

To prescribe or not to prescribe – Is that the question?

A PATIENT is speaking to the doctor, relating several months of sadness, loss of appetite and sleep, irritability and just plain ‘feeling lousy’. After further discussion the doctor concludes the patient is experiencing significant depression and decides upon a course of treatment: psychotherapy and the short-term use of an antidepressant. The doctor takes out a pad, writes a prescription for one of the newer antidepressant medications, and arranges to start psychotherapy with the patient next week while monitoring the response to the medication. A psychiatrist? No, a psychologist in the State of New Mexico. In March 2002 New Mexico became the first state in the United States to permit psychologists, with additional training, to prescribe medication for nervous, emotional and mental problems.

While New Mexico is the first of the 50 states to obtain the legal right to prescribe medications used in mental health practices, it is not alone. Eleven other states will be introducing proposed modifications in their state laws to permit psychologists to prescribe medications. An additional 20 states have groups of psychologists laying the groundwork to introduce such legislative change.

CORE POINTS

- Psychologists can already prescribe medication in some areas of the US, and some non-medical practitioners can already prescribe in the UK.
- Psychologists trained to prescribe medication could meet urgent mental health needs.
- Psychologists can contribute an understanding based on a health model rather than a disease model, focusing on strength before weakness.
- The right to prescribe is also the right to stop inappropriate medications.



ROBERT RESNICK argues that psychologists should be allowed to prescribe medication.

Why do psychologists want to prescribe? The answer is a bit complicated. Physicians have historically been the only professionals permitted to prescribe, but in the last 50 years, in addition to dentists and podiatrists (who can prescribe medications but are not medical doctors) many other healthcare professionals have added this service through changes in state law. Nurses and optometrists are permitted to prescribe medications in all states, physician assistants and pharmacists in many. For psychology it is not a case of ‘me too’ or ‘monkey see, monkey do’. It is about quality care, and it is about accessible care.

To illustrate: I am a specialist in attention deficit disorder, and frequently medication is used as part of the overall treatment plan. Recently, a 10-year-old child was referred to me. Jason had significant problems with inattention and hyperactivity, and was failing in school. His parents had tried everything they could to get him to pay attention in school and complete homework. After the evaluation and a diagnosis of attention deficit hyperactivity disorder, I decided upon a four-part plan: work with Jason to develop better coping mechanisms for his behaviour; help his parents develop different ways of parenting

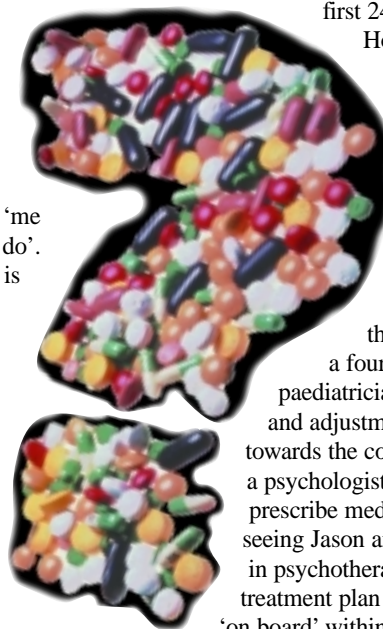
and relating to him; establish school-based strategies aimed at reducing classroom distraction and ensuring that homework and classwork was completed; and the use of a medication known to be effective in reducing the impulsivity and hyperactivity.

The first three parts of the treatment plan were put in place within the first 24 to 48 hours.

However, it took six weeks (with another report card grading period ending) before Jason and his parents were able to get an appointment with their paediatrician who would prescribe the medicine. Then,

a four-week wait to see the paediatrician again for follow-up and adjustment of the medication towards the correct dose. If, as a psychologist, I had the right to prescribe medication, as I was seeing Jason and his parents weekly in psychotherapy, this part of the treatment plan would have been ‘on board’ within 24 hours as well.

