Chapter 2 illustrated that at any given point in the history of clinical psychology, the field is defined by a few topical issues, challenges, and controversies. The present is certainly no exception. The issues facing the field today have an undeniable influence on clinical psychologists and those with whom they work, and the way these issues are resolved will shape the field for decades to come.
Prescription Privileges

Historically, the ability to prescribe medication has been one of the primary distinctions between psychiatrists and psychologists. In fact, in the eyes of the general public, it is a defining difference between the professions (Balon, Martini, & Singareddy, 2004). However, in recent years, some clinical psychologists have actively pursued prescription privileges (Burns, Rey, & Burns, 2008; DeLeon, Kenkel, Gray, & Sammons, 2011; McGrath, 2010; Tryon, 2008). The roots of the movement were established in the 1980s, but in the 1990s and 2000s, it rose to the level of a high-profile, high-stakes debate. The American Psychological Association published numerous articles endorsing prescription privileges (e.g., American Psychological Association, 1996a) and offering suggestions for training of psychologists to become proficient in the knowledge necessary to prescribe safely and effectively (American Psychological Association, 1996b). In addition, several outspoken and prominent individuals have also promoted the movement toward prescribing, including Patrick H. DeLeon, a former president of the American Psychological Association (DeLeon & Wiggins, 1996); Morgan T. Sammons, a widely recognized expert on psychopharmacology and 1 of 10 psychologists who took part in the first experimental pilot program of psychologists prescribing medication (Dittman, 2003); and Robert McGrath, training director of the Psychopharmacology Postdoctoral Training Program in the School of Psychology at Fairleigh Dickinson University and president of the American Society for the Advancement of Pharmacotherapy (American Psychological Association, Division 55).

The prescription privilege movement scored notable victories when two states—New Mexico and Louisiana—granted prescription privileges to appropriately trained psychologists in 2002 and 2004, respectively. Many other states have given serious consideration to similar legislation in recent years. Other significant steps in the movement toward prescription privileges include the creation of the aforementioned APA Division 55 in 2000, as well as the psychopharmacology training programs available for psychologists in the U.S. military (Sammons, 2011). Nonetheless, the issue remains hotly debated, with significant numbers of clinical psychologists and worthy arguments on both sides (e.g., DeLeon, Dunivin, & Newman, 2002; Heiby, 2002).

Why Clinical Psychologists Should Prescribe

- Shortage of psychiatrists. In some parts of the country, there simply aren’t enough psychiatrists to serve the population adequately. Especially in some rural areas, there is a strikingly low ratio of professionals with the training and ability to prescribe psychoactive medications to the number of people who need them. In fact, when clinical psychologists successfully lobbied for prescription privileges in New Mexico and Louisiana, a cornerstone
of their argument was the low number of psychiatrists per capita in many parts of these two states (Long, 2005). Underserved segments of society would benefit from a higher ratio of prescribers to patients.

- **Clinical psychologists are more expert than primary care physicians.** Although psychiatrists have specialized training in mental health issues, they aren’t the only ones prescribing psychoactive medications. In fact, by some estimates, more than 80% of the prescriptions written for psychoactive medications come from primary care physicians (e.g., Cummings, 2007). When it comes to expertise in mental health problems, clinical psychologists’ training is more extensive and specialized than physicians’; therefore, clinical psychologists could be better able to diagnose problems correctly and select effective medications.

- **Other nonphysician professionals already have prescription privileges.** Dentists, podiatrists, optometrists, and advanced practice nurses are among the professionals who are not physicians but have some rights to prescribe medication to their patients. Their success in this activity sets a precedent for specially trained clinical psychologists to do the same. Especially when we consider that general practitioner physicians—whose specific training in psychological issues is limited—currently prescribe a high proportion of psychoactive medication, it seems reasonable to allow clinical psychologists to use their specialized expertise for the purpose of prescribing.

