



A Publication of the Society of Clinical Psychology (Division 12, American Psychological Association)

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**Professor Emeritus**  
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## PRESIDENT'S COLUMN

### Presidential Update of the Society of Clinical Psychology

Diane J. Willis

The Society had a very successful and productive Board of Directors (BOD) meeting in January. I was personally pleased to look around the room and see the cultural and racial diversity among the members. The Board meeting was attended by two Asian Americans, one Hispanic, one African American, and two American Indian psychologists who are making contributions to the initiatives of the Society. As demographics of the nation (and APA) change, it is my hope that the leadership of the Division will reflect this change also. The membership will soon be asked to vote a bylaws

change to hold one of our four seats for Council of Representatives for an ethnic minority. Also, it is with great pleasure to report to the membership a new award unanimously approved at the January 2003 BOD meeting. It is called the Award for Distinguished Contributions to Diversity in Clinical Psychology; the first awardee will be Stanley Sue, the new chair of the Science and Practice Committee. A description of the award can be found elsewhere in this issue of *The Clinical Psychologist*

As you know, there are enormous concerns about financial issues across the nation. States are millions of dollars below budget and the stock market is down, affecting many of us whose retirement funds may be invested in the market. The American Psychological Association is having to make cuts in its overall budget and most Divisions within APA are suffering losses. As a result of budgetary concerns within Division 12, and considering the impending renegotiations of the contract with Oxford University Press who publishes the Division's journal, I appointed a lawyer/psychologist—Robert Woody, PhD, JD—to chair the Finance Committee. When I asked what financial information needed to be shared with the membership, Dr. Woody said, "For the past three years particularly, the Board of Directors has carefully monitored expenditures. However, revenues have declined (mainly because declining incomes have led to psychologists' trending away from affiliation with professional associations), members have been lost to new divisions, and costs for operations continue to increase. Also, budget cuts to university libraries have resulted in a disappointing number of subscriptions to *Clinical Psychology: Science and Practice* (notwithstanding that it has established

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peerless quality), which required continuing subsidization from the operating budget. Despite these negatives, our Society has clear-cut fortitude for planning new projects that will benefit our members and society. The real world of finances must not dampen our professionalism. Now is the time when all members should step forward to help build a stronger Society. Among other things, if every member would bring one new member to the Society in 2003, the surge to professional strength would be profound."

Prior to the January BOD meeting the President asked the membership committee to present a plan for recruitment and retention of members in the Society. Lahoma Schultz, student representative, presented a proposal to give authored books to students who get other students to join the Division. For every new member recruited by a current student member, that member gets two chances placed in the drawing for signed books. Lahoma has received over 17 books thus far from noted members of the Society. It is my hope that you, as members of the Society, will help us recruit new members. Bringing the Society back to good

financial health remains a priority for 2003.

Despite the concerns about financial matters, there are many exciting initiatives underway by members of the Society. First, the President's initiatives focused on special populations, including discussion at the January BOD meeting on the book proposal entitled, "Effective Treatment of Low Income and Ethnic Minorities." Low income people, including the "working poor," suffer discrimination by our distancing ourselves from them in life, in practice, and in research. According to Lott, we have made invisible those who are not middle or upper class (Lott, 2002). Indeed, we seem to lack interest in lives different from our own as evidenced by the paucity of literature on poor women, and the omission of this group of people in our research. Please watch the Division listserv for more information on this topic, and participate in our discussion about the planned book.

Second, the Society is concerned about the children of incarcerated parents. Given the 2 million people incarcerated, the 3.5 million on probation, the 1.5 million children who have at least one parent in state or federal prison, and given the lack of

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research and treatment resources for this population, the Society is forwarding a proposed resolution on "Families of Incarcerated Offenders" to the Council of Representatives for consideration. Those interested in reading the resolution may contact Gary (gmelton@clemsun.edu) and Robin K. Melton (rkimbro@clemsun.edu).

Third, Elizabeth 'Betty' King produced a comic book called KEMOSHARK, and a video, "My Mom has Breast Cancer," developed to help families when one of the parents has been diagnosed with cancer. The goal is to help families see the experience through the eyes of the child and to assist the child with coping during the difficult process of cancer treatment. A link between the Division 12 web page and the KIDSCOPE web page will be developed. By March 2003, psychologists working with this population can download the comic book in English or Spanish free of charge to families or individuals.

For more information on this initiative contact Dr. King at helizking@aol.com. With the new publications chair, Dr. Annette LaGreca of University of Miami, the Division hopes to develop numerous products for members and the general population. Members who have ideas for product development can help by e-mailing diane-willis@ouhsc.edu and alagreca@miami.edu.

Finally, I hope that you as members will want to become involved in the activities of the Society of Clinical Psychology. We have several task forces and committees, and if you have interest in being involved in any of them, please e-mail me. □

**References**

Loft, B. (2002). Cognitive and behavioral distancing from the poor. *American Psychologist*, 57, 100-110.

***Clinical Psychology Brochure***

The popular brochure "What Is Clinical Psychology?" is available from the Division 12 Central Office. It contains general information about Clinical Psychology, and is suitable for both the general public and high school/college students.

*The cost is \$15 per 50 brochures  
Orders must be pre-paid.*

***For more information, contact::  
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**New Division 12 Award for 2003**

**The Stanley Sue Award for Distinguished contributions to diversity in Clinical Psychology**

The Stanley Sue Award for Distinguished Contributions to Diversity in Clinical Psychology will be given by Division 12 (Society of Clinical Psychology) to a psychologist who has made remarkable contributions to the understanding of human diversity and whose contributions have significant promise for bettering the human condition, overcoming prejudice, and enhancing the quality of life for humankind. Other contributions may be broadly conceived as advancing knowledge through research; developing innovative approaches to service delivery, teaching or consultation; or providing mentoring and active promotions of people of color.



# The Clinical Psychology of Women CALL FOR NOMINATIONS FOR AWARDS

Section IV of Division 12  
(The Clinical Psychology of Women)  
seeks nominations for two awards to be presented at  
the Division 12 Awards Ceremony in Toronto.

## The Mentoring Award

The Mentoring Award acknowledges the importance of mentors to female clinical psychologists. The awards will be given to a female or male psychologist who has aided women in clinical psychology to succeed at critical periods in their careers: as graduate students working toward the doctorate, as new practitioners setting up practice, as faculty working toward tenure, as agency staff learning the rules of procedure, or as women seeking to participate in association leadership.

Nominations may be made by one individual, but letters of support from others who have been mentored by the nominee will also be considered in selecting the winner. A letter of nomination describing the mentor's helping behavior should be submitted by May 30, 2003 to the chair of the Section IV Professional Awards Committee. **A copy of the nominee's curriculum vitae must be included with the primary letter of nomination.** Send nominations and curriculum vitae to:

Faith-Anne Dohm, Ph.D.  
GSEAP, CNS 221  
Fairfield University  
1073 North Benson Road  
Fairfield, CT 06824  
fdohm@fair1.fairfield.edu

## The Student Research Award

The Student Research Award is given to a graduate or undergraduate student whose research efforts involve the study of the clinical psychology of women. Every entrant will receive free student membership in Section IV, and the winner will receive an award of \$100. Applications must include a cover sheet with name, address, telephone, fax, and e-mail address; a 250 word abstract describing the research; and a curriculum vitae. Deadline for receipt of applications is May 23 to the Chair of the Student Research Award Committee:

Faith-Anne Dohm, Ph.D.  
GSEAP, CNS 221  
Fairfield University  
1073 North Benson Road  
Fairfield, CT 06824  
fdohm@fair1.fairfield.edu

# CALL FOR NOMINATIONS

## Three Awards for Distinguished Contributions in Clinical Psychology

### ***Distinguished Scientific Contribution Award***

This award honors psychologists who have made distinguished theoretical or empirical contributions to basic research in psychology.

### ***Florence Halpern Award for Distinguished Professional Contributions***

This award honors psychologists who have made distinguished theoretical or empirical advances in psychology leading to the understanding or amelioration of important practical problems.

### ***Stanley Sue Award for Distinguished Contributions to Diversity in Clinical Psychology***

This award shall be given to a psychologist who has made remarkable contributions to the understanding of human diversity and whose contributions have significant promise for bettering the human condition, overcoming prejudice, and enhancing the quality of life for humankind. Other contributions may be broadly conceived as advancing knowledge through research; developing innovative approaches to service delivery, teaching or consultation; or providing mentoring and active promotions of people of color.

## Two Awards for Early Career Contributions in Clinical Psychology

### ***David Shakow Award for Early Career Contributions***

This award shall be given for contributions to the science and practice of Clinical Psychology. The awardee will be a person who has received the doctorate within the past seven years and who has made noteworthy contributions both to the science and to the practice of Clinical Psychology.

### ***Theodore H. Blau Early Career Award for Outstanding Contribution to Professional Clinical Psychology***

This award will be given to a Clinical Psychologist who has made an outstanding contribution to the profession of Clinical Psychology. Outstanding contributions are broadly conceived as promoting the practice of Clinical Psychology through professional service, innovation in service delivery, novel application of applied research methodologies to professional practice, positive impact on health delivery systems, development of creative educational programs for practice, or other novel or creative activities advancing the profession. Given the difficulty of making such contributions very early in one's career, the award will be given to a person who is within the first 10 years of receiving his or her doctorate. This award is made possible through the sponsorship of Psychological Assessment Resources, Inc.

