in hospitals.[8] Despite this opposition, psychologists now operate as independent psychotherapy practitioners as well as in hospital contexts. It is interesting that in one legal case the federal court for the Southern District of New York referred to 'more than a hint of commercial motive' behind the opposition of the psychiatric profession to developments in psychology.[9] Some might suggest that similar motives inform the opposition to psychologists obtaining the RTP from psychiatrists and other branches of medicine.

It has also been argued by psychologists in other countries that they are already implicitly involved in the prescription of medication, and that the RTP would be a legitimation of this activity. In the USA 45% of psychologists report frequently being consulted by physicians regarding prescription of medication.[1] A similar pattern is reported in the UK.[2] While acknowledging that such practices have not yet been legalised, their widespread occurrence suggests that the competence of psychologists in this area should be recognised. RTP would both legitimate this practice and provide the training for psychologists to perform this activity more competently.

OPPOSITION TO PSYCHOLOGISTS BEING GRANTED RTP

From other professions

There is considerable opposition from other professions to psychologists obtaining RTP psychotropic medication. Most of this opposition comes from the medical profession, in particular psychiatrists. While trade union issues, especially economic issues, are probably an important part of the motivation for this opposition, there are clearly other grounds for opposition that need to be seriously addressed. There are principally two arguments for opposing the granting of RTP to psychologists. First is protection of the physical safety of patients. Second is the argument that other professions, nurses in particular, would be better placed to prescribe medication, given the acute shortage of medical professionals.

First the issue of physical safety. The strongest argument used to oppose psychologists being granted the RTP is based on concern for the physical safety of patients. It is argued that the only appropriate training for prescribing medication is medical training. Points made include the following: psychologists are not competent in differential diagnosis of physical disorders (e.g. neurological, endocrinological) and psychiatric disorders; the hazards of dangerous or life-threatening side-effects of certain drugs are beyond the competence of psychologists to assess, monitor or treat; and the possible pre-existence of physical conditions for which certain psychotropic medications are contraindicated.[2] All of these considerations, it is argued, provide evidence that psychologists are not in a position to guarantee the physical safety of patients, and should therefore not be granted the RTP.

Advocates for psychologists being granted the RTP have responded to these important safety concerns. First, psychologists acknowledge that these are very important considerations when applying for prescribing privileges, and that they cannot be overlooked or underestimated. If prescribing privileges are granted to psychologists, this needs to be done in a way that will guarantee the physical safety and well-being of patients. However, important as safety is in the prescription of psychotropic medications, the danger exists that safety issues may be exploited as a means of withholding RTP from psychologists for other reasons, for example, trade union reasons. Therefore, rather than use such safety considerations as an absolute rationale to preclude psychologists from obtaining the RTP, these considerations should be translated into thorough training programmes and protective guidelines as part of granting psychologists the RTP. Issues of training are addressed in a separate section of this paper.

Second, psychologists generally accept that in the interests of the physical safety of patients it would only be appropriate for psychologists to be granted limited RTP. This issue is considered in more detail below.

Third, research suggests that there is no evidence of special medical difficulties having arisen in areas where non-physicians (including psychologists) have been granted limited prescribing rights.[2] Studies[8] of non-physician health care professionals who have had limited RTP in the USA conclude that these health care practitioners (including psychologists) can be cost-effectively trained to safely prescribe medications. Furthermore these studies show very high levels of consumer satisfaction with non-physician prescribing.

Opposition to psychologists being granted the RTP may also come from those who see this as unnecessary in South Africa. While the acute shortage of mental health practitioners in South Africa is acknowledged, such critics may propose that professionals other than psychologists should have the RTP

psychotropic medications. The most obvious group is psychiatric nurses, who have training in a broad range of mental health disciplines, including some training and competence in psychopharmacology.[9] Psychologists seeking the RTP will probably have to recognise the value of limited prescribing rights for professional psychiatric nurses (presumably after further training in psychopharmacology). This is especially the case given that nurses form the backbone of the primary health care system. However, nurses and other health care providers such as pharmacists have no formal psychological training, and therefore can hardly claim to be in a position to offer the kind of integrated treatment that might be offered by psychologists with prescribing privileges.