- **Convenience for clients.** Antonio is a 9-year-old boy with attention-deficit/hyperactivity disorder (ADHD). Angela is a 38-year-old woman with major depression. Antonio and Angela could benefit from both nonpharmacological interventions (psychotherapy, counseling, etc.) and prescription medications. Without prescription privileges, clinical psychologists can provide the therapy, but they cannot provide the medication. The result is that Antonio (and his parents) and Angela will both need to be referred to a physician, such as a psychiatrist, to be evaluated for medication. Of course, this increases the time and money that these clients must spend on appointments. In addition, it requires the two busy mental health professionals to communicate consistently with each other about their shared clients, and a misunderstanding between the two could result in complications for the clients. With prescription privileges, Antonio and Angela could get both their therapy and their medication from the same source—the clinical psychologist. From the client’s perspective, treatment is streamlined, saving both time and money. And the risk of problems due to miscommunication between professionals is eliminated.
• *Professional autonomy*. With prescription privileges, clinical psychologists can feel capable of independently providing a wider range of services to their clients. Without them, they may feel restricted in what they can accomplish for their clients. Of course, clinical psychologists should always strive to work collaboratively with other professionals involved in their clients’ treatment. But at the same time, with prescription privileges, their ability to treat the physical and psychological aspects of their clients’ difficulties autonomously, without relying on psychiatrists or other physicians, is greatly increased.

• *Professional identification*. In the eyes of the general public, psychologists may be difficult to distinguish from other nonprescribing therapists or counselors such as licensed professional counselors, social workers, and the like. The ability to prescribe immediately sets psychologists apart from—and, many would argue, above—these other professions.

• *Evolution of the profession*. Clinical psychology has undergone many significant changes in its brief history. It has incorporated many treatment techniques (e.g., therapy approaches) that were initially unfamiliar, and in the process, the profession has thrived. Embracing prescription privileges is seen by many as the next logical step in the progression. To stand in its way, some argue, is to impede the evolution of the field (DeLeon et al., 2002). Prescriptive authority could open multiple doors to professional opportunity for clinical psychologists, from direct pharmaceutical treatment of clients to consultation with physicians about psychoactive medications for their patients (Burns et al., 2008).

• *Revenue for the profession*. The profession and its members stand to benefit financially from prescription privileges as well (Cummings, 2007). The potential for increased income as a result of prescription practices may offset some of the salary decreases reported by psychologists in recent decades, including those occurring as a result of the impact of managed care (as reported by Murphy, DeBernardo, & Shoemaker, 1998). In fact, strong opposition to the prescription privilege movement has emerged from psychiatrist organizations, whose members stand to lose business if psychologists gain the ability to prescribe. And the scope of this business should not be underestimated: During the 1990s, the percentage of people in treatment for depression who received an antidepressant drug doubled, from 37% to 74%, and in 2007, antidepressants were the most commonly prescribed category of drug in the United States (Sammons, 2011).

**Why Clinical Psychologists Should Not Prescribe**

• *Training issues*. What kind of education should clinical psychologists receive before they are licensed to prescribe? What should it cover? Who should teach them? When should it take place? (Early in graduate school? During the predoctoral internship? As specialized training after the doctoral degree?) All these questions complicate the pursuit of prescription privileges. Some have argued that for a comprehensive understanding of everything involved in a prescription decision, the prescriber needs something close to full-fledged medical
school training. Only in this way could they appreciate the potential impact of a drug on the multiple systems of the body, the possibility of drug interactions, and all other medical factors (Griffiths, 2001; Robiner et al., 2002). Others have argued that with far less training, clinical psychologists could gain a basic competence in psychopharmacology (Resnick & Norcross, 2002; Sammons, Sexton, & Meredith, 1996). Most proposals fall somewhere between these two extremes, but the scope of pharmacology training for clinical psychologists is not entirely resolved. In fact, debates about current training standards are ongoing, with some arguing that pharmacologically trained psychologists are better trained in psychoactive medications than are the physicians and nurses who prescribe them (Muse & McGrath, 2010) and others strongly disagreeing, labeling psychologists’ training substandard (Heiby, 2010). Some have even promoted the notion that clinical psychologists should receive some training in psychopharmacology even if they don’t plan to prescribe, because without such training, they are unable to communicate effectively with medical professionals with whom they share clients (Julien, 2011). Moreover, the pragmatics of pharmacological training remain uncertain. If such training were added to existing graduate programs, it might extend them by many semesters. And many graduate programs in clinical psychology currently lack faculty with the expertise to teach these courses.