**To nominate someone for any of these five awards, send nominee's name, recent vita, and a concise (1-2 page) typewritten summary of his/her achievements and contributions to:**

**Diane Willis, Ph.D., Chair  
2004 Awards Committee  
c/o Division 12 Central Office  
P.O. Box 1082  
Niwot, CO 80544-1082  
Deadline: October 31, 2003**

**The awards will be presented at the 2004 APA Convention in Honolulu, HI**



# Division 12 Elections Candidate Statements

Elections for several Division 12 positions will occur this Spring. Ballots will be mailed to members in the middle of April, 2003, and must be returned to later than June 1, 2003

## PRESIDENT-ELECT

### **Janet R. Matthews, Ph.D., ABPP**

Janet R. Matthews received her Ph.D. in clinical psychology from the University of Mississippi in 1976. She is a tenured Professor at Loyola University New Orleans, a consultant to the predoctoral internship at the New Orleans VAMC, and in part-time private practice. She is a Fellow of the Division and a member of Sections 4, 6, and 9. She has been active in Division 12 for over 20 years. Among her Division 12 service are Program Chair and Secretary-Treasurer of the former Section 2; Membership Chair, Secretary, and President of Section 4; three years on the Division Fellows Committee; three years as Division Secretary; APA Council Representative; the Division Finance Committee; and currently serves as Membership Chair of Section 9. She is a past recipient of the Section 4 mentoring award.

I am honored to have been nominated and respectfully ask for your vote to be your next President-elect. I believe I bring a combination of experience with both Division 12 and APA governance that will allow me to work within our Division as well as with the APA leadership when appropriate. My combination of academic and applied work gives me an appreciation of the diversity of interests of our membership. If I am selected for this position, I would hope to work collaboratively with my predecessors so that we have continuity of projects. Of special interest to me is to

increase the appeal of Division 12 as a "comfortable home" for a larger proportion of APA members. My goal is for more APA members to view Division 12 as their "base" division and other division memberships to reflect their specialty interests. Our membership does not reflect the large numbers of clinical psychologists within APA. As a step toward that goal, I would hope to focus on two areas during my term of office: new professionals and the role of traditional clinical assessment in the 21st century. To develop initiatives with new professionals, I would hope to work closely with APAGS and the APA Task Force on New Professionals. A goal of this collaboration is to develop meaningful roles for new professionals within the Division. For clinical assessment initiatives, I would hope for collaborative efforts between our Division and specialty organizations in the clinical assessment field. An internal Division 12 issue of interest to me is the Division's finances. Having just completed a term on the Finance Committee, I am aware of initiatives to improve our finances. I hope our leadership would continue to consider ways to address budget problems, including active consultation with former Division Treasurers and Finance Chairs and creative approaches to product development.

I would be happy to discuss my ideas and interests in more detail and can be reached at [matthews@loyno.edu](mailto:matthews@loyno.edu). □

## PRESIDENT-ELECT

### **Linda Carter Sobell, Ph.D., ABPP**

Linda Sobell is Professor of Psychology and Associate Director of Clinical Training at the Center for Psychological Studies at Nova Southeastern University (Florida). She received her Ph.D. in psychology from the University of California at Irvine in 1976. Her academic qualifications include faculty appointments at Vanderbilt University, University of Toronto, and the Addiction Research Foundation (Senior Scientist; Chief of a Clinical Treatment Unit). What best characterizes her 30-year career is a blending of science and practice.

She is a long time member of Division 12, a Fellow in Divisions 12, 25, 28, and 50, holds a Diplomate in Behavioral Psychology (ABPP), and is a licensed psychologist in Florida. She has received several awards, including the APA Division 28 Brady/Schuster award (2003). She is currently Chair of Division 50's Fellows and Awards Committee. She is known nationally and internationally for her work on the assessment and treatment of addictions, and has published over 250 articles and book chapters, and 6 books. She also has 20 years of organizational experience, having served on the Board of the



# Division 12 Candidate Statements

Association for Advancement of Behavior Therapy as Secretary-Treasurer and President ('93-'94). Dr. Sobell serves on the Editorial Boards of six clinical journals.

The most serious issue I feel confronting the Society of Clinical Psychology is developing a new agenda for furthering and strengthening clinical psychology. Two reasons are of particular consequence. First, there has been a proliferation of specialties within clinical psychology. The result, while increasing knowledge, has distracted us from unifying themes that bind us together as clinical psychologists. A second reason to develop a new agenda relates to surviving in a competitive marketplace—we need to enunciate why clinical psychology is unique among the health professions. Regardless of the specialty, what makes us unique is the science-practice intersection that ties what we do to the growth of knowledge in the study of behavior.

To define a new agenda for our Division, upon being elected, I will appoint a task force representing all our major constituents to work with haste

and prudence to propose a statement of purpose and to outline detailed steps to fulfill that purpose. Other issues such as reversing the erosion of the membership base are also important and certainly, the budget needs attention.

Recognizing that our elected officers have been struggling with these issues, an important question is “How is what I am proposing different?” The difference is that although individual issues are important (e.g., membership, finances), I propose to address these and other issues within the broader context of re-evaluating what our Division is about, what our Division stands for, and why new graduates should join our Division.

Identifying an agenda that binds us will articulate our purpose and methods so that young clinical psychologists see the Division not only as an extension of themselves, but also as their professional home. In short, we need a long-term solution to the problems that presently are confronting our Division. I would be honored to lead the Society through the initial steps of this critical journey. □

## PRESIDENT-ELECT

### **Robert H. Woody, Ph.D., Sc.D., J.D.**

Robert H. Woody is Professor of Psychology (and former Dean for Graduate Studies and Research) at the University of Nebraska at Omaha. From 2000-2002, he served on the Division 12 Board of Directors and as Treasurer, and is now Chair of the Finance Committee. He is the Florida Representative to the APA Council of Representatives. From 1997-1999, he was on the APA Ethics Committees. His degrees include: Ph. D. (Michigan State University); Sc. D. (University of Pittsburgh); and J. D. (Creighton University School of Law). He is a Fellow of the Divisions 12, 16, 17, 38, 40, 41, 42, 43, and a Diplomate in Clinical Psychology and Forensic Psychology, ABPP, and a Diplomate in Assessment Psychology, ABAP. He is a Licensed Psychologist in Florida and Michigan, and admitted to the Florida, Michigan, Nebraska, and Tennessee Bars. He has authored/edited thirty-three books, and approximately one hundred and fifty articles. In his law practice, he defends, represents, and counsels psychologists.

Division 12 must build a bridge from behav-

ioral science research to modern clinical practice. I am committed to helping clinical psychologists attain improved quality care, risk management, and financial strength. Since both APA and D12 are operating with deficit budgets, there is no doubt that the near future will require considerable financial expertise. Being experienced with financial matters and having legal training, I am prepared to lead our Division to a more positive fiscal position.

Over the past few years, a number of clinical psychologists have dropped their membership in Division 12. I place high priority on recruitment of members. One of my primary efforts will be to convince clinical psychologists who have left Division 12 to return “home.” The scientist-practitioner model provides a buttress for the real world of day-to-day services, and Division 12 must be the voice of advocacy and conduit of information for strengthening all clinical psychologists.

I will promote collegiality, emphasize the positive contributions made to society by clinical psychology, convey justifiable consternation about managed care



# Division 12 Candidate Statements

to government sources, and assert that clinical psychologists must shape managed care organizations as much or more than they shape psychological practices. Licensing boards must provide equal protection for consumers and psychologists by assuring a level playing field for processing complaints. I particularly hope to help clinical psychology be more in command of the standards that apply to judging psychological practices.

In representing clinical psychology, I will

strive to be scholarly, rational, assertive, and persuasive. Pursuing benefits for clinical psychology is pursuing benefits for society. Thus, there is no place for cowardice or hesitancy. Unreservedly, I pledge a creative and high-energy approach to problem solving on behalf of clinical psychology. Being trained in both psychology and the law, I am confident that I can offer unique strategies to improve clinical psychology. I will appreciate your support for my candidacy for President-Elect. □

## APA COUNCIL REPRESENTATIVE

### ***Asuncion Miteria Austria, Ph.D.***

Asuncion Miteria Austria is Professor, Chair, and Director of Clinical Training, Department of Psychology, Cardinal Stritch University. She received her Ph.D. in Clinical Psychology from Northwestern University, completed her internship at the Institute for Juvenile Research in Chicago, and postdoctoral fellowship at the Neuropsychiatric Institute, University of Illinois Medical Center.

A Division 12 Fellow, she has held leadership positions within the Division since 1981, including committees on Membership, Fellowship, and Nominations and Elections. She currently chairs the Governance Committee; she chaired the Division's Task Force on Diversity Representation in the Society Governance; was a member of the Task Force on Women in Academia; and Chair of EOAA (the precursor of Sections IV and VI). She was President, Editor of the *Clinical Psychology of Women*, and Chair of the Awards and the Mentoring Award Committees of Section IV (Women). She was

Treasurer of Section VI (Ethnic Minorities) and currently serves as its Representative to the Division Board. Within APA, she served as Chair of CEMA, currently serves on the Policy and Planning Board, and is the Lead Consultant for the APA/NIGMS Project. She has received numerous awards including the Distinguished Humanitarian Award from the American Association of Applied and Preventive Psychology, and Outstanding Contribution to the *Clinical Psychology of Women* from Division 12, Section IV.

I am informed of the many challenges facing Clinical Psychology. Diversity and multicultural competence are going to be critical issues for psychology as a science and profession. It is imperative that the Division has a representative on Council who can actively and effectively represent these issues. With my extensive experience within the Division for more than two decades, I believe I can provide a strong voice in representing the Division on Council and would be honored to do so. □

## APA COUNCIL REPRESENTATIVE

### ***Thomas H. Ollendick, Ph.D.***

Thomas H. Ollendick is University Distinguished Professor of Psychology and Director of the Child Study Center at Virginia Tech, where he also served as Director of Clinical Training for 12 years. "Tom" is a Fellow of Divisions 12, 25, and 53 of APA. The Past-President of the Association for the

Advancement of Behavior Therapy (1995) and Division 12 (1999), he is the current president of Division 53. In addition, he presently serves as an Associate Editor of the *Journal of Consulting and Clinical Psychology* and Co-Editor of *Clinical Child and Family Psychology Review*. His clinical and research interests focus on the internalizing disorders of childhood and adolescence (i.e., anxiety and



# Division 12 Candidate Statements

depression) and the delivery of services for such children and their families. He maintains a small private practice in which he struggles with issues of managed care and related professional matters.