Lest the reader believe the paediatrician should have been involved earlier, the referral came from the paediatrician! This is not an uncommon experience among psychologists who see, and are referred, patients who need both psychotherapy and medication management. Frequently these referrals come from physicians who are ill



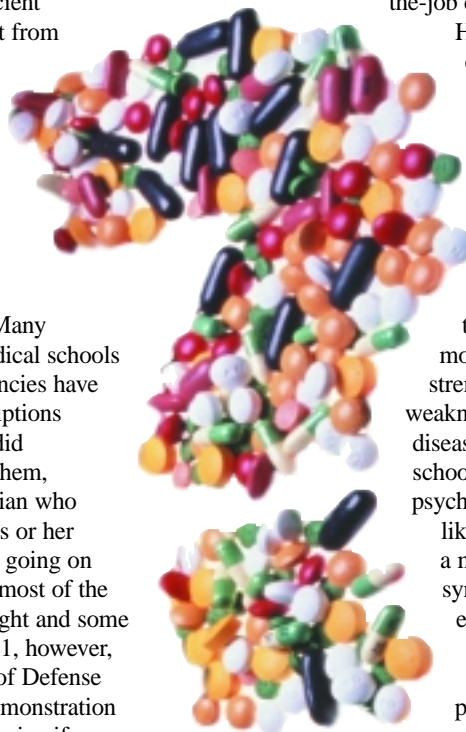
equipped or trained to diagnose and treat psychological and mental issues.

There is clear evidence in the US that there are very grave and urgent unmet mental health needs. These needs could be met by professionals who can provide both psychotherapy and, when needed, medication. For example, there are over 450 counties in the United States with no psychiatrists in residence. An additional concern is that only about a third of the psychiatry training positions (residencies) are filled with American medical school graduates, with the majority of the remaining residency position being filled by physicians whose first language is not English. Language problems make it very difficult to work with minorities, inner-city families, Native Americans and rural communities. To illustrate the concern: A foreign-trained psychiatry resident whose English comprehension was passable but not extensive, admitted a man for 'being crazy', 'because he talks to animals'. After I evaluated him the next morning, he was released with apologies. This was a African-American jazz musician who, when speaking about his band members told the resident 'I says to this cat, and the cat says to me'. Talks to animals! Right!

Also of concern is the fact that 85 per cent of prescriptions used to treat mental problems are written by physicians who have little or no training in psychiatry (Zimmerman & Wienckowski, 1991). The average psychiatric training is less than seven weeks and the average number of instructional hours in psychiatric medications is only 99 in the four years of US medical school training (see www.aamc.org). Thus another component

of the complicated answer would include the ability of families to obtain quality and accessible mental health services in a timely fashion and at the lowest cost. It is much more efficient (in terms of time lost from work or school) and more cost-effective to see one professional rather than two.

Can psychologists be trained to be psychologist prescribers? They already have been! Many psychologists in medical schools and government agencies have either written prescriptions 'under the table' or did everything but sign them, seeking out a physician who would simply add his or her name. This has been going on for decades, though most of the training was self-taught and some by 'osmosis'. In 1991, however, the US Department of Defense began a four-year demonstration programme, to determine if psychologists who were in the military could be trained to prescribe medications. Several years later and thousands of prescriptions written, there has not been one inappropriate use, missed physical diagnosis or complication; nor has there been one untoward outcome. Clearly, psychologists can be trained to provide medication management at a very high level of competence as well as to provide high-quality psychotherapy.



The demonstration project was modified, over time, and evolved into a two-year postdoctoral programme. The first year is didactics, and the second on-the-job clinical experience.

How is this training different from medical school? Prescribing psychologists embrace a more integrative or psychological model of prescribing. Psychological training is a health model focusing on strengths first then weaknesses, rather than the disease model of medical school. As a consequence psychologists are less likely to 'knee-jerk' a medication to treat symptoms. Indeed, the experience of the military psychologists has demonstrated this point over and over again.