- **Threats to psychotherapy.** If clinical psychologists can prescribe, what will become of psychotherapy? Some have wondered if we will see a drift within the profession from “talk therapy” to pharmacological intervention. Clients may come to expect medication from clinical psychologists, and clinical psychologists may discover that prescribing is more profitable than therapy. The way psychologists understand and intervene with their clients may fundamentally shift from an appreciation of behavioral, cognitive, or emotional processes to symptom reduction via pharmacology. Some have pointed out that the profession of psychiatry has witnessed a drift of this sort and that clinical psychology could lose something of its essence if it does the same (McGrath, 2004; McGrath et al., 2004). As Cummings (2007) put it,

  Undoubtedly, the acquisition of prescription authority . . . would significantly expand the economic base of psychological practice. When that day comes, it remains to be seen, however, whether they abandon the hard work of psychotherapy for the expediency of the prescription pad. (p. 175)

- **Identity confusion.** Until all active psychologists prescribe (which, if it occurs at all, is certainly decades away), an identity crisis could emerge within the clinical psychology profession. Some clinical psychologists will prescribe, whereas others won’t. Some may have been trained during graduate school; others may have returned for specialized training long after they gained their doctoral degrees. Without an effective effort to keep the public educated about our profession, a client referred to a particular clinical psychologist may feel justifiably puzzled about whether prescription medication might be part of the treatment program.
• The potential influence of the pharmaceutical industry. Reports of drug companies’ attempts to increase profit—by offering gifts to prescribers, funding research, and controlling the publication of research results—have become widespread (e.g., Healy, 2004; Lane, 2007). Some opponents of the prescription movement have expressed concern that if psychologists prescribe, they will inevitably find themselves targeted by the pharmaceutical industry and will be pressured to consider factors other than client welfare when making prescription decisions. Some psychologists have gone so far as to call for formal professional guidelines to address how psychologists should interact with drug companies (McGrath et al., 2004).

**BOX 3.1**

**Prescription Privileges: What if You Were the Client?**

If you were the client, would you prefer that your clinical psychologist have the ability to prescribe medication? Does your answer depend on the amount or type of training the clinical psychologist has received? Or on the availability of other qualified prescribers (primary care physicians, psychiatrists, etc.)? Which of the pros and cons listed in the text have the greatest influence on your answer?

**Evidence-Based Practice/Manualized Therapy**

Like the prescription privilege movement, the movement in favor of evidence-based practice and manualized therapy has intensified in recent decades, as has the reaction to it. In fact, “few topics in mental health are as incendiary, consequential, and timely as evidence-based practices” (Norcross, Beutler, & Levant, 2006, p. 3; see also, Ollendick & King, 2012). Before we consider both sides of the argument, let’s consider a brief history of the factors that have led to the debate.

For many decades, researchers in the field of psychotherapy have sought to answer questions about its benefits, or how well therapy “works.” Hans Eysenck’s (1952) bold statement that therapy had no proof of positive outcome sparked much research on the topic, and this early wave of research basically proved Eysenck wrong—psychotherapy
was found to be quite efficacious (Smith & Glass, 1977; Smith, Glass, & Miller, 1980). However, much of this research was specific neither to any particular type of psychotherapy nor to any particular disorder; it simply supported the idea that therapy of any kind was more helpful than no therapy for people with any disorder. Subsequent steps in this line of research addressed more specific, targeted questions. Rather than asking broadly, “Does therapy work?” researchers began asking more specifically, “Which forms of therapy work best for which disorders?”

Take an insider’s perspective on the methodological differences between the more general and more specific types of therapy outcome studies. Imagine that you are one of the therapists involved in an early study on psychotherapy efficacy, perhaps in the 1970s. You and the other therapists are each assigned a certain number of clients and are instructed simply to provide therapy to them. The instructions are no more specific or detailed than that. As a result, the therapy done in this study varies widely from one client to the next and from one therapist to the next. This lack of uniformity between therapies is not a problem, though, because the aim of the study is simply to compare those receiving therapy of any kind with similar individuals not receiving therapy (the control group).