I have been an active member of Division 12 for over 25 years and have served the Division in a variety of capacities: Representative to the Board, former Council Representative, Publications Committee member and chair, and as its President. I have found my activities to be both rewarding and frustrating over the years. Rewarding because there have been opportunities to impact the field of Clinical Psychology and to play some small part in its evolution. Frustrating because many of my aspirations for our profession have simply not been realized. As a scientist-practitioner who has sought to

both generate and utilize advances in assessment and treatment, I have found this process to be an unusually slow and admittedly complex one—one that has been characterized at times, however, by considerable inertia and many attempts to maintain the status quo at all costs. Clinical Psychology, as a health service profession, has much to offer the health care industry from both a scientific and professional standpoint. The gap between science and practice has widened in recent years and we must work to build constructive bridges. I would look forward to serving our profession as one of its Council Representatives and pursuing these initiatives with vigor. As scientist-practitioners, we must do more, and we must do more now! □

## APA COUNCIL REPRESENTATIVE

### *Charles Spielberger, Ph.D.*

Charles D. Spielberger is Distinguished Research Professor and Director, Center for Research in Behavioral Medicine and Health Psychology at the University of South Florida, where he has been a faculty member since 1972. He previously directed the USF Doctoral Program in Clinical Psychology, and was a tenured faculty member at Duke, Vanderbilt, and Florida State University, where he was also Director of Clinical Training. An ABPP Diplomate in Clinical Psychology and Distinguished Practitioner of the National Academies of Practice, his current research focuses on: anxiety, depression, curiosity, the experience, expression and control of anger, stress management and health psychology. His State-Trait Anxiety Inventory has been adapted in 66 languages. His Test Anxiety Inventory, State-Trait Anger Expression Inventory, and Job Stress Survey are also widely used.

During 1991-1992, Spielberger served as the 100th President of the American Psychological Association, and was APA Treasurer in 1987-1990. He

has also served as President of the Society for Personality Assessment, International Association of Applied Psychology, Southeastern Psychological Association, National President of Psi Chi, and as Chair of the National Council of Scientific Society Presidents. He has also chaired five APA committees (Accreditation, Budget, Finance, Elections, International Relations), served on three major APA Boards (Scientific Affairs, Policy and Planning, Publications and Communications), and currently serves on the BEA.

Although I have enjoyed working in a number of organizations, my personal identity and strongest commitment has always been to the science and practice of clinical psychology. It was my pleasure to serve as President of Division 12, and to receive our Division's Distinguished Contributions Award. I sincerely believe my experience in Division and APA Governance can help me to represent the interests and values of our members, and I will greatly appreciate your support of my reelection to a second term as your Council Representative. □



## Invited Editorial and Commentaries

**Editor's Note:** The following editorial and commentaries were invited by the editor. They were not subjected to formal peer review, and they were not edited substantially, except for minor copy editing. As with all articles appearing in *The Clinical Psychologist*, the views presented in this series are those of the authors.



### ***Psychopharmacology 102 (...What They Neglected to Mention in Psychopharmacology 101)***

**David Healy**, University of Wales College of Medicine

*Correspondence may be addressed to* David Healy, MD, North Wales Department of Psychological Medicine, Hergest Unit, Bangor, Wales LL57 2PW, United Kingdom; Tel: 44-1248-384453; Fax 44-1248-371397; Email: Healy\_Hergest@compuserve.com

 A lot of bitter disputes later, and a lot of psychopharmacology training later, psychologists are prescribing. For sociologists and historians of health care, this encroachment on apparent medical privilege offers a fascinating natural experiment. If nothing goes wrong some will draw the implication that medical training, far from equipping practitioners with critical specialist knowledge, is really a protracted affair, the primary purpose of which is to ensure that those who emerge at the far end are cautious and responsible types (Ray, 1998). If, far from going wrong, everything goes well, prescribing privileges might be extended much further or, indeed, prescription only status itself might come under review.

The debates that have circled about these issues hitherto have primarily focused on the technical knowledge supposedly needed for prescribing. This paper seeks to open up other areas for debate.

#### **Sales and Marketing**

To the media and others, it has been clear for a long time that psychopharmacology means never having to go without a pen or Post-It Notes, or a range of other little reminders. It also means free literature searches, free articles, support to attend educational meetings, and support for activities such as Grand Rounds. In addition to training on pharmacokinetics and pharmacodynamics, as well as the latest on the biochemistry of receptors, psychologists who prescribe will almost certainly have had lectures or dis-

cussions on issues surrounding the selling of psychotropic compounds and the ethical dilemmas that may result. They will no doubt have been introduced to the nuances of relationships in which one side gives gifts.

Every so often, the medical world is convulsed by spasms of concern that lead to strictures on the cost of gifts that can be given to prescribers, the frequency with which they can attend meetings without presenting at those meetings, or even the grade of the hotels in which they can stay when they are being supported by pharmaceutical companies. Repeated surveys undertaken of psychiatrists visiting the exhibition halls at American Psychiatric Association meetings, however, suggest that psychiatrists are not influenced by factors such as this. What are psychiatrists influenced by? Well, in response to these surveys, psychiatrists reassuringly claim that they are primarily influenced by the evidence.

The proponents of psychopharmacology argue that psychopharmacology is more evidence-based than other areas of mental health care and that it has helped teach psychiatrists to respect the evidence. What possible harm could there be, therefore, in extending this therapeutic discipline to encompass a greater part of mental health care on the one side and to pull in psychologists as prescribers on the other?

The perception that psychiatrists have that marketing does not influence them, however, is a classic misconception. The mistake is to see the pens and

## **Psychopharmacology 102** *(...What They Neglected to Mention in Psychopharmacology 101)*

Post-It Notes as part of the marketing of psychotropic drugs when these trinkets, in fact, are part of the tactics of selling rather than the strategy of capturing a market place. Are prescribing psychologists likely to be any more immune to this misconception than psychiatrists?

In contrast to the sales department, the marketing department of a pharmaceutical company gets involved long before a product is sold. Indeed from the point of origin of a new compound, marketing now plays a part in shaping what kind of clinical trials are undertaken, in which parts of the world, for what indications, leading to what publications in which journals, with which distinguished names appearing as the apparent authors of these articles. This argument is developed below.

***“...marketing now plays a part in shaping what kind of clinical trials are undertaken...”***

### **FDA and Prescribing**

The impression most people have is that regulators such as the FDA are in some way responsible for the clinical trials that get done to establish that a compound works for a particular condition, or if not that, that the regulators have some say in the choice of investigators and the determination of protocols. Some will know that this is not true, but will think that at the very least, the FDA analyzes the data and then reports on it before finally storing the evidence base somewhere in their archives for re-inspection

should problems arise with a compound later on.

In fact, companies decide what they will investigate. The SSRIs, when they came on stream, were therefore investigated for depression rather than for premature ejaculation, even though their treatment effect size in clinical trials is much greater for premature ejaculation. Why? The depression market at the time looked more profitable (Healy & Nutt, 1998). The companies choose the subject samples, and these are populations of convenience, which are ordinarily not representative of the population to be treated at large (Healy, 2001a). They choose investigators or clinical research organizations that can be trusted to deliver an appropriate patient flow. Companies themselves or contract organizations analyze these results. Medical communications agencies determine what series of articles, appearing in which journals, with which opinion leaders as authors, would best meet the needs of their corporate clients. Tendering for this communications business is a competitive process in which communications agencies strive to exceed their client's expectations.

Far from analyzing the resulting data, the role of the FDA is to audit the books in a very similar manner to the way that Arthur Andersen or other accountancy firms audit the books of corporations like Enron. The FDA investigators review data that have been pre-tabulated by companies or other communications agencies. They audit approximately one in twelve of the case records to ensure at least some

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notional correspondence between the clinical material and the tabulated data. Should a problem arise at any point after the marketing of the drug, the FDA are poorly placed to investigate it in that the data has by this point been returned to the companies. The usual approach from the FDA involves asking the company to prepare a further report on the issue in question.

This scenario raises the question as to whether the FDA is more likely to be successful than any other set of auditors in the corporate field in preventing a future pharmacological Enron from happening. Unlike corporate auditors in the financial sector, however, the FDA has one weapon other than a simple inspection of the books. The primary regulatory mechanism put in place to prevent a future pharmacological Enron is not the FDA's auditing of a company's books, but rather the steps

***“It was not thought fitting that a system designed for addicts should be extended to the citizens of a free country.”***

it has taken to make new medications available on prescription only.

### **Prescription Only Dilemmas**

There is profound misunderstanding about the nature of prescription only status for

medicines. Physicians have for centuries supposedly had prescribing privileges. This, however, did not mean that patients could only access their medications through a physician. Even in the case of drugs like the barbiturates and stimulants, the majority of patients right up to the 1950s might get a first prescription from a physician, but thereafter could get further supplies from a pharmacy, having satisfied themselves that these new drugs seemed to help. Discharge summaries on patients leaving hospital frequently did not mention the drugs they were on as this was something patients could organize for themselves. Any psychologists could have advised on what might be an appropriate pharmacological remedy.

This practice intersected with a war that started in 1914. The Harrison's Narcotics Act of that year effectively began what has since been termed a War on Drugs. One of the primary instruments of this war was the institution of prescription only status. Unlike the normal prescribing of drugs, heroin and

cocaine were to be limited to prescription only status. The hope was that medical personnel could thereby be recruited as front-line troops in campaigns to eliminate addiction. Prescription only status meant that physicians would monitor the use of these drugs, thereby controlling their supply, while simultaneously monitoring the health of the addicts. This system failed.