We in the psychologist prescription movement acknowledge two truths that are – or should be – self-evident: medications are indeed effective for some patients, and current prescription writing practices are inadequate and dangerous, especially for underserved populations. We also recognise a very important 'treatment' given to prescribing psychologists: the authority to discontinue medications that have been prescribed by other professionals. Particularly with mental problems, there has been a tendency to practise 'polypharmacy' – prescribing more and more medications to treat newly created symptoms. In part, this is due to the problems cited earlier in psychiatric and medical training. A quick example: A depressed patient is given an antidepressant then gets the side-effect of sleep problems. Now a sedative is prescribed, but there are side-effects of morning drowsiness and fatigue. When a stimulant is added to provide 'alertness', extrapyramidal symptoms such as severe dry mouth and lip-smacking develop and an anticholinergic drug is added. So the right to prescribe is also the right to *stop* inappropriate medications. You should note that over 7000 people a year die from legally prescribed medications (Kohn *et al.*, 2000: www.nap.edu/books/0309068371/html).

THE LOGICAL NEXT STEP

The professional practice of psychology began about a hundred years ago. At each step in its evolution internal opposition from psychologists and vehement opposition by medicine have routinely occurred. Psychology's interest in prescription privileges is no exception. When the First World War catapulted American psychology into testing, many psychologists were concerned and opposed. Testing went on to become a staple of psychological practice and training. The end of the Second World War brought an urgent need for psychotherapy for returning military personnel and their families, and training of psychologists as psychotherapists began. Again, training to be psychotherapists was not quickly or unanimously embraced within psychology. As with psychological testing, it took years, but eventually psychotherapy became mainstream psychology. By the late 1960s and early 1970s psychologists had become the pre-eminent and dominant providers of psychotherapy. Psychological practice has continued to evolve from outpatient therapists to hospital-based practice, in nursing homes, residential treatment centres, and so on. Wherever there are mental health services, you will find psychologists. So the evolutionary next step towards prescribing medications is not surprising. Indeed it is the logical next step as we embrace, and no longer deny, the mind/body integration that has been so amply demonstrated by the brain/behaviour research of the last 25 years.

For almost a hundred years American psychology has debated the expansion of its competence and scope of practice. While never achieving unanimity, it has matured as a healthcare profession (see box, previous page) and will continue to do so. Clearly, a larger scope of practice will enable a psychologist to offer comprehensive services, including assessment, consultation, psychotherapy and, yes, when needed, medication. As psychology, like other professions, began the quest for independent prescriptive authority, organised medicine and some psychologists ominously warned of health hazards. In each instance the woeful predictions of wrongly treated patients flocking to hospitals and thousands of deaths never materialised.

Finally, I would argue that the best reason for psychologists having the ability to prescribe medication is not that it is good for psychology, but that it is good for the consumers. Psychologists have not entered this area of practice quickly or impulsively, but did so with deliberation and debate beginning in 1984. As a result, the additional training required for psychologists to prescribe medications has crucial differences from medical school training. Our training model is not disease-based. We include intensive and extensive training in the interaction of psychotherapy and medication, stressing when one is therapeutically superior to the other and when the use of both is in the best interest of the patient. In the final analysis, isn't this what this should be about? Isn't it what is best for the individuals, families and public we serve? It should be.

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References

- Kohn, L.T., Corrigan, J.M. & Donaldson, M.S. (Eds.) (2000). *To err is human: Building a safer health system*. Washington, DC: National Academy Press.
- Zimmerman, M.A. & Wienckowski, L.A. (1991, Winter). Revisiting health and mental health linkages: A policy whose time has come...again. *Journal of Public Health Policy*, 510-524.

WEBLINKS

The APA division of the Association for the Advancement of Pharmacotherapy:
www.apa.org/divisions/div55
 Information on medications as well as herbs, vitamins and supplements:
www.drugdigest.org/DD/Home/AllAboutDrugs

Back to basics



LUCY JOHNSTONE responds with the first peer commentary.

