

# Comment

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## Saving Our Psychosocial Souls

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Considering the frequency of polypharmacological treatment relative to the evidence for its safety and incremental efficacy, as well as the widespread use of antidepressants with their meager advantage over placebo (e.g., Kirsch, Moore, Scoboria, & Nicholls, 2002), one of the most important contributions psychologists seeking prescriptive authority can make to the practice of pharmacotherapy is the promulgation of a judicious approach to prescribing. It would be naive, though, to assume that prescribing psychologists will not be subjected to the forces that led to the overreliance on medications in other prescribing professions, and it is essential that psychology anticipate and develop strategies for resisting those forces now. Antonuccio, Danton, and McClanahan (December 2003) are to be complimented for raising the issue of what safeguards are needed to avoid the mistakes of the past. It is premature to conclude whether the guidelines they proposed are the most appropriate for meeting the goals they have set, because this judgment will require a dialogue among psychologists, but I hope that their article will instigate reasoned debate.

I would like to respond to two aspects of Antonuccio et al.'s (2003) analysis. First, perhaps inspired by Healy's (1998) work, Antonuccio et al. focused on the pharmaceutical industry as a reason for the excessive use of medication. There can be

no doubt that drug advertising is an important part of the equation, but Luhrmann (2000) and most psychiatrists I know consider managed care the much greater evil. The pressure from managed care companies to reduce session length is considered by many to be the primary reason that the standard of psychiatric care has been reduced to the "15-minute med check."

Given regional differences in the penetration of managed care, prescribing psychologists will vary in the degree to which they experience similar pressure, but the pressure will undoubtedly be felt. Reimbursement policy already has a substantial impact on the character of psychotherapy practice, and although it may be possible to create a firewall between psychology and the drug industry as Antonuccio et al. (2003) proposed, the same cannot be said of the relationship between provider and payer.

One possible response to this risk is an ethical guideline forbidding psychologists to prescribe to individuals for whom they are not providing psychosocial interventions as well. However, a second justification for awarding psychologists prescriptive authority is to provide adequate psychopharmacological care to a larger portion of the population. If prescribing remains an advanced practice specialty in psychology, as many would prefer (e.g., McGrath et al., 2004), providers who do not prescribe will still be referring their patients to colleagues for medication management. Managed care organizations will likely try to use this division of labor as they do now, pushing patients toward less expensive professionals for psychotherapy and putting financial constraints on the amount of time spent with the more expensive prescriber. Though it is important for psychologists to begin the discussion of how to interact with the pharmaceutical industry, it is equally important to begin the discussion of how best to manage the managed care industry.

My second point is that it is important to acknowledge and use those features specific to psychology that should serve as resistance factors against the overreliance

on medication. These include the continuing emphasis on the psychosocial rather than the medical perspective in predoctoral training; the receipt of prescriptive authority after much of the early irrational exuberance over medication as a panacea for mental disorders has dissipated; and the popularity of psychology as an undergraduate major, resulting in a greater proportion of native-born practitioners who are comfortable with the cultural and semantic aspects of psychotherapy.

One other factor that I think will become increasingly important is psychology's traditional academic and scientific roots and the existence of a group of psychologists who have little or no investment in clinical work. This is a unique characteristic among mental health professions. With prescriptive authority, psychologists will likely involve themselves increasingly in studying the act of prescribing as a psychosocial event as well as a medical one. This research will inevitably make important contributions to the development of a psychological model of prescribing. There are a variety of topics likely to interest researchers: questions about identifying who is most likely to benefit from medication, which medications are most likely to help which patients, predicting and enhancing the likelihood of adherence among those most likely to benefit, the relative role of biological and psychosocial factors in etiology, and the optimal combination of psychotherapy and medication. What may prove to be the greatest contribution of research psychologists to prescribing psychology, though, is the objectivity with which they can approach questions of treatment efficacy. The continuing vitality of a community of psychologists who are not clinicians is essential to maintaining this objectivity.