In the wake of the pharmacological revolutions surrounding World War II, which led to the introduction of antibiotics, antihypertensives, anti-diabetic drugs, and other agents, the FDA moved to make all new drugs available on prescription only. In great part, the rationale for this move was that while these new drugs were among the first demonstrably effective agents for some of the conditions being treated, they were also hazardous in a way not seen before. The first manuals of drug side effects appeared in the early 1950s, and the potential for disaster with these new agents became clear with thalidomide in the early 1960s.

Prescription only status in the 1950s was predicated on a belief that physicians would be more cautious in prescribing these new drugs than patients would be in taking them, that physicians would restrict the use of these drugs to disease entities only rather than give them for lifestyle purposes or trivial indications, and that physicians would be best placed to monitor the hazards that might appear from the new agents. The paternalism inherent in this approach was not universally appreciated. There were vigorous campaigns against the extension of prescription only status. It was not thought fitting that a system designed for addicts should be extended to the citizens of a free country (Healy, 1997).

While psychologists who can now prescribe, therefore, may think that they are gaining privileges, in fact this perception involves looking back to an earlier era rather than any clear-sighted scrutiny of what is happening now. Rather than gaining privileges, they are arguably becoming agents of a “machine” in ways they might not have expected.

### **Agents of the Machine**

What kind of machine? At its initiation, prescription only status made prescribers agents of the regulatory and control apparatus. However, it is far from clear that this is how they function now. Where once



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physicians were cautious prescribers and much more skeptical than the general population that anything worked, they are now widely perceived, with some justification, as little more than a conduit for the latest pharmacological panacea. Drug-induced morbidity is now the fourth leading cause of morbidity in medical systems (Lazarou, Pomerantz, & Corey, 1998). And far from being celebrated by either the regulatory apparatus or the institutions for which they work, physicians raising concerns about the hazards of drugs are likely to find themselves ostracized, they may even lose their jobs, and the regulators almost certainly will not listen to them (Thompson, Baird, & Downey, 2001).

In fact, prescription only arrangements, which were initially opposed by pharmaceutical

***“Algorithms and treatment guidelines are drawn up and portrayed as standards...”***

companies, have become the key component of the astonishingly effective marketing apparatus of pharmaceutical companies. Previously, companies had to market to the population at large. Now they

can restrict their efforts to a much smaller population of prescribers on whom, according to current estimates, over \$10,000 per year can be spent (Kirkpatrick, 2000). \$10,000 per year buys a lot more than the few pens and post-its that physicians appear to see.

Arguably prescription only status has meant that when the benzodiazepine anxiolytics ran into trouble in the 1980s, companies bringing a new group of drugs, the SSRIs, on stream were able to market them as antidepressants (Healy, 2003). Getting them licensed as antidepressants was a simple matter. The trick was in being able to change the mindset of clinicians to recognize depression where they had formerly recognized anxiety. Educating them in a manner that led to the transformation of cases of Valium into cases of Prozac.

Even before that, the same mechanism helped in achieving widespread recognition of the concept of panic disorder. Since then, we have seen the cultivation of social phobia and, more recently, even disorders like compulsive shopping disorder. We are at present in a process of reconverting cases of depression back to anxiety, as Paxil, Zoloft and

Effexor are being repositioned for generalized anxiety disorder (GAD) and PTSD (Healy, 2003). In the natural course of events, a switch back from depression to anxiety could have been predicted as a marketing strategy for a new post-SSRI group of compounds, but a combination of drug development failures and increasingly sophisticated marketing has led to a 1984-like scenario in which the consumers (prescribers) can be persuaded to endorse one set of beliefs one month and almost precisely the opposite the following month.

How can such mental plasticity be achieved? As mentioned, psychiatrists claim to be primarily influenced by the evidence. Companies therefore first undertake an appropriate portfolio of clinical trials. These are designed to suit a company's marketing purposes rather than address any scientific question. These trials are then dressed up with appropriate authorship lines and placed in appropriate journals. The resulting articles are then distributed through an efficient distribution system to clinicians. This will be assisted by the help of sponsorship to attend symposia, by support for continuing medical education and by the co-option of opinion leaders in the field onto consultancy panels for pharmaceutical companies.

The process is furthered by communications agencies commissioning and perhaps even writing, and certainly helping to place hostile reviews of books or articles that might be critical of a company's drug in any respect, such as happened with Joseph Glenmullen's Prozac Backlash (Healy, 2003). When the Hastings Center Reports published an article of mine on Prozac some years ago (Healy, 2000), Lilly withdrew their funding from the Center.

There are many who are worried that companies can now increasingly exert an indirect influence through the increased funding of medical research by pharmaceutical companies. This appears to have led universities and others to stand back and fail to support staff who point out hazards of current treatment practices—a growing number of clinical academics may have lost their jobs as a result (Thompson, Baird, & Downey, 2001; Turk, 2000).

### **The Evidence Base**

If treatments such as the antidepressants work and if the extension of prescribing privileges to psychologists



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means that a greater number of people, who might otherwise escape treatment, are detected and treated, is there much harm in all this?

In fact, the clinical trial systems that are used to get psychotropic agents licensed are assay systems that demonstrate a treatment effect rather than treatment efficacy or effectiveness. In order to be licensed, these treatments simply need to be shown in some trials to do something. This something is quite different to curing. It is a something that is picked up on rating scales rather than something that is demonstrated by a patient leaving hospital or returning to work, or by having their condition resolved so he or she is now symptom-free. In fact,

***“is it possible for clinicians using this drug to elicit informed consent from patients to take it?”***

since the introduction of the antidepressants there appears to have been a close to one thousand-fold increase in the apparent incidence of depressive disorders (Healy, Savage, Harris et al., 2001). This is hardly something that should

have happened if the treatments worked. The efficacy or lack of efficacy of antidepressants is brought out wonderfully in a recent set of articles by Kirsch and Sapirstein (1998) and Kirsch, Moore, Scoboria, and Nichols (2002 with associated commentaries).

What these authors appear to ignore is that

these trials were never constructed as trials of antidepressant efficacy in the first instance, but rather were constructed as trials aimed at getting a compound onto the market by demonstrating a treatment effect of some sort. Once demonstrated, this treatment effect, however, has been parlayed into evidence of efficacy and prescribers are urged to practice according to the evidence. Algorithms and treatment guidelines are drawn up and portrayed as standards, deviations from which may attract a legal suit, or may complicate any legal suit that might result in the case of a significant adverse event.

This evidence derives from patients who, participating in trials for free, take the risk of trying new agents, which pharmaceutical companies often find are too hazardous to market. Patients also take risks with agents that turn out to pose hazards that pharmaceutical companies never tell us about. This voluntary participation of patients makes these companies the richest corporations on the planet. A selection of the data that results from their efforts is then marketed back to clinicians as science and this is the evidence psychiatrists claim has the greatest influence on them.

But this situation is fundamentally unscientific. This is not evidence that anyone should be following for the simple reason that no one has any rights to access the remainder of the data. For example, Khan et al. (2002) have recently published an article on numbers of suicides and suicidal acts in the clinical

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trials that led to the licensing of the antipsychotics risperidone, quetiapine, and olanzapine. In trials, these agents were compared to older agents and to placebo. Khan and colleagues accessed this data from FDA records, but their paper contains a blank for the number of suicidal acts on olanzapine. An inspection of the FDA documents for this compound reveals that there is no mention of the number of suicidal acts on the compound or on placebo. A request to the company for the missing data has in my case drawn a blank. Not even the Minister for Health in the UK or the Secretary of State for Health in the US can access this data. In such circumstances, is it possible for clinicians using this drug to elicit informed consent from patients to take it? Yet this is now the most prescribed antipsychotic in the US.

***“How is it possible for clinicians to elicit informed consent from anyone who might participate in such a trial?”***

This drug is used increasingly in trials for bipolar disorder and, in particular, in children. How is it possible for clinicians to elicit informed consent from anyone who might participate in such a trial?

In a similar fashion, the academic articles stemming from sertraline’s use for OCD and

depression in children refer to only one suicidal act in one child when FDA records indicate that the number of suicidal acts in this program was somewhere between six and nine (Expert Report, 1997). It is difficult to see how prescribers giving sertraline to children in clinical practice can elicit appropriate informed consent.

Most prescribers will argue that if the Secretary of State can’t even readily access the data, how can they be expected to? But here’s the catch. The FDA and the Secretary of State fall back on the fact that these drugs are being prescribed by prescribers with specialized knowledge. And these drugs are available on prescription only so that prescribers will bring the true situation to light in a way that the ordinary consumers could not do.

### **Pharmacotherapists or Pharmacologists?**

Psychologists may in fact turn out to be particularly

hamstrung when it comes to ferreting out missing data. One of the few ways to get such information at present is as an expert witness in a legal process. However, companies are likely to be able to get psychologist prescribers disbarred as expert witnesses in legal cases on the hazards of psychotropic drugs, on the basis that psychologists are not psychopharmacologists. Simply being a prescriber doesn’t suffice, it would seem, to qualify as an expert in prescribing – that distinction goes to experts who, in fact, probably prescribe relatively rarely.

The legal process reveals a further side effect of prescription only arrangements, one that might not have been expected by medical practitioners when these arrangements were first put in place. Over the course of the past ten years, the combination of managed care and more stringent reimbursement policies has meant that psychiatrists, who would have once seen themselves as therapists, have been restricted to prescribing, and any psychotherapy they might have done is being done by psychologists and others. This has led to a situation in which the lawyers involved in medico-legal cases openly refer to prescribing physicians as pharmacologists.