It sounds so obvious, doesn't it? There aren't enough psychiatrists, other professions already have some prescribing rights, a lot of bad prescribing goes on, so wouldn't it be easier and simpler if psychologists could be trained to do their own prescribing alongside their psychological work, all in one package?

I could accept and even welcome these arguments as applied to general medicine. I would be very happy to see nurses, for example, take on more of the prescribing in oncology or any other branch of medicine. But psychiatry is different.

The differences stem from the important fact that, strictly speaking, there is no such thing as a pharmaceutical 'treatment' for any form of mental distress. This follows logically from the fact, seldom openly admitted, that we have not established the hypothesised biological basis of any of the 'mental illnesses'. Resnick may be aware of these quotes from the Surgeon General's report on mental health (US Public Health Service, 1999; the Surgeon General is the US equivalent of our Chief Medical Officer):

...there is no definitive lesion, laboratory test, or abnormality in brain tissue that can identify the illness... (p.44)

The precise causes (etiology) of most mental disorders are not known... (p.49)

All too frequently a biological change in the brain is purported to be the 'cause' of a mental disorder... [This] cannot and does not, by itself, mean causation. (p.51)

Lacking this knowledge, we are unable to design medications that target specific conditions. Speculations about the role of, say, dopamine levels in schizophrenia and drugs as 'correcting' them are without any factual basis whatsoever. What do psychiatric drugs do then? Quite simply, they cut people off from their feelings, either by sedation (e.g. neuroleptics) or

stimulation (e.g. SSRIs). In other words, they make people *feel less*. Some people in extreme distress may experience this as a relief, but it cannot legitimately be described as 'treatment', any more than a sleeping pill for someone whose partner has died is a 'treatment' for bereavement.

Psychiatric medications, then, are not quite what they claim to be, and in general

'psychological and pharmaceutical interventions simply do not mix'

we (much aided and abetted by the pharmaceutical industry) have been guilty of wildly overestimating their benefits while grossly underplaying their drawbacks. Recent reviews have argued that antidepressants are not significantly more effective than placebo (Moncrieff, 2002). At the same time, the history of psychiatry reveals a devastating sequence of unacknowledged damage caused by medication. To take just one example, the true figure for irreversible neurological damage (tardive dyskinesia) caused by neuroleptics probably runs into millions of cases worldwide (Hill, 1992). Worryingly, Resnick seems unaware of the controversies surrounding the prescription of Ritalin for an estimated 1 in 20 American schoolchildren on the basis of the highly dubious diagnosis of ADHD. We

References

- Hammersley, D. (2000). Developing a policy on drugs and alcohol. *Counselling Psychology Review*, 15(3), 18-25.
- Hill, D. (1992). Major tranquillisers: A good buy? *Clinical Psychology Forum*. Issue 49, pp.20-22.
- Moncrieff, J. (2002). The anti-depressant debate. *British Journal of Psychiatry*, 180, 193-194.
- US Public Health Service (1999). *Mental health: The Surgeon General's report*. Retrieved 14 February 2003 from www.surgeongeneral.gov/library/mentalhealth/home.html



Do we want to get all aboard the Ritalin ride?

seem to have to learn these lessons anew with every wonderdrug introduced onto the market – see the unfolding story of Seroxat.

I do not wish my profession to join in the prescription of substances that are of such dubious and limited benefit and carry such frightening possibilities for harm. However, for psychologists, the argument should go further, and this is because psychological and pharmaceutical interventions simply do not mix. The rhetoric, of course, is that you do best with a bit of both – some pills and a few sessions of CBT. A moment's thought will tell us that this has to be nonsense, and for a very good reason: psychological work depends on our clients being able to be in contact with their feelings. This is true both in psychotherapy (e.g. someone coming to terms with the pain of an early rejection) and in CBT (e.g. a client learning to deal with panic attacks). If the clients can't access the feelings, they can't do the work – or only to a limited extent. Psychology and pharmacotherapy 'work' in opposite ways, and to try and combine them is simply to undermine our psychological interventions.