But this lack of uniformity between therapies would be a major problem in the type of therapy outcome study more common in recent years, such as a more targeted study on the effects of a specific form of therapy. In fact, if you designed this type of study, you would want to make absolutely sure that the therapy was somewhat uniform across all clients, even if different therapists provided it. After all, defining the therapy in exact terms is a prerequisite to demonstrating how effective that particular type of therapy is and offering a description of it to others. So rather than broadly instructing the study’s therapists to practice therapy, or providing a vague description of the category of therapy to practice, you would provide much more detailed instructions. In short, you would provide a therapy manual. One purpose of this manual is to keep variability between therapists to a minimum, such that if the technique proves effective, it can be shared with others in exact, unambiguous terms.

Since the 1980s, publications of this type of outcome research—how well a manualized therapy works on a particular disorder—have proliferated. As examples, researchers have tested exposure plus response prevention, a specific form of behavior therapy, for the treatment of obsessive-compulsive disorder; dialectical behavior therapy for the treatment of borderline personality disorder; and specific cognitive therapy techniques for the treatment of depression (Woody & Sanderson, 1998). In each of these cases, the specific therapy proved effective in the treatment of the target disorder, and the authors published their results in professional journals. As such published reports accumulated, Division 12 (Clinical Psychology) of the American Psychological Association created a task force to compile them into a list to serve as a reference for therapists who sought the most proven therapies for particular disorders. The therapies on this list were originally called “empirically validated” treatments, but the terminology soon
changed to “empirically supported” treatments and eventually to “evidence-based” practice (e.g., Kazdin & Weisz, 2003; La Roche & Christopher, 2009). This change in terminology is important because the current term, evidence-based practice, incorporates not only the particular treatment itself but also factors related to the people providing and receiving it. More specifically, evidence-based practice is defined as “the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 273). So research (often in the form of clinical trials of manualized therapies) is just a piece of the puzzle; the other pieces focus on the clinician’s knowledge and capability regarding the treatment and the qualities of the client (including culture and personal preferences) that could influence how effective the treatment will be (Norcross, Freedheim, & VandenBos, 2011; Spring & Neville, 2011).

The first list of empirically validated treatments was published in 1995, and updates appeared in 1996 and 1998 (Chambless et al., 1996, 1998; Task Force on Promotion and Dissemination of Psychological Procedures, 1995). A landmark book titled A Guide to Treatments That Work was also published around this time, with more detailed information about these therapies (Nathan & Gorman, 1998). In the years that have followed, numerous books of this type, offering chapter-by-chapter guides to “what works” for which disorders, have emerged (e.g., Carr, 2008; Roth & Fonagy, 2005).

Such lists of “therapies that work” have been celebrated by some as a major step forward for clinical psychology, legitimizing it as a scientific enterprise. Others have voiced concern or disapproval of the implications of evidence-based, manualized therapy.
up front. For example, we’d have to define the teaching techniques very specifically. We couldn’t simply compare, say, a “lecture-based” style with a “discussion-based” style, or a “laid-back” approach with a “high-pressure” approach—these descriptions are too vague. Instead, we would need to instruct chemistry teachers exactly how to teach—in other words, give them a manual with detailed instructions—to determine exactly what works and what doesn’t.

We’d also have to define up front the outcomes, or the results, of the teaching methods we’re examining. From our empirical point of view, objective and measurable results would be best. Scores on standardized chemistry exams might work well, for example. We certainly would want to avoid more subjective outcome measures such as, say, students’ level of interest in chemistry or the degree to which the course inspired a general passion for learning—these are simply too hard to measure reliably and validly.

Once we have our methods and outcome measures defined, we could run our “chemistry teaching experiment.” If the results demonstrate that a particular approach to teaching high school chemistry was in fact effective (especially if these results were obtained in multiple studies), we could share our results with high school chemistry teachers around the world. They, in turn, might adopt our “proven” method rather than use their own personal or idiosyncratic methods, which lack any such empirical support. Eventually, it is possible that all high school chemistry teachers would teach chemistry the same way, using the one method that has the most empirical evidence.