The notion of prescribers as pharmacologists conveys some of the complexities of the current situation. Prescribing is something that takes place within a dynamic relationship. Even minimal contact has a message. The increasing focus on pharmacology in recent years, however, has led to a set of medical therapists who are, in all probability, becoming increasingly less sensitive to the dynamics of their relationships with patients. They are increasingly insensitive to the hostage dynamics that can develop when psychotropic prescribing goes wrong for a patient, and insensitive to the possibilities of pharmacological abuse in prescription only relationships.

In the wars between psychiatrists and psychologists in recent years, a common jibe on the psychiatric side, in response to revelations of recovered memories and sexual abuse by psychotherapists, has been that at least no one ever got raped by Zoloft or Paxil. In fact, there are very good grounds to think that the prescribers of psychotropic agents can construct prisons in which patients are abused as systematically as they ever have been in any other therapeutic modality (Healy, 2001b).



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So what lies ahead for psychologist prescribers? Potential frustration after struggling so hard to become a therapist who can prescribe, only to find that a cadre of others all but completely circumscribe your freedom to intervene to the best advantage? Slowly finding you have become a pharmacologist, when this had never been the intention? Can psychologists make a difference? Psychiatrists should hope so, for all of our sakes. If not, we have found that the confusion and pain can be soothed by those things that don't have any influence—the stays in five star hotels, the meals in the best restaurants, and the friendship and networks of friendships that pharmaceutical companies are so good at cultivating. □

**“Can psychologists make a difference? Psychiatrists should hope so, for all of our sakes.”**

**About the Author:** David Healy studied in University College Dublin and University of Cambridge. He became a Reader in Psychological Medicine in University of Wales

College of Medicine, Director of the North Wales Department of Psychological Medicine from 1992. Former Secretary of the British Association for Psychopharmacology. Author of over 120 peer reviewed articles and 12 books, including the reference history of the antidepressants—*The Antidepressant Era* Harvard University Press—and *The Creation of Psychopharmacology*, Harvard University Press. Other books include *The Psychopharmacologists Volumes 1,3a* series of interviews with leading figures in the field. Healy is also a Visiting Professor at the University of Toronto.

**Competing Interests:** In recent years Dr. Healy has had consultancies with, been a principal investigator or clinical trialist for, been a chairman or speaker at international symposia for, or been in receipt of support to attend meetings from: Astra, Astra-Zeneca, Boots/Knoll Pharmaceuticals, Eli Lilly, Janssen-Cilag, Lorex-Synthelabo, Lundbeck, Organon, Pharmacia & Upjohn, Pierre-Fabre, Pfizer, Rhone-Poulenc Rorer, Roche, SmithKline Beecham, Solvay, and Zeneca. Dr. Healy has been an expert witness for the plaintiff in five legal actions involving SSRIs

and has been consulted on a number of other attempted suicide, suicide and suicide-homicide cases following antidepressant medication, in the majority of which he has offered the view that the treatment was not involved. Dr. Healy has also been an expert witness for the defense on a series of LSD (46) and ECT (1) cases.

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### COMMENTARY

## Prescription Privileges 102: Biting the Hand that's Trying to Feed You

By David O. Antonuccio and William G. Danton

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In a hard hitting piece about the influences of the pharmaceutical industry on our scientific database, Healy (2003) argues that marketing efforts go deeper and start long before we are offered labeled pens and post-it notes. He points out that psychiatrists generally claim to only be influenced by scientific evidence despite a great deal of data showing that marketing has considerable influence over prescribing behavior. Because of publication biases, he argues that prescribers do not really have access to all of the data in any case. He points out that the FDA relies on prescribers themselves to provide data about drug hazards while prescribers rely on the FDA to protect consumers from hazardous drugs. He suggests that drug treatments such as antidepressants

have become so universally accepted that some prescribers may actually blame the patient when something goes wrong with the treatment. Healy's premise is that the drug industry has become so powerful that prescribing psychologists are likely to become additional "agents of the marketing machine." Business marketing does not encourage the sort of scientific debate psychologists embrace either. Healy argues that physicians raising concerns about the hazards of drugs are likely to find themselves ostracized and worse.

We agree with many of the points Healy makes. As organized psychology moves into a new era of prescription privileges (Daw, 2002), it will likely be faced with increasing financial and marketing influences from the pharmaceutical industry (Antonuccio, Burns, & Danton, 2002; Beutler, 2002). It is entirely reasonable for a business like the pharmaceutical industry to market its products as effectively as possible. The real question is whether this marketing qualifies as science.

Advertising and science have fundamentally different goals. A primary goal of advertising is to influence sales and turn a profit. A primary goal of science is to produce objective data. It is not hard to see how these primary goals could come into conflict. A discipline like psychology that prides itself on the highest standards of scientific methodology in the study of human behavior, has an obligation to separate science and drug industry influence if it wishes to maintain its credibility with the public. In other words, psychology has to be willing to publish data that are in the public interest, even if they conflict with corporate interests (see Nathan & Weatherall, 2002; Moses, Braunwald, Martin, & Their, 2002). The infrastructure must be set up now to create an impenetrable boundary between the drug industry and psychological science, before significant financial influences are brought to bear, rather than waiting until later when it will be impractical. If the most recent American Psychiatric Association meeting is any indication, it could be argued that organized psychiatry has indeed become the primary distribution arm for the psychotropic medication division of the pharmaceutical industry. For the American Psychiatric Association, there is no turning back because the organization's financial survival now depends substantially on pharmaceutical



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company support. For the American Psychological Association, there may still be time to prevent such dependence if we act quickly.

For these reasons, we have recommended constructing a “firewall” between the drug industry and organized psychology (Antonuccio & Danton, 2002) that includes full public disclosure of all financial conflicts of interest, a ban on drug advertising in psychology science journals, restrictions on psychology continuing education credit for pharmaceutical company sponsored presentations, a ban on contact between the industry and psychology students, strict limitations on gifts, and various methodological safeguards (e.g., requirements for testing the blind in studies that claim double blind status, no placebo washout exclusions, publicly accessible data, and assurances of independent access and publication rights to all data

by all investigators).

**“The infrastructure must be set up now to create an impenetrable boundary between the drug industry and psychological science...”**

Some have argued that psychologists’ strong training in scientific methodology puts them in a good position to resist groundless marketing claims and serious conflicts of interest. However, without serious preventative steps, we don’t believe that organized psychology will be able to manage the relationship with the industry any better than organized psychiatry has. We think that Healy is like the Ghost of Christmas Future, giving us a not so flattering view of our own future as organized psychology aggressively pursues prescription privileges. He is offering us an incredibly generous gift, although many will not see it that way. We would do well to pay attention. □

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## COMMENTARY

### Prescribing Privileges for Psychologists: A Cost Benefit Comment

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Healy (2003) presents a cogent argument about some of the perils and pitfalls of the acquisition of prescribing privileges by psychologists. In this comment, I extend his argument by considering a potential cost of this professional change, and I contrast it to one of its supposed benefits. Specifically, I consider the threat to the independence of our scientific journals and the supposed efficacy of antidepressants.

### The Threat to the Scientific Review Process

The financial support of medical journals by pharmaceutical company advertising makes those journals vulnerable to pressure. Healy (2003), for example, cited two instances of what appears to be direct



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pharmaceutical company influence on the publication of scientific data, but there is also a more subtle, indirect form of influence. To the extent that the income of a profession is dependent on prescribing drugs, the members of the profession will be motivated to discount data arguing against them and biased toward confirmatory data.

My own experience seeking outlets for meta-analyses of clinical trials of antidepressants is illustrative. Before being published in the American Psychological Association journal *Prevention and Treatment* (Kirsch, Moore, Scoboria, & Nicholls, 2002; Kirsch & Sapirstein, 1998), I submitted them to a number of medical and psychiatric journals that refused to even send them out for review. The distinguished journal *Science* (which is also partially supported by pharmaceutical advertising) sent it to two reviewers, both of whom reviewed it favorably and recommended publication. One of the reviewers wrote: "The research presents surprising, very relevant results on the potency

***"...prescribing privileges to psychologists will be followed by advertising dollars to psychological journals..."***

(better: impotency) of antidepressants...The interest exceeds the borders of science. The paper should and will enter teaching of pharmacology, psychology and psychiatry as a nice spinoff of applied science...Unchanged publication is highly recommended." The other commented: "This paper is important for many reasons. It provides an independent analysis of FDA data which has been hard to get and is of great importance to scientists, industry, ethics committees, and consumers who are concerned about the results from placebo controlled studies in depression." Nevertheless, the manuscript was ultimately rejected.

Unlike medical journals, psychology journals are not currently supported by pharmaceutical company advertising, and clinical psychologists are not financially dependent of writing prescriptions. This renders them more open to data challenging the efficacy of medications. My prediction is that prescribing privileges to psychologists will be followed by advertising dollars to psychological journals, thereby threatening their scientific independence.

### **And For What?**

Some of the benefits of prescription privileges are uncontested. Prescribing psychologists stand to benefit economically from enhanced competitiveness with psychiatrists and more directly from the acquisition of the various perks provided by pharmaceutical companies to practitioners with the ability to prescribe their products. As Healy (2003) notes, a potential benefit to depressed people is the potential increase in the number of them who get treated with a larger base of prescribers. He goes on to note that this is a benefit only if the treatments really work and cites data by my colleagues and I suggesting that they might not (Kirsch et al., 2002; Kirsch & Sapirstein, 1998). In the remainder of this comment, I describe those and other efficacy data in more detail.

Kirsch and Sapirstein (1998) reported a meta-analysis of 19 published clinical trials of the efficacy of antidepressant medication on patients with a primary diagnosis of depression. Because our primary interest was in the placebo effect in the treatment of depression, we also analyzed data from 19 clinical trials of psychotherapy, in which some patients had been randomized to a wait-list or no-treatment control group. This allowed us to calculate the magnitude of placebo effect by subtracting changes occurring in patients in the no-treatment groups, who had not even been given a placebo during the study period.