The two approaches also carry contradictory messages. Unless we are very careful, the message that is given by a pill is 'You cannot sort this out yourself – the problem is in your biochemistry and you need to hand responsibility for your treatment over to an external agent'. This is disempowering both for the client and for us as therapists. No wonder our clients often seem so stuck. I believe that medication – in both its numbing effects and the messages it conveys – is a major unrecognised barrier to psychological interventions (Hammersley, 2000).

I can't help noticing that Resnick has put forward some rather strange arguments for the extending of prescription rights. He

points out, correctly, that polypharmacy is common, that thousands of people a year die from legally prescribed medications, and so on. The implication seems to be that psychologists would manage it all so much better. Well I'm sorry, but I don't have that much faith in my profession. Why should we be uniquely capable of avoiding the

over-medicalised approach he describes, resisting the pressures of the pharmaceutical companies and the temptation of the 'quick fix' when faced with desperation and despair? I don't even have that much faith in myself. I value the discipline of having to think of an alternative response to human distress. This is what makes me a psychologist rather than a psychiatrist.

Resnick's final point is that prescribing would be in the best interests of our clients. It's strange, but although over the years service users have told me many, many tragic stories of lives blighted by psychiatric drugs, not one of them has ever told me that we need more prescribers. I am with them on this one. I hope my profession can resist this move.

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Yes, but there is another question



MORGAN T. SAMMONS and RONALD F. LEVANT *question how psychologists will be affected by the pharmaceutical industry.*

WE agree with Resnick that appropriately trained psychologists should be allowed to prescribe medication. In fact, most American psychologists would also agree (Sammons *et al.*, 2000). However, there is an important issue that has emerged recently that Resnick did not address which we would like to discuss in this comment: the enormous influence of the pharmaceutical industry's marketing and promotion arm (Healy, 2002). Wazana (2000) reported that pharmaceutical companies spend more than \$11 billion each year on marketing and promotions, \$5 billion of which goes directly to sales representatives. Furthermore, as Healy noted, one unintended consequence of the

postwar policy that patients must obtain a prescription to purchase medications has been to dramatically reduce the number of people on whom these dollars are spent. Wazana (2000) estimates that the pharmaceutical industry spends \$8000 to \$13,000 a year per physician.

As folk singer-philosopher Bob Dylan so wisely observed, money doesn't talk, it swears. Pharmaceutical marketing money does have a profound impact on prescribing patterns of physicians. Based on an extensive review of 538 studies, 29 of which were included in the analysis, Wazana (2000) found that drug company-sponsored continuing medical education preferentially highlighted the sponsor's drugs, physicians who attended drug

company-sponsored education (including accepting funds for travel or accommodation) increased their prescription of the sponsor's drugs, and meetings with sales representatives of drug companies were associated with changes in prescribing practices, including adding the company's medications to the hospital formulary.

But above and beyond these issues of influencing prescribing patterns, Healy (in press) asserts that the drug companies, with the Food and Drug Administration playing a role analogous to that of Arthur Andersen in the Enron affair, subvert the science of pharmacology. If this allegation is true, it would most certainly call for reform on the broadest scale, addressing not only psychoactive drugs, but rather all drugs. These reforms would have to go beyond the management of conflicts of interests in the conduct of clinical trials (Morin *et al.*, 2002) to their outright regulation.

Healy (in press) goes further to assert that as patents run out and the drug companies shift over to marketing new drugs, they 'change the mindset of the clinician', getting them 'to recognize depression where they had formerly recognized anxiety', in the case of the shift from benzodiazepine anxiolytics to the SSRIs.