Like teachers, psychologists each have their own unique methods when practicing psychotherapy. But which methods are best for which disorders? Hundreds of empirical studies by clinical psychology researchers have addressed this question, using an approach similar to the one we considered above for teaching high school chemistry. First, the researchers defined the therapy in specific terms in a therapy manual and instructed therapists to follow it closely. They also defined therapy outcome in measurable, objective terms. Then they tested their manualized therapy with clients diagnosed with a particular disorder—for example, depression. When the results were positive, the researchers shared their results with other psychologists in journal articles, book chapters, or conference presentations. These psychologists, in turn, have the option of adopting this “proven” method with their own clients, rather than using their own personal or idiosyncratic methods, which

(Continued)
lack any such empirical support. Eventually, it is possible that all psychologists would treat depressed clients the same way, using the one method that has the most empirical support.

Champions of evidence-based treatment manuals see this movement as a significant step forward for the science of clinical psychology. In fact, some have argued that psychologists should use only therapies that have demonstrated empirical support and that to shun these approaches in favor of other approaches that lack empirical support is professionally irresponsible (e.g., Lilienfeld, Lynn, Ruscio, & Beyerstein, 2010; Lohr, Fowler, & Lilienfeld, 2002). On the other hand, some psychologists feel strongly that the push toward evidence-based treatments and policies that require their use overly restricts psychologists from customizing/personalizing treatments for particular individuals or is based on flawed scientific methods (e.g., Rosenfeld, 2009; Silverman, 1996), or that the problems clients bring to therapists are too idiosyncratic and span too wide a range to ever be captured by a catalogue of treatment manuals (e.g., Zedlow, 2009).

Again, think about your high school chemistry teacher and the thousands of others who teach the same material. If a single, manualized method of teaching high school chemistry had more empirical support than any other, should all high school chemistry teachers use it? If your chemistry teacher had taught “by the manual” in this way, how would your experience as a chemistry student have changed? Those of us whose chemistry teachers were incompetent may have learned more, but those of us whose chemistry teachers were uniquely innovative and effective may have learned less. The same questions, certainly, apply to the issue of evidence-based practice/manualized psychotherapies.

Advantages of Evidence-Based Practice/Manualized Therapy

- **Scientific legitimacy.** Before the emergence of manualized therapies with empirical support, clinical psychology might have been described by empirically minded critics as a “cottage industry” of sorts. In other words, each psychologist provided his or her own unique, “homespun” form of psychotherapy for a particular disorder. A depressed client who saw Dr. A might have received Dr. A’s idiosyncratic brand of therapy, but the same client might receive an entirely different brand of therapy from Dr. B, with the differences in treatment stemming from differences in training or the psychologist’s professional preference. Such inconsistency hardly seems appropriate for a discipline that calls itself a science. A more scientific, empirical approach to the treatment of depression, or any other disorder, requires that the discipline of clinical psychology determine a beneficial treatment
for the disorder and that members of the discipline uniformly practice that treatment. We expect such standards of treatment from medical doctors treating physical diseases, and if clinical psychology subscribes to the medical model of diagnosis and treatment, the same expectation should apply to our field as well.

- **Establishing minimal levels of competence.** Inevitably, if all clinical psychologists are allowed to practice their own unique brands of therapy, a few of them will be ineffective or even harmful to clients. However, as manualized, evidence-based treatments are disseminated and used by clinical psychologists, their presence ensures that a potentially incompetent or detrimental therapist will be educated in treatments with demonstrated effectiveness. Moreover, as these treatments evolve into professional standards, psychologists will be obligated to follow them to some degree. As a result, the public will receive a more consistent, proven brand of treatment for each disorder, and psychologists can be held to a greater standard of accountability (Sanderson, 2003).

- **Training improvements.** Just as therapy in a “cottage industry” can vary widely among psychologists, the training that psychologists receive can also fluctuate widely among graduate programs. As the list of manualized, evidence-based therapies grows, they can be incorporated into graduate programs. In fact, when the American Psychological Association makes accreditation decisions about graduate training programs, it does consider criteria related to training in evidence-based treatments (Lyddon & Chatkoff, 2001). The result is that upcoming generations of psychologists will have been educated in the therapies that have empirical data supporting their success with particular disorders. Some programs may emphasize evidence-based treatments more than others (Hebert, 2002), but all programs can benefit to some extent from their inclusion.