We found a pre-post effect size of 1.55 standard deviations for the medication response and 1.16 SDs for the placebo response. A pre-post effect size of only 0.37 SDs observed in the no-treatment groups indicates that most of the placebo response was really a placebo effect, that is, it was due to the administration of the placebo. In contrast, most of the drug response was duplicated in patients given placebo. Specifically, about 50% of the drug response was due to the placebo effect, and 25% occurred in patients given no treatment at all (presumably because of such factors as regression towards the mean, spontaneous remission, and the natural history of depression). That left only 25% of the drug response as a true drug effect.

These data were seen as surprising and disturbing, and some critics (e.g., Klein, 1998) opined that these studies might not be representative. In response to this concern, my colleagues and I sought



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to replicate these data using a different set of clinical trials (Kirsch et al., 2002). Specifically, we analyzed the efficacy data sent to the FDA by the manufacturers of the six most widely prescribed antidepressant medications, which we obtained by using the Freedom of Information act. One of the advantages of the FDA data set is that it includes data from unpublished trials, thereby avoiding the publication bias that is found in the published literature. Indeed, the FDA data set revealed an even smaller effect of medication. Eighty-two percent of the drug response was duplicated by placebo, which means that only 18% of the drug response was due to the administration of the drug.

Another advantage of the FDA set data is that all of the studies included the same dependent variable,

**“Perhaps the potential loss of independence of scientific journals would be worth it, if the treatments were indeed effective.”**

the Hamilton Rating Scale for Depression (HAM-D). The advantage of this is that we could bypass calculation of effect sizes and look at the changes on this scale, changes that are easily interpretable clinically. Drug treatment produced a mean improvement of 10.13 points on the HAM-D, which is a clinically meaningful response. However, placebo treatment produced a mean improvement of 8.34 points, which is also clinically meaningful. In contrast, the difference between improvement on the active medication and improvement on placebo was less than two points on the HAM-D, which is not clinically meaningful.

As if this were not bad enough news, a recent meta-analysis of published trials of the use of antidepressants with depressed children shows an even smaller effect (Michael & Crowley, 2002). They reported that the effect size for drug as compared to placebo was 0.19 SDs. In the Kirsch & Sapirstein (1998) meta-analysis, which was limited to clinical trials of depressed adults, the drug-placebo effect size was 0.39 SDs. Thus, the effect of antidepressants on children is about half of that on adults.

Perhaps the potential loss of independence of scientific journals would be worth it, if the treatments were indeed effective. But the data suggest

that the most frequently prescribed psychotropic medications (i.e., antidepressants) are not effective. In contrast, their ability to produce serious negative side effects has been well established (Mulrow et al., 1999), and data suggest that they might increase the risk of suicide (Healy, in press). Thus, we may be trading our independence for the privilege of prescribing ineffective, but potentially dangerous, medications. □

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## COMMENTARY

### What History 103 can teach us about Psychopharmacology 102: A reply to Healy

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**Note:** The opinions expressed by the second author are wholly his own, and do not reflect the official policies or positions of the US Navy or Department of Defense.

Perhaps the most destructive notion in modern conceptualizations of mental and emotional illness is that these are purely diseases of the brain and that therefore direct manipulation of brain physiology represents both a necessary and sufficient cure. David Healy, like Thomas Szasz and R. D. Laing before him, provides a bracing tonic that should assist the field in moving beyond the simplistic philosophies that currently guide, and significantly undermine the effectiveness of, modern mental health treatments.

In his book *The Creation of Psychopharmacology*, Healy (2002) convincingly argued that psychiatry fell prey to the seductions of the pharmaceutical industry in large part because of a need to

be fully accepted as a true member of the medical tribe. If mental disorders have demonstrable organic etiologies and demonstrable organic cures, then psychiatry could shed the uncertain legacy of its psychodynamic past and become a legitimate branch of medicine. Certainly this search for acceptance as a bona fide medical specialty did much to influence the wholesale adoption of pharmacotherapy by modern psychiatry, but factors more subtle, and more clearly linked to the underlying schemata that guide psychiatric training, are equally at play.

A decade ago, Pies (1991) asserted that psychologists could never be trained to administer psychotropic medications because their intellectual heritage was rooted in *logos* (knowledge) rather than *iatros* (treatment). This is a rather bizarre argument on the face of it, flying as it does in the face of the long history of psychology in the clinical arena. But the argument becomes even more absurd when one examines the damage that wholesale adoption of allopathic medical cures has brought to psychiatry at the beginning of the 21st century. If modern psychiatry is, as Pies believed, a proud representation of a history of *iatros*, then psychologists should heave a collective sigh of relief that we have avoided these unfortunate antecedents.

We would, however, go further to assert that the training of psychologists, based as it is on the understanding of the scientific method, and emphasizing a holistic perspective, actually confers some immunity to psychologists, which will likely protect us from making the same mistakes of physicians. Hence we would disagree with Pies, and say that psychologists' training in *logos* actually better prepares us to administer psychotropic medication in the irrational world of psychopharmacology as characterized by Healy. Simply stated, our grounding in the scientific method makes us more skeptical than psychiatrists, and hence more likely to critically evaluate the evidence of safety, efficacy and effectiveness of psychopharmacological agents before we will prescribe them to our patients.

Sigmund Freud, despite his own training in neurology, once tartly observed that analysts should be neither priests nor doctors. This opinion reflected his discomfort over the incongruities of extensive allopathic medical training of psychiatrists who



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would not, under a dynamic model, be expected to rely on medical treatments. The impracticability of balancing the medical and psychological training of psychiatrists has, then, been recognized for many years, and, up until the recent past, this remained a lively and contentious debate among educators of psychiatrists. But it is clear that those who do not follow the allopathic medical model have lost. Because the fundamental training of psychiatrists is allopathic medicine, and because they have foresworn appropriate training in non-medical and non-allopathic methods of treating mental distress, the medical model has triumphed. This is most regrettable, because there is little evidence that the medical model, when applied to the treatment of mental ill-

***“Our science, like that of any other discipline, is less precise than we would like and less exact than we pretend it to be.”***

ness, has resulted in improvements in patient care. If modern psychiatric treatment can be said to have improved, much of the variance here is likely accounted for by the abandonment of inhumane and ineffective treatments. Here we are speaking of early somatic cures and prolonged institutionalization, (We acknowledge that the flight from the asylum was at least in part assisted by the development of antipsychotic agents like chlorpromazine, however, societal shifts demanding more humane treatment of the mentally ill was likely the driving force). Thus, improvements in psychiatric treatment cannot be said to have improved as a result of the development of truly effective cures. Psychotropic drugs palliate (and this is not a bad thing in spite of the protestations of psychologists opposed to prescriptive authority) but they do not cure. Our thinking about psychotropics becomes dangerously muddled when we regard them as curative agents. This leads to unfortunate clinical practice and a misallocation of resources seeking the “magic bullet.” Thus did psychiatry fall prey to the sirens of the pharmaceutical industry.

While the influence of the pharmaceutical industry on psychiatry is indisputable, both psychiatry

and psychology are influenced by cultural factors far more subtle than the marketing of psychotropics. Attitudes towards mental illness, the compensability of such illnesses via the disability system, the success of lawsuits regarding the infliction of mental distress, and the expansion of legislation mandating parity for the treatment of psychological and physical disorders are examples of the cultural factors influencing our conceptualizations of, and treatments for, mental illness. The expansion of diagnostic categories for mental distress under the DSM system has led to the unsupportable belief that we can provide increasingly specific treatments for increasingly specific diagnostic subtypes. Both psychologists and psychiatrists persist in this belief in spite of history that clearly demonstrates the susceptibility of the social sciences to fads in both diagnosis and treatment—fads that, as Healy argues, are often influenced by the marketing strategies of pharmaceutical firms.

So let us be pragmatic. Our science, like that of any other discipline, is less precise than we would like and less exact than we pretend it to be. But psychologists cannot wait for the perfection of a cure before we adopt it in clinical practice. Psychotropics, though their effects are usually nonspecific and their mechanisms of action incompletely understood, remain useful adjuncts in the treatment of many mental disorders. If we recall that they are simply that—adjuncts—we will not fall prey to misguided optimism as to their curative powers. If we accept their limitations, and at the same time strive to understand the mechanisms of nonspecific or placebo responses and attend carefully to this literature, we will have developed at least partial immunity to the seduction of the pharmaceutical industry and may indeed be able to lay claim to a truly psychological model of pharmaceutical service provision. □

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## COMMENTARY

### Comments on **Psychopharmacology 102**

**Matig R. Mavissakalian**

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The main message of Dr. Healy's article "Psychopharmacology 102," if I understood it correctly, is to caution psychologists against the overwhelming marketing/selling strategies on the part of pharmaceutical companies that risk turning them into prescribing agents of a "machine," like psychiatrists before them. He ends in a hopeful note, wishing that psychologists will be able to withstand this pressure... "for all of our sakes."

There is much that is true in what he says. Pharmaceutical companies are big business and their *raison d'être* is making a profit; the more the better, and lots of it. It is also important to be reminded of the limited, and at times inadequate, role played by the FDA. Certainly, industry's failure to disclose all available efficacy and safety data on products in development should not be allowed to continue for scientific, policy, and humanitarian reasons.