This scenario actually has some face validity, since over 80 per cent of psychoactive drugs are prescribed by primary care physicians who have minimal training in the diagnosis and treatment of mental illness (DeLeon & Wiggins, 1996). This does not augur well for their being able to conduct the first prerequisite for prescribing, namely making an accurate diagnosis. And the data suggest that they don't. Primary care physicians have been

CHRIS CHAFFERON

Some of a GP's daily postbag – pharmaceutical marketing money has a profound impact on prescribing patterns

shown to miss the diagnosis of depression in women 30–50 per cent of the time (McGrath *et al.*, 1990). Moreover, the Agency for Health Care Policy and Research noted that 'depression is underdiagnosed and undertreated, especially by primary care and other nonpsychiatric practitioners, who are, paradoxically, the providers most likely to see these patients initially' (AHCPR, 1993, p.v).

On the other hand, clinical psychologists obtain more training in the identification of mental disorders and illnesses than any other healthcare practitioner, including psychiatrists. It has been our strong and oft-stated conviction that fundamental differences in the training of psychologists and physicians will ineluctably alter the prescribing practices of psychologists. Psychologists' training is rooted in behaviourism and cognitive processes and not in the biologic/allopathic roots of medicine. This will, we believe, provide the profession with a unique understanding of the limits of pharmacotherapy and will provide partial insulation against the marketing efforts of pharmaceutical firms.

The major argument for psychologists prescribing is that it would improve public health (DeLeon *et al.*, 1995). Equally powerful is the continuity of care argument and the fact that outcome research has demonstrated that the most effective treatment for many mental health disorders is a combination of psychotherapy and medication (Sammons & Levant, 1999). Allowing appropriately trained psychologists to prescribe medication will result in increased continuity, integration and quality of patient care. Patients who are treated by prescribing psychologists will need to see only one doctor for all of their mental health treatment and will be spared the expense, burden and inefficiencies of seeing a psychiatrist or primary care physician solely for the purpose of receiving medication.

There is also the argument of precedent. Many health professionals other than medical doctors currently prescribe safely (e.g. osteopaths, podiatrists, dentists, advanced nurse practitioners, optometrists, physician assistants), and their services are highly beneficial to the public. Fortunately, the only thing as constant as organised medicine's warnings about impending disaster if one profession or another is granted prescription privileges, is the consistency with which state legislatures have batted away these arguments.

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References

Agency for Health Care Policy and Research (1993). *Depression in primary care: Volume 2. Treatment of major depression*. Clinical Practice Guideline: Number 5. (AHCPR Pub. No. 93-0551). Washington, DC: US Government Printing Office.

DeLeon, P.H., Sammons, M.T. & Sexton, J.L. (1995). Focusing on society's real needs: Responsibility and prescription privileges? *American Psychologist*, 50, 1022–1032.

DeLeon, P.H. & Wiggins, J. (1996). Prescription privileges for psychologists. *American Psychologist*, 51, 225–229.

Healy, D. (2002). *The creation of psychopharmacology*. Cambridge, MA: Harvard University Press.

Healy, D. (in press). Psychopharmacology 102 (...what they neglected to mention in Psychopharmacology 101). *The Clinical Psychologist*.

McGrath, E., Keita, G.P., Strickland, B.R. & Russo, N. (Eds.) (1990). *Women and depression: Risk factors and treatment issues. Final report of the APA National Task Force on Women and Depression*. Washington, DC: American Psychological Association.

Morin, K., Rakatansky, H., Riddick, F.A., Morse, L.J., O'Bannon, J.M., Goldrich, M.S. *et al.* (2002). Managing conflicts of interest in the conduct of clinical trials. *Journal of the American Medical Association*, 287, 20–26.

Sammons, M.T., Gornoy, S., Allen, R. & Zinner, E. (2000). Prescriptive authority for psychologists: A consensus of support. *Professional Psychology: Research and Practice*, 31(6), 604–609.

Sammons, M.T. & Levant, R. (1999). Combined psychosocial and pharmacological treatments: Introduction. *Journal of Clinical Psychology in Medical Settings*, 6, 1–10.