One other point needs to be made. The most acute shortage of mental health workers is probably in rural areas and among poorer people, i.e. not in the sectors most commonly served by psychologists. Statistics regarding the distribution of psychologists in South Africa suggest that most psychologists tend to work in areas that are well served by GPs/specialists who can prescribe medication. Strictly speaking, therefore, the community is not likely to benefit greatly by psychologists being granted the RTP. However, if psychologists were granted the RTP it is likely that they would be more inclined to practise in rural areas, given the greater range of services they could offer.

Finally, alongside considerations for the physical safety of patients, the issue of competence must also be addressed. This section cannot end without reference to a rather strange anomaly. The law, as it stands, allows all registered medical practitioners to prescribe all medications, including psychotropic agents. As such it is possible for medical professionals with very limited training or experience in matters of the human psyche to prescribe medications that will substantially alter these domains of human functioning. Surely the ideal must be for all practitioners to work within the bounds of their competence.[10]

From within psychology

Just as there is strong opposition to RTP for psychologists from outside the profession, so there is also opposition from inside professional psychology. The following are some of the points of opposition.

Various reservations are raised by psychologists regarding the RTP, but the most important reservations focus on the potential loss of the unique contribution of psychology to mental health care. While recognising the bio-psychosocial nature of most psychological experience and the multidimensional aetiology of psychological/psychiatric disorders, psychologists have a distinctive and important contribution to make in terms of psychological understanding and intervention, at the level of both treatment and prevention. Some argue[11,12] that psychology is valuable because of its uniqueness as a discipline and profession that provides a vital balance and complement to a narrow biomedical approach. This perspective has been characterised by a developmental, historical, contextual and functional approach as opposed to a syndromal approach to the understanding of psychological difficulties.[11] The importance of this unique perspective and contribution may be blurred or lost in the mind of the patient, the psychologist, other professionals and the community, if psychologists were to attain RTP.[6] McColskey[13] has stated this view strongly, suggesting that attempts by psychologists to gain the RTP constitute 'the ultimate denial or betrayal of our own scientifically grounded knowledge base and professional competency in favour of an alien, biomedical model, for no logical or conceptually defensible purpose'. While the central role of biological factors in psychological/psychiatric disorders is fully acknowledged, intervention by psychologists on this level is thought to be unnecessary.[11]

Some of the strongest critics from within psychology argue that the claim for RTP is primarily motivated by economic considerations and the desire for improved status.[6,9,12,13] Ironically, this would be accomplished through greater participation in the medical model, which much of psychology has opposed for a considerable period of time. These same critics suggest that it is more in the interests of the discipline of psychology and the community to support RTP for other professions (e.g. psychiatric nurses), while maintaining and developing the unique contribution of psychology to mental health care and enhancement.

Related to the issue of the unique contribution of psychology is the longstanding confusion that exists in certain sectors of the community regarding the difference between psychologists and psychiatrists. Confusion in the mind of the public could be exacerbated by granting RTP to psychologists, with some psychologists having RTP and others not, to the detriment of the professions. There may also be conflicts within the psychology profession if practitioners with RTP regard themselves as more prestigious than non-prescribers.[12] Evidence from American consumer surveys indicates that where the difference between the two professions is clearly understood, psychological services are preferred to psychiatric service because of psychology's non-drug orientation.[11,14] It is the loss of this distinctive behavioural orientation that worries some of the opponents to RTP from within psychology.

There is also concern that the RTP may soon degenerate into the norm of prescribing, for reasons of ease, work pressure or shortage of staff in the public sector. This might undermine the need and the unique opportunity for psychologists to continue to develop socially appropriate, psychologically effective and economical forms of psychological intervention, to the advantage of the community.[12]

Another argument against psychologists being granted RTP involves the issue of professional indemnity. If psychologists are granted RTP, the risk of error and possible prosecution is likely to be substantially increased, necessitating greater

professional insurance for psychologists and further escalating the costs of psychological practice.[12]

In response to these cautionary comments it could be said that while psychology must look to the unique contribution it can make to mental health in South Africa, this should not preclude the possibility of prescribing medication. During the course of its professional development in South Africa and other countries, the profession has frequently had to redefine and/or broaden the nature of its contribution to the community it serves. Many of these steps in professional development have involved increasing autonomy from other professions, especially psychiatry, on whom they were expected to depend. In addition, psychology has been integrally involved in research into biological dimensions of the aetiology and treatment of psychiatric disorders,[5] so that interest in psychopharmacology can hardly be seen to be outside of the definition and scope of psychological practice. With regard to the risk that the RTP may degenerate into the norm of prescribing, it needs to be remembered that psychologists have thorough training in human/social science as well as exposure to biological issues.[15] They will therefore always have a broad range of intervention options. Finally, as indicated by the APA task force on psychopharmacology,[5] it is likely that only a minority of registered psychologists with particular interest in pharmacology will elect to undergo the full training necessary for independent prescribing.