However, it is not sufficient to point the finger at pharmaceutical companies because they make a profit every time a prescription is filled. It is the profit motive of the professionals that is more important to consider in this context. That is, the investigators developing research mills to process innumerable drug trials, academicians agreeing to become spokespersons for pharmaceutical products, psychiatrists who restrict their practice to the more lucrative pharmacological management in association with current reimbursement contingencies, etc. And then, there is the business of classification and expansion of the number of authorized disorders to

be treated by clinicians which has led, at least in the area of anxiety and depressive disorders, to largely redundant, uninteresting clinical trials to establish indications for every conceivable disorder. This is not unfamiliar to psychologists who have seen the development and marketing of many similar manuals for cognitive behavioral treatments. Some entrepreneurs have even, under the guise of a huge, unmet need in the population, marketed self help treatment for general consumption, totally circumventing the clinical process.

Secondly, his treatment of the "evidence base" implying that inefficacious drugs are introduced into the market is misleading and the criticism that SSRIs were developed and marketed as antidepressants and subsequently received indications for the treatment of anxiety disorders is misplaced. In fact there may be too much evidence for efficacy, repetitive, at times contradictory, and yes, often presented in a biased self-serving way. But when all is said and done, it becomes clear that research has fulfilled its important mission, at least in the area of anxiety disorders, by providing clinicians with specific, effective treatment principles that currently include the serotonergic antidepressants, the benzodiazepines, and exposure-based cognitive behavioral approaches. Now, what vehicles are used to administer these principles, in what sequence or combinations, in what conceptual framework and dynamic context, is a clinical decision that should ideally be based on a critical unbiased interpretation of the evidence. This is the responsibility that individual clinicians have toward their individual patients.

Finally, it is not clear how this advanced course helps prevent the psychologists' insidious metamorphosis into pharmacologists. It is doubtful that they can resist the combined pressures from the marketing of pharmaceutical products and those of personal gain and greed better than psychiatrists. But if the real problem is the over-reliance on, and therefore, the over-utilization of drugs by psychiatrists, then there is hope, because in contrast to psychiatrists who have restricted their field to pharmacological management, psychologists will be expanding theirs, to include pharmacological treatments. The challenge they face will be of a different kind: overcoming their age old rivalry, even antago-



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nism to pharmacological interventions, gaining a real appreciation of the normalizing effects of medications, and developing and practicing a truly integrated psychobiological treatment approach. Because after all, only a treatment plan that is open to all of the evidence, evidence on efficacy but also on the relative and combined effects of psychological and pharmacological treatments, and on the moderators and mediators of therapeutic effects, can undo bias, balance excesses that come from advocacy based treatments, and provide optimal and economical care for patients. Then Dr. Healy's hope may come true "for all of our sakes" psychologists, psychiatrists, and above all, patients. □

### **COMMENTARY**

## **Who Can Challenge a Gadfly? Must Only Those Without Honoraria Checks Cast Stones?**

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 Dr. David Healy writes a compelling polemic about some of the issues facing clinical psychologists who are contemplating obtaining the privilege of prescribing psychotropic medications. Healy's paper concerns ethical issues pertaining to interactions between prescribers and the pharmaceutical industry, a topic of increasing controversy for psychiatrists and the rest of medicine. Much of Dr. Healy's paper centers on the following facts:

1) pharmaceutical companies make large profits from the sales of newer, patent-protected medications;

2) antidepressants are one of the most profitable products of this industry;

3) prescribers (like other consumers) are influenced by marketing and sales strategies;

4) there are clear limits to what can be expected from or ensured by regulatory agencies (such as the United States Food and Drug Administration) to protect prescribers from the pharmaceutical industry's various profit-motivated activities;

5) the exalted empirical basis of evidence-based medicine is often weaker than one might suspect; and

6) psychologists who prescribe are likely to encounter the same potential conflicts of interest and ethical challenges that other prescribers already face.

As is usually the case, Dr. Healy should be applauded for both his compelling prose and willingness to raise our consciousness about these important issues. Over the past few years he has become an increasingly outspoken critic, or gadfly, of the alliance between academicians and the pharmaceutical industry (hereafter referred to as Big Pharma). There is indeed a dark side to this relationship and much of what Dr. Healy describes does happen, although (it is this commentator's opinion that) the motivations, magnitude, propriety, and breadth of Big Pharma's trespasses are not as problematic as asserted in his editorial.

Before turning to several issues concerning rhetoric and presentation of fact, my own credibility as a commentator is tainted by long, productive, and profitable collaborations with Big Pharma. I have, have had, or will have, financial relationships with the manufacturers of every patent-protected medication used to treat depression or bipolar disorder. Thus, it is likely that some (or perhaps even all) of what I think and write on the topic of conflicts of interest is influenced by these relations. To the best of my knowledge, the editor who invited this commentary was not coerced or bribed (by Big Pharma) to invite my comments and I can assure you that in no way am I being compensated or otherwise reimbursed for this effort. Nevertheless, caveat emptor!

Pharmaceutical companies do influence physicians' awareness of certain conditions when

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there is a new product for that therapeutic indication. (Some unfriendly to Big Pharma have referred to this conduct as disease mongering.) Sales of antidepressants have tripled over the past decade. But, is florid overstatement needed to make this point? Dr. Healy states that the introduction of antidepressants has led to a one thousand-fold increase in the “apparent incidence” of depressive disorders. I do not know how this factoid was computed, but it must be recognized that a condition has zero incidence before it is recognized in the diagnostic nomenclature. For example, there were “no” cases of dysthymia or generalized anxiety disorder before the diagnoses were introduced in DSM-III (American Psychiatric Association, 1980), even though the problems of chronic depression and anxiety have

***“The FDA does not have a for-profit consulting arm that assists Big Pharma in circumventing the regulatory standards that it is proposed to enforce.”***

existed for as long as people have been able to record descriptions of their feeling states. Taking the data of Kessler et al. (1994) and working backwards, the current estimated lifetime risk of 17% for major depressive disorder would have had to have been 0.017% (i.e., roughly 2 per 10,000 adults) in 1956 in order to support Dr. Healy’s claim! While assuredly there were no diagnosed cases of major depressive disorder (the diagnosis did not yet exist), the rudimentary epidemiologic surveys of the day (e.g., Sroles et al., 1962) did demonstrate that there was plenty of misery in the general population before antidepressants were introduced, whatever you called it.

Dr. Healy does not point out that disease mongering is not limited to the pharmaceutical industry. Not-for-profit organizations are permitted to call this activity “raising public awareness.” The National Institute of Mental Health undertook a massive public relations initiative on depression in the 1980s (the Depression Awareness, Recognition, and Treatment program; Regier et al., 1988), as did the Royal College of Psychiatrists and the Royal College of General Practitioners in the early 1990s (Defeat Depression Campaign; Priest, 1994). I understand that the American Psychological Association

has similarly undertaken periodic public relations campaigns to educate the public about the beneficial effects of professional psychotherapy.

Human beings are creatures of effect and those effects are not simply monetary. Notoriety, career advancement, seeing one’s name in print, and doing ‘good’ are all potent reinforcers. Multidisciplinary groups and consumer-led organizations descend upon Congress annually to lobby for more funding to study and treat a wide range of health problems. Gadflies with decidedly antipharmaceutical leanings publish books and go on speaking tours to disseminate cautionary tales about disease mongering and other forms of industry excess. Is it really nobler to profit from warning the public about the problems of one profit-based industry than it is to extol the real benefits of treating a condition that can cause people to commit suicide, ruin lives, and cost society billions of dollars? Of course, it is possible that the World Health Organization’s (Murray and Lopez, 1996) pronouncement that depression is the fourth greatest cause of global disease burden was merely a marketing ploy orchestrated by Big Pharma. Perhaps, but then again, isn’t it also possible that the Church of Scientology underwrites some or even all antipharmaceutical activities?

Beyond exaggerating the impact of disease mongering, Dr. Healy’s passionate stance is buttressed by a fair amount of rhetoric. Here are a few colorful examples: that the FDA is to Big Pharma as Arthur Andersen was to Enron; that physicians are enticed by industry to “endorse one set of beliefs one month and almost precisely the opposite the following month;” or that Big Pharma will get psychologist prescribers “disbarred” from giving expert testimony because they are not psychopharmacologists. How about the eloquent, albeit unsupported claim that there are “good reasons” to suspect that pharmacotherapists can construct medicinal prisons in which their patients can be “abused systematically?” Please, Dr. Healy, none of this hyperbole advances this very important debate one inch.

In addition to the bias humorously revealed by using the sordid relationship between Arthur Anderson and Enron as the mother of all straw men, there are some important factual differences. Big Pharma does not employ the FDA; the latter’s capac-



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ity to audit is more akin to that of the IRS (in relation to our tax returns). The FDA does not have a for-profit consulting arm that assists Big Pharma in circumventing the regulatory standards that it is proposed to enforce. Mistakes do happen during regulatory review, but consumer groups are more likely to challenge the FDA's conservatism than its laxity. And, the US FDA did not approve the notorious fetus-malforming sleeping pill thalidomide, as implied, it was consumers who purchased the drug in Europe and brought it into the country.

The tragic tale of thalidomide is particularly interesting in relation to Dr. Healy's surprisingly quasi-libertarian rhetoric about consumers' former right to purchase medications without a prescrip-

***“Physicians’ treatments of choice do change over time, but not solely in response to the marketing efforts of the pharmaceutical industry.”***

tion. In the United States, consumers also formerly had the right to purchase farm laborers, scalps, and machine guns! Moreover, the right to poison oneself foolishly or accidentally with over-the-counter medicinals has never protected ill-informed prescribers from the consequences of mistreating their patients. A higher

standard of accountability is both expected and demanded of professionals entrusted to prescribe medications.