Wazana, A. (2000). Physicians and the pharmaceutical industry: Is a gift ever just a gift? *Journal of the American Medical Association*, 283, 373–380.

Don't go there

ONE must always be suspicious when a topic known to be controversial is addressed as if there could only be one conclusion. In his article Robert Resnick accepts a number of assumptions about the theory and practice of psychology as if they were unproblematic. He touches on, but does not debate, matters that are highly contentious. From the off he declares himself as a specialist in attention deficit disorder as if there was no controversy about the appropriateness of so labelling children's behaviour or, more generally, no question that it is the role of the psychologist to accept and work within a diagnostic framework. The example of good practice that he gives would combine psychotherapy and medication. The supposed advantages are logistical: greater accessibility of treatment for people who might benefit from both psychological and medical treatments, better coordination, even more competent and discriminating prescribing. But the implied mission of psychology and the preferred model of practice are taken for granted and are not addressed.

Psychotherapy has been widely criticised (e.g. by Smail, 1993, and by Prilleltensky, 1994) for its tendency towards reductionism, its failure to acknowledge the wider contextual influences on our health and well-being. Behavioural and systems theories, for all their promise to address such influences, in practice settled down to focus on the individual and, at most, the



JIM ORFORD believes most British psychologists do not want prescription rights.

family. Great strides have been taken in developing forms of psychotherapy such as cognitive behaviour therapy and motivational enhancement therapy that have some effectiveness and that, unlike some of the specialist forms of psychotherapy that preceded them, can be made widely available for a wide range of problems. The demand for such treatments is great, and clinical psychology has developed in the direction of satisfying that demand. But psychotherapy, whatever its form, remains a set of techniques for trying to help people change in order to fit their circumstances; and before psychology becomes irreparably committed to that mission, the debate should be kept alive about whether psychology, as an academic discipline and a body of practice, should do more to try to change people's circumstances to fit people. What Robert Resnick urges us to do is to move in precisely the opposite direction.

In her model of psychotherapy and social action, Holland (1988), using the example of the west London estate where she was working, showed how a psychology that was sensitive to people's psyches and their environments might move

from prescribing (the predominant form of intervention prior to her involvement), via individual psychotherapy, to group interaction, to the taking of social action to counter toxic social influences in the neighbourhood. The movement was away from prescribing not towards it.

In places Robert Resnick's article appears transparent in its recommendation that psychologists should become more medical. He refers to the people he helps as 'patients', without comment. He refers to a shortage of psychiatrists, and seems to see no irony in the suggestion that psychologists should take their place. He wants to take us somewhere I believe most British psychologists do not want to go. There are other ideological locations where psychology might do more good. Some of us are disturbed that clinical psychology has already moved quite far in the direction of acquiescing in an individualistic, diagnostic model of human distress and difficulty – prescribing will only escalate that trend. At the very least it would encourage the split that already exists in the discipline, with clinical psychologists looking more and more like medics. At worst, prescribing would infect the whole discipline, skewing psychology further and further towards a reductionist and decontextualised model of the human condition.

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References

- Holland, S. (1988). Defining and experimenting with prevention. In S. Ramon & M. Giannichedda (Eds.) *Psychiatry in transition: The British and Italian experiences*. London: Pluto.
- Prilleltensky, I. (1994). *The morals and politics of psychology: Psychological discourse and the status quo*. Albany, NY: State University of New York.
- Smail, D. (1993). *The origins of unhappiness*. London: HarperCollins.

No harm in a coat of many colours

ROBERT RESNICK *has the final word.*

SAMMONS and Levant's comments address an issue that is of genuine concern for all who are supportive of the prescriptive privileges movement. We are acutely aware that vast amounts of money are spent by drug manufacturers attempting to influence prescribing patterns and use. Indeed, the American Psychological Association has already formed a task force to examine the issue. We shall need to be vigilant. However, what is encouraging is the data available from the prescribing psychologists in the military. They have not been seduced by the pharmaceutical salespeople and marketing. They prescribe less often and for a shorter duration and always give primacy to psychological interventions. This experience is over several years and thousands of patients. Furthermore, they view themselves as psychologists who can prescribe and not 'junior psychiatrists'.