As a psychologist I share the concern to preserve the unique contribution that psychology can make to health care and health enhancement in South Africa, especially to mental health care. Organised psychology will continue to be responsible for examining ways in which the discipline and the profession can contribute to this task through psychological research and practice. In the past the psychology profession has been criticised for being too preoccupied with intrapsychic processes and failing adequately to address the impact of broader sociopolitical factors on the mental health of the community. A broad commitment to mental health must continue whether or not psychologists are granted RTP, as preoccupation with the latter could thrust psychology and mental health care back into an individualistic, narrow biomedical model, which is likely to be of limited value in the current South African situation.

LIMITED PRESCRIBING OPTIONS

Those who have argued for granting psychologists RTP have all recognised that psychologists would only receive limited RTP. Various forms of limitation have been suggested[2,3,15] in this regard. Among the possibilities are the following: (*i*) prescription limited by diagnosis — this would entitle psychologists to prescribe medication for certain types of disorder only; (*ii*) prescription limited by drug type — psychologists would be restricted to prescribing those psychotropic medications less commonly associated with major physical complications; (*iii*) psychologists limited to prescribing under medical supervision — an option put forward in some countries is that medical practitioners could provide parameters of prescription for particular patients, and that psychologists could start, stop or change medications within these parameters; (*iv*) psychologists only permitted to prescribe psychotropic medications for patients with major medical complaints in collaboration with medical practitioners; and (*v*) psychologists required to refer all patients for prior medical examination if there is any evidence or question of a medical condition that might require other medical treatment or that might contraindicate the use of certain psychotropic medications. Various combinations of these approaches would also be possible.

Considering the acute shortage of psychiatrists and other medical mental health workers, the requirement that patients be examined by medical practitioners before psychologists prescribe would be self-defeating, as would the possibility of psychologists prescribing only under medical supervision. However it is acknowledged that medical precautions are essential, and that psychologists granted the RTP would need to be educated regarding these risks. At present, the most widely accepted form of limited prescribing is restriction of the drugs that psychologists are entitled to prescribe.

The APA task force on psychopharmacology[5] suggests that psychologists might potentially prescribe the following medications: anxiolytics, antidepressants, antipsychotics, mood stabilisers, anti-Parkinsonian agents, smoking cessation agents, medications for substance abuse and pain control, and β-blockers for anxiety disorders.

Consideration is currently being given to this matter in South Africa in collaboration with medical consultants and pharmacologists. While the APA's pioneering work is being used as a base and guideline for developments, it seems likely that in this country psychologists will seek a more restricted list of medications that they are entitled to prescribe.

TRAINING

Psychologists in this country as well as in the USA and the UK agree that psychologists who are already qualified will be required to undergo further training in pharmacology in order to be granted the RTP. Two questions in particular have arisen regarding training. First, should training in pharmacology be an integral part of future training in psychology? Second, what form should training in psychopharmacology take, and what should the training offer?

First, there are no doubt pros and cons to including courses in pharmacology in training courses for professional psychology. Some essential instruction in psychopharmacology is probably part of all basic training programmes in clinical, counselling and educational psychology. However this is insufficient to prescribe. PsySSA has recommended that

training in pharmacology with a view to being accredited to prescribe should not be part of the standard training at Master's level. Unless the length of training at Master's level is to be extended (and there are many arguments against this in South Africa), including a full course in psychopharmacology will inevitably mean a reduction in course content in psychology, or a less specialised focus on psychological intervention. For reasons stated above it is important that the specific and unique contribution of psychology to mental health care should not be undermined. It is therefore suggested that any training in psychopharmacology be a separate, postgraduate course. Such courses would probably be examined by an independent college of psychology parallel to the College of Medicine.