Physicians' treatments of choice do change over time, but not solely in response to the marketing efforts of the pharmaceutical industry. Evidence of efficacy, convenience, safety, and cost also play prominent roles. For example, numerous new antidepressants introduced in the early 1980s flopped commercially because they did not offer tangible advantages over the tricyclic antidepressants (TCAs), despite Big Pharma's best efforts to convince prescribers otherwise. It took some number of years for SSRIs to supplant TCAs for depression and even longer to replace the potent benzodiazepines for anxiety disorders. Finally, a psychologist prescriber will have no less right to give expert testimony on the witness stand than a physician who prescribes: the word expert is operative here and few prescribers (regardless

of discipline) are expert psychopharmacologists.

Another area of distortion involves the effectiveness of antidepressants, which are likely to be the psychotropics most commonly prescribed by psychologists. Dr. Healy cites the evidence that these medications have relatively small effects in randomized clinical trials. However, he overlooks other analyses of the same data sets (e.g., Khan et al., 2000; Walsh et al., 2002) that lead to somewhat different conclusions. Nor does he discuss the methodologic issues that affect this area of research (Klein, 1998; Thase, 2002a, 2002b).

The ability to prescribe is a privilege and, while still relatively uncommon, that privilege has been lawfully extended to some psychologists. As fledgling psychologist-prescribers may have already learned, there are subtle yet meaningful differences in what is required from clinicians who work with people variably called consumers, clients, or patients. I agree with Dr. Healy that the privilege to prescribe does come attached with critical responsibilities, although perhaps we disagree about which ones are of greatest concern. To bastardize an old surgical aphorism, the opportunity to prescribe also conveys the opportunity to injure. I have greater worries about a new prescriber's capacity to take a relevant medical history, to ask about other medications and anticipate certain drug-drug interactions, to monitor side effects closely, to orchestrate complex treatment regimens, and to distinguish between delirium and symptom exacerbation than I worry about the responsibility to be aware of, and to manage, potential prescriber-manufacturer conflicts of interest. To each their own! Having worked with physician's assistants and nurse practitioners for more than 20 years, I know that some nonphysician professionals become excellent prescribers. Having worked in close proximity to both physicians and the pharmaceutical industry for the past 15 years, I am also sure that ethical psychologist-prescribers will learn to manage the allure of Big Pharma's darker side in service of better care for their patients. □

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Robert H. Woody, Ph.D., J.D.

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**C - Psychopharmacology for Non-Physician Therapist**

Sheldon Whitten-Vile, M.D.

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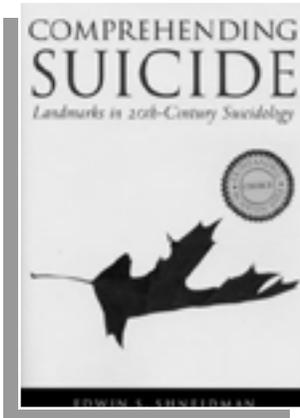
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# Book Review

Shneidman, E. S. (2001). (Ed.).  
*Comprehending suicide: Landmarks  
in 20th century suicidology*  
Washington, D.C.: American  
Psychological Association.

Reviewed by Lanny Berman, Ph.D., ABPP,  
Executive Director, American Association  
of Suicidology



Ed Shneidman has long held deep appreciations for historical antecedents, his teachers and mentors, and the multidimensional nature of his chosen area of study, suicide, all the while being the staunchest defender of the psychological perspective as the most relevant.

His study of suicide began serendipitously in the early 1950s when, quite by accident, he came across a suicide note at the Los Angeles County Coroner's Office. He later recollected that he immediately heard a favored professor's voice in his head reminding him of John Stuart Mill's "method of difference;" an experimental study of genuine versus simulated suicide notes ensued and a passion (no less, career) was born.

He credits his intellectual debt to Henry Murray who, in addition to being a life-long mentor, introduced Shneidman to treasure a diversity of views while on a year's postgraduate fellowship at Harvard in the early 1960s. This appreciation was no more apparent than when, while directing the Center for the Study of Suicide at the NIMH in the late 1960s, he convened a meeting on suicidology, a neologism he coined, comprised of several intellectual giants of that day, all older than 70. This group consisted of a philosopher, a statistician, a psychoanalyst, an educator, and three psychiatrists. Of note, Shneidman chose these participants purposefully, attempting to recreate a similarly comprised group that met in 1910 in Sigmund Freud's apartment in Vienna to discuss an alarming increase in suicides among the young (Friedman, 1967).

Now in his mid-80s, and dean of American suicidologists, Shneidman has produced his 13th book *Comprehending Suicide: Landmarks in 20th*

*Century Suicide*. In this volume Shneidman once again has gathered an elite group of astute observers, this time from throughout the century, each with a distinct, and in Shneidman's view, a "legitimate," perspective on suicide. Shneidman's goal is to be the reader's mentor and to share his passion for both the study of suicide and its historical context through the voices of others.

This volume is not a textbook in the traditional sense. It does not pretend to teach students all one needs to know about the very complex topic that suicide is. Rather, it is intended to stimulate insights and to appreciate those of our forbearers. It is a tasting menu prepared by a great chef who has been schooled, in turn, by great chefs. Moreover, it is an opportunity to sit at the knee of a master teacher who, himself, offers insights and observations on what we are about to read. Perhaps, in that sense, the more appropriate metaphor is to think of Shneidman as our docent in his own richly filled museum of suicidological treasures.

The heart of the volume is comprised of 13 excerpts from a century (1897-1997) of previously published books. These are organized into five sections: Historical and Literary Insights (2 chapters), Sociological Insights (3 chapters), Biological Insights (1 chapter), Psychiatric and Psychological Insights (4 chapters), and Insights on Survivors and Volunteers (3 chapters). Each excerpt is introduced by our guide who reviews the book from which the selection is abstracted, places the book and/or its author(s) in historical and biographical context, and, gives the reader some hints about how to appreciate the tastes that will be experienced. He then offers us a picture of the book's Table of Contents, and follows that with his preferred and reprinted selection.

Above all else, Shneidman is a scholar and the selections he offers us are eminently scholarly. His tour begins with Georges Minois's *History of Suicide*, a study of the past millennium which Shneidman urges us to use, as did George Abbott in writing *Flatland*, to think about yet other dimensions and future time. Anthony Alvarez's *The Savage God* is described as "lyrical" and "brilliant" in its exposition of a literary and existential, no less highly self-revealing, point of view.

Section II introduces the reader to Emile Durkheim whose late nineteenth century empirical and sociological masterpiece *Le Suicide*, perhaps the best-known text in Suicidology, was not translated



into English until 1951. Shneidman describes Le Suicide as both “Talmudic” and “endlessly fascinating.” Next is Louis Dublin’s *Suicide: A Sociological and Statistical Study*, an “elegant” look at social trends our docent tells us contains “wonderful surprises.” We finish this section with an introduction to Mamoru Iga’s *The Thorn in the Chrysanthemum: Suicide and Economic Success in Modern Japan* and an exhortation from Shneidman to both widen and deepen our understanding of suicide from a bicultural perspective.

Perhaps, the weakest link in this baker’s dozen of landmarks is the single chapter representing biology, Stoff and Mann’s *The Neurobiology of Suicide: From the Bench to the Clinic*; not because the selection Shneidman offers is anything other than the best, but because this is not where Shneidman’s heart and ardor reside. In his words, “What is true is my belief that the reductionistic biological analyses do not provide the lubricating

***“It is a tasting menu prepared by a great chef who has been schooled, in turn, by great chefs.”***

fluids for the essence of suicide. In the last analysis, I do not think that the key answers about suicide are to be found in the brain; I think the key action is in the mind.” (p. 73-74).

The section on psychiatric and psychological insights is replete with mixed messages of praise. For the psychoanalytic and psychodynamic perspective, we are introduced to Karl Menninger’s *Man Against Himself* and Maltzberger and Goldblatt’s *Essential Papers on Suicide*. This is a perspective that Shneidman respects for its intellectual, theoretical and historical impact, but concurrently makes known to us is contains “many ...Freudian orthodox-

ies...[that are] realistically beyond defense.” In contrast, Baechler’s *Suicides* and Aaron’s *The Inman Diary* are honored as (referring to the former) “one of the most insightful and analytic volumes on suicide that exists” and filled with (referring to the latter) “high scholarship.”

The concluding section focuses on more modern treatments of what was overlooked in earlier works, notably the impact of suicide on survivors and the significant role of non-professionals in the suicide prevention movement. Albert Cain’s now out-of-print *Survivors of Suicide* is “catalytic” in introducing clinicians to the dyadic pain created by suicide. Varah’s introduction to *The Samaritans* and Colt’s *The Enigma of Suicide*, written essentially for the lay reader, may seem out of place in this volume, but they are not, as they truly reflect Shneidman’s need for inclusion.

The apparent enigma in this “catholicity” of views is, perhaps, best explicated in the book’s epilogue *This I Believe*. Here, Shneidman tells the reader what he really thinks, i.e., that pain (“psychache”) is “key” to suicide and presents his own brand of psychological reductionism: “no psychache, no suicide.” But this is classic Shneidman. If nothing else and right up to his last paragraph, he has led us on a fulfilling and provocative tour, allowing us to appreciate the multifaceted breadth of his collection and, then unable to resist the opportunity, telling us that there ultimately are only “two basic questions in clinical thanatology: ‘Where do you hurt?’ and ‘How may I help you?’”

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- Human learning/cognitive
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 *The Clinical Psychologist* is a quarterly publication of the Society of Clinical Psychology (Division 12 of the American Psychological Association). Its purpose is to communicate timely and thought provoking information in the broad domain of clinical psychology to the members of the Division. Topic areas might include issues related to research, clinical practice, training, and public policy. Also included will be material related to particular populations of interest to clinical psychologists. Manuscripts may be either solicited or submitted. Examples of submissions include: position papers, conceptual papers, data-based surveys, and letters to the editor. In addition to highlighting areas of interest listed above, *The Clinical Psychologist* will include archival material and official notices from the Divisions and its Sections to the members.

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Inquiries may be made to the editor:

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