- **Decreased reliance on clinical judgment.** Clinical judgment can be susceptible to bias and, as a result, quite flawed (Dawes, Faust, & Meehl, 1989; Garb, 2005). When subjective, personal judgment of this type is applied to therapy decisions, the outcome of therapy can be compromised. Vrieze and Grove (2009) surveyed clinical psychologists about the way they make decisions in their practices and found that they did, in fact, rely much more often on their own clinical judgment rather than mechanical or actuarial judgment based on empirical evidence. To the extent that manualized therapies lessen the reliance on clinical judgment and replace these components of therapy with evidence-based techniques, outcome may be enhanced (Lilienfeld et al., 2010).

### Disadvantages of Evidence-Based Practice/Manualized Therapy

- **Threats to the psychotherapy relationship.** Although some of “what works” in therapy is attributable to specific techniques that therapists employ, a greater proportion of therapy’s success is due to the quality of the therapeutic relationship (or “alliance”) between the therapist
and the client (Norcross & Wampold, 2011a; Rosenfeld, 2009; Wampold, 2001). Therapy manuals typically don’t emphasize this relationship; instead, they tend to emphasize technique. In other words, they generally overlook “how” therapists relate to their clients in favor of “what” therapists do with (or to) their clients. A therapist who operates as a technician carrying out mechanical, predetermined methods can do a disservice to clients who seek a meaningful human connection (Sommers-Flanagan & Sommers-Flanagan, 2009). Soon after proponents of the manualized treatment movement published their landmark book *A Guide to Treatments That Work* (Nathan & Gorman, 1998), a group of highly esteemed psychologists responded with contrasting viewpoints in a book fittingly titled *Psychotherapy Relationships That Work* (Norcross, 2002), insisting that the therapist–client relationship should not be neglected but should be recognized and studied as a focal point of what makes therapy work.

- **Diagnostic complications.** Each evidence-based treatment manual targets a particular disorder or issue. Such specificity is at the heart of testing specific treatments for specific disorders. In fact, when manualized treatments are tested in clinical trials, the clients who are allowed into the study are those with the target problem—for example, panic disorder—and without other complicating factors. In other words, researchers typically strive to test their manualized therapies on clients with “textbook cases” of a disorder. But that’s not necessarily how clients present themselves in the real world of clinical psychology. In a private practice, a community mental health center, or a hospital, a client with panic disorder might also have something else—another anxiety disorder, a mood disorder, a personality disorder, or cognitive limitations, perhaps. This comorbidity means that the therapy that worked on clients with “clean” (i.e., uncomplicated) disorders in a treatment outcome study may not work as well on clients with more “messy” diagnostic features who commonly seek therapy from clinical psychologists in real-world settings (Angold, Costello, & Erkanli, 1999; Kessler, 1994; Zedlow, 2009).

- **Restrictions on practice.** To some, the evidence-based practice/manualized therapy movement has suggested that the only therapies worth practicing are those with empirical support (Lohr et al., 2002). In other words, if a therapy is not on the list of evidence-based treatments, it is unfounded and should be avoided. That is, “narrowly interpreted, evidence-based practice has become a rationale for mandating particular treatments” (Wampold, 2009, p. ix). In fact, some psychologists have used the term *malpractice* in reference to the act of using a therapy that lacks empirical support (Nathan & Gorman, 1998). In the “advantages” section above, a decreased reliance on personal, clinical judgment was praised, but if empirical support trumps personal decision making completely, the therapist’s role may include little more than the routine application of prescribed techniques. Such a job description may prove unsatisfying for many psychologists who seek autonomy and who rely on clinical creativity to customize their treatments, and it may not justify the extensive training they have obtained (Beutler, Kim, Davison, & Kario, 1996; Lebow, 2006; Rosenfeld, 2009). Also, because many treatment manuals emphasize brief (inexpensive) treatments, managed-care and health
insurance companies can use empirical support to argue that psychologists should practice
them exclusively, further limiting psychologists’ autonomy (Seligman & Levant, 1998).
Proponents of manualized therapy often respond that manuals get a “bad rap” of sorts:

We believe that manuals are mischaracterized when they are described
as rigid . . . specifying the components of the therapy does not have to
deprive a therapy of its lifeblood. At best, it can help everyone involved
come to understand what that lifeblood actually is. (Spokas, Rodebaugh,
& Heimburg, 2008, p. 322)