Second is the issue of training in psychopharmacology. Psychologists unanimously recognise the need for thorough and extensive training in psychopharmacology, and for supervised practice before being granted the RTP. Various levels of training for psychologists in psychopharmacology have already been established and recognised in different parts of the world. A relatively low level of training would provide background knowledge of psychopharmacology, an intermediate level would make it possible for psychologists to be consulted on prescriptions or to modify prescriptions within certain parameters defined by medical consultants, and comprehensive training would lead to independent, but limited, RTP.[16] A number of university psychology departments in South Africa (e.g. the Department of Medically Applied Psychology at the University of Natal) have already developed curricula for training in psychopharmacology in collaboration with medical departments. There are currently also courses in psychopharmacology for psychologists offered by various departments even though psychologists do not currently have the RTP. The APA has already developed extensive multilevel training programmes in psychopharmacology that are being used as the basis for developing training programmes in South Africa.

The APA task force on psychopharmacology has identified three levels of training.[5] The first level, seen as the minimal level of training for all practising psychologists, would involve basic psychopharmacological education, including biological bases of neuropsychopharmacology and classes of medications used in the treatment of mental disorders. The second level would develop the knowledge base for active collaboration with licensed prescribers to manage medications for the treatment of psychiatric disorders. In the USA there are already some psychologists operating on this level. In addition to more advanced knowledge of neuropsychopharmacology, level two training also involves training in diagnosis, physical assessment, physical function tests, drug interactions, drug side-effects and abuses of medications. Level three would involve training towards independent limited prescribing. The APA envisages that a 'small but important minority of psychologists'[5] would opt for this level of training. Level three training is envisaged by the APA task force as being similar to training in other professions that have independent prescribing rights. In addition to further training in fields covered at levels one and two, level three training would involve physiology and pathophysiology, pharmacology and psychopharmacology, physical and laboratory assessment and clinical pharmacotherapeutics.[8] Also included in the curriculum would be training in developmental psychopharmacology, emergency treatment, substance-abuse treatment and psychopharmacology research. Supervised clinical experience is seen as an important component of level three training. The APA task force envisages a 2-year full-time (300 hours) postgraduate training course plus additional supervised clinical experience for qualification at level three.

The APA has made these curricula, and their technical resources, available to PsySSA for use in South Africa. These programmes are currently being considered, modified and adapted for use in the South African context by a committee of PsySSA.

THE SUBTEXT OF THE PRESCRIBING DEBATE

As already mentioned, a fair number of views in the literature suggest that the debate over psychologists' RTP is not about service to the community or patient well-being and safety, but about power, status and money. It has been suggested that the RTP offers a power base vis-à-vis patients and other professions, and that this is the critical subtext in the debate. Just as psychiatrists and other medical professions have been criticised for refusing to share or relinquish this power, so psychologists' attempts to gain the RTP have been described as 'introduced solely as a desire to help the professional psychologist gain wealth, prestige, personal power etc., rather than a desire to help patients'.[11] It has also been argued[17] that especially in the American context the campaign for psychologists to attain the RTP has been fuelled by the pharmaceutical industry who become the overall winners, to the detriment of patients who might have benefited from a range of other non-biological treatments.

Various cautionary voices[18] have suggested that in the power-based debate over prescribing rights for psychologists the very considerable gains attained for the mental health of the community through inter-disciplinary collaboration could be seriously threatened to the disadvantage of all. We are reminded that especially in the face of managed care, 'mental health professionals must work together to ensure that there will be enough pie for all consumers who need it, rather than pursuing battles over who will have the greatest role in delivery of the crusts that remain'.[18]

CONCLUSION

The issue of psychologists being granted the RTP is in the process of serious consideration in South Africa at present. Arguments for and against the RTP are complex and varied, and are both theoretical and professional. There are also indications that the debate is, at least partially, driven by a latent political (and even economic) agenda. There is support and opposition for psychologists being granted the RTP both from within the profession of psychology and from outside. Wherever psychologists and other health care professions stand on this debate, the importance of this issue cannot be ignored or denied. In the process of rethinking the future health care system and service in South Africa, including mental health care, the issue of who should prescribe medication deserves serious attention, alongside other major considerations regarding health care delivery.

The views expressed in this paper are the views of the author and do not necessarily express the views of PsySSA or organised psychology.

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