Whether a reasonable person perceives the movement for prescriptive authority with cautious optimism or thoughtful skepticism, it is clear that the challenges and opportunities created by this movement are substantial. Now is the time to discuss these challenges in a deliberate manner, before psychologists lose control

of their fate to others. This discussion must include both advocates and critics of prescriptive authority and must deal both with how to protect psychology from the influence of economic forces and how best to use the strengths of the discipline to the advantage of psychologists.

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## Facilitating Objectivity When Orchestrating the Interaction Between Pharmacotherapy and Psychotherapy

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I read with interest Antonuccio, Danton, and McClanahan's (December 2003) article concerning psychology in the prescription era and their advice for psychologists, as a discipline, to build a firewall between the marketing of drugs and the conduct of our science and practice. I heartily agree; we should take steps now to protect our discipline from the conflicts of interest that currently beset modern medicine germane to mental disorders (many of which Antonuccio et al. discussed in their article). Although not mentioned in the article, the article provides for a cogent argument for psychologists to work toward prescription privileges. Here is how I see it.

With very few exceptions, psychologists currently do not have prescription privileges. Consequently, we are subject to the charge that we have a conflict of interest in promoting therapies that use our unique education (e.g., developed expertise in cognitive-behavioral therapy). Therefore, when and if an article published in a psychology journal presents evidence, for example, that a psychotherapy for mild depression (e.g., cognitive-behavioral therapy) is as good as or better than the prescription of a drug (e.g., an SSRI), we are subject to the charge that we are merely looking out for our professional, financial interests.

The only way we as psychologists can be freed of this charge and, indeed, be freed from the possible basis for that charge, is if we have prescription privileges without financial ties to the companies selling drugs. We need to be objective and, further, to arrange the circumstances in which objectivity is easy to achieve. I contend that the way to preserve our objectivity is for psychologists to have prescription privileges and to conduct research in which the outcomes do not benefit or harm the daily practice of psychology as a whole or the research enterprise. Further, psychologists must adhere to the ideal of practicing what our science—our objective science—prescribes.

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## Intended Consequences

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The National Council of Schools and Programs of Professional Psychology (NCSPP) has intentionally and systematically pursued quality and relevance in professional psychology training for nearly 30 years. Peterson's (October 2003) controversial article, "Unintended Consequences: Ventures and

Misadventures in the Education of Professional Psychologists," and Kenkel, DeLeon, Albino, and Porter's (October 2003) response list some of the intended consequences and accomplishments of NCSPP and its member programs: pioneering and continuing contributions to the development of competency-based training, ongoing work to define and support new roles for psychologists, and holding diversity central in how we train, who we are, and who we train. Peterson's critique of professional schools and programs ends with an impassioned plea for a Flexner-like study of education and training programs. Program evaluations that have the limited focus and the unsupervised power of Flexner's (1910) study would result in many damaging and unintended consequences. Assessment of education and training in professional psychology programs must include examination of their relevance to communities, attention to diversity, and evidence of quality and outcomes.

Relevance is important. Peterson's (2003) continuation of the old and unsupported claim for the superiority of professional programs based in research universities seems particularly ill timed. Schools of Education (professional schools housed primarily in research universities) are actively discussing the crisis of their growing lack of relevance to primary education in the United States. Schools of Psychology are defining new and essential contributions to primary health care, legal and prison systems, and employment settings. Professional psychology programs housed in a great diversity of settings provide the best array of forums to conduct the necessary dialogues with the world regarding the relevance of psychology. Flexner's (1910) attention to a small and circumscribed set of assessment criteria likely contributed to making medical education and training less relevant to populations and their needs (Rosner, 1991; Smedley, Butler, & Bristow, 2004). Modern medical curricula now emphasize building working relationships with both patients and colleagues in order to provide more effective medicine; NCSPP curricula prepare practitioners as local clinical scientists with the core professional competency of relationship as "the foundation and prerequisite of other competencies" (Peterson, Peterson, Abrams, & Stricker, 1997, p. 380).

Diversity is important. NCSPP supports diversity as a major competency in its training model, and its programs have changed the face of psychology through admission practices that recognize the importance of a diverse community of practicing psychologists. Our profession knows too much about the relationship between