Indeed, within the larger debate over manualized therapy, the debate regarding the extent
to which strict adherence to manuals produces better outcomes also rages (Norcross et al.,
2006). Some studies have actually found that, compared with therapists who follow manuals
rigidly, therapists who demonstrate flexibility while using manuals are more successful in
terms of engaging clients in therapy and ultimately producing better outcomes (e.g., Chu &
Kendall, 2009). The option of flexibility, as opposed to required, rigid adherence, also helps
the clinicians themselves accept manualized therapies as a means of practice (Forehand,
for this balance between rigidity and flexibility regarding therapy manuals by referring to
training in musical instruments: It requires the learning of standard techniques but also
allows for (or even encourages) improvisation.

- Debatable criteria for empirical evidence. What should it take for a manualized therapy to
make the “empirically supported” or “evidence-based” list? Some have argued that the current
criteria are questionable or do not account for failed trials of a treatment (Garfield, 1996).
Others have argued that the criteria are biased in favor of more empirically oriented therapies
(e.g., behavioral and cognitive), while therapies that produce less easily quantifiable results
(e.g., psychodynamic or humanistic) are shut out (Lebow, 2006). Behavioral and cognitive
therapies do dominate the lists of evidence-based therapies, although other orientations are
also represented to a more limited extent (Norcross et al., 2006). In any case, the debate over
what constitutes empirical evidence will significantly affect which therapies make the list and,
in turn, how clinical psychologists treat their clients.

Since evidence-based practice and therapy manuals have risen to a place of prominence in
the field, many experts have begun to focus on the issue of disseminating these techniques
(Beidas & Kendall, 2010; Godley, Garner, Smith, Meyers, & Godley, 2011; McCloskey,
2011). In other words, it’s one thing to develop treatments that work but another to educate
therapists about them and persuade therapists to use them. Numerous strategies have been
employed, with varying results. Stewart and Chambless (2010), for example, found that
psychologists in private practice find case studies (i.e., detailed descriptions of a single
client successfully treated) more persuasive than research reviews (i.e., presentations of data
indicating that the treatment works). Stewart, Chambless, and Baron (2012) found that psychologists in private practice were more willing to undergo training in an empirically supported treatment if the training was brief (i.e., 3 hours) and inexpensive, as opposed to lengthy (i.e., 1 to 3 days) and expensive. Jensen-Doss, Hawley, Lopez, and Osterberg (2009) found that an organization that forces its clinicians to use evidence-based treatments, especially without any attempt to get clinicians “onboard” first, can encounter significant resistance and resentment. Even clinicians who are themselves psychotherapy researchers don’t always rank empirical research at the top of their list of factors by which to make clinical decisions (Safran, Abreu, Ogilvie, & DeMaria, 2011).

Despite the ongoing heated debate, evidence-based practice needs not be an “either/or” issue. Messer (2004) argues, “As practitioners, we cannot manage without nomothetic and idiographic data, findings based on quantitative and qualitative method, and a mixture of scientific and humanistic outlooks, which are psychology’s dual heritage” (p. 586).

BOX 3.3

Evidence-Based Practice/Manualized Therapy: What if You Were the Client?

If you were the client, would you prefer that your clinical psychologist adhere to an evidence-based, manualized form of therapy? Or would you prefer that the clinical psychologist ignore such techniques and allow nonempirical factors, including his or her own clinical judgment, to guide your treatment? Which of the advantages and disadvantages listed in the text influence your decision the most? To what extent would you welcome a compromise between the two positions? How would a clinical psychologist create such a compromise?

Overexpansion of Mental Disorders

As we discussed in Chapter 2 (and will discuss further in Chapter 7), the size and scope of the Diagnostic and Statistical Manual (DSM) has vastly increased since its inception in the 1950s. Correspondingly, the number of people with mental disorders has climbed—half of the US population is diagnosable at some point in their lifetime, and 11% of the population is currently taking antidepressant medication (Paris, 2013a). This climb in mental disorder rates goes by many names: overdiagnosis, diagnostic expansion, diagnostic inflation, diagnostic creep, medicalization of everyday problems, false positives, and in severe cases, false epidemics (Pierre, 2013; Frances, 2013a).
The authors of the DSM, including the current DSM-5