From the commentaries of Lucy Johnstone and Jim Orford, it appears they have very different views on the 'subject matter' of psychology but converge on the negation of an additional treatment modality: prescriptive authority. Both positions are reminiscent of American psychology of 25–35 years ago (including the 'dubious diagnosis of ADHD'), suggesting the evolutionary nature to training and practice. Johnstone seems to posit the psychology of today as the mind–body dualism of 17th century Descartes. To suggest there is psychological experience and awareness without commensurate change in the biochemistry of the brain's neural netting is untenable in the 21st century. She negates drug treatment, as they do not deal with 'cause'. However, drug therapy often reduces symptoms and not cause from the common cold to asthma to menopause, from delusions to hallucinations to mania. Further, she negates the wealth of data that demonstrate that we are susceptible to different emotional disorders as our neural nets develop, mature and age. Johnstone believes successful psychotherapy is

talking about 'feelings'. Yet there are therapies that minimise or are not interested in feelings. One example: cognitive-behaviour therapy focuses on symptoms and facilitates rethinking not 're feeling'.

There are data that show that medication management and psychotherapy are superior to either intervention alone. One cannot always wait several months before quality of life and functioning improve. Would Johnstone object to a drug that would improve the life and functioning of an autistic child, or an

'one group of psychologists should never decide what is good for another group of psychologists'

antipsychotic that would reduce or eliminate the crippling hallucinations of schizophrenia? I hope not. I would hope that a proven drug intervention for a proven disorder would be acceptable to her. Or does she believe that psychologists cannot be trained to use pharmacological agents appropriately and discreetly? Again, I hope not.

Conversely, Jim Orford believes we are too much in the mind and not enough in the environment. If we can change life's 'circumstances to fit people' things would be better. I would agree. Reducing or eliminating society's malaise would contribute to our improved mental health. And in some instances (anxiety, depression, phobias, etc.) environmental manipulation can be very productive and helpful in improving quality of life. However, environmental manipulation, while a component of mental health issues, is not demonstrably the *sine qua non*.

Let us look to the future and not be inhibited by the traditions of our past. Psychological treatments must be driven by science. We have learned that mind and body do interact and that both interact with the world around them. It is regressive to

deny treatments that are demonstrably effective in reducing symptoms, pain and suffering. Not all psychologists are interested in prescribing medications. This is as it should be. Not all psychologists are psychoanalysts, psychodynamic or cognitive-behavioural in orientation. We can agree to disagree. As psychologists, we are trained in psychological interventions first and would continue to be so. All prescriptive authority training models are postdoctoral. The US experience with prescribing military psychologists unequivocally demonstrates they are psychologists first. Lucy Johnstone says that the Surgeon General of the United States (Dr Satcher) stated that the cause of mental problems is not known. She concludes that psychologists, therefore, should not prescribe medications. However, the same Dr Satcher has also stated that he supports prescriptive authority for appropriately trained psychologists.

Psychology, after all, is like Joseph's coat of many colours. We are a diverse group of professionals with diverse professional interests. But, one group of psychologists should never decide what is good for another group of psychologists resulting in: 'If I don't want it you can't have it.' That would, indeed, be a crippling and divisive blow to our profession.

However, I am optimistic. Practice and training are, indeed, evolving. Britain will, like the US, and in its own good time, further expand its treatment competencies, as the Norwegian Psychological Society has, to include prescription privileges in its professional and legislative agendas. Lastly, it is worth repeating: the ability to prescribe is also the ability to discontinue inappropriate and ineffective medications.

Does this debate affect your working life? Would you like to see the US-style changes here? Have your say by sending us your letter for publication to the Leicester address, or to psychologist@bps.org.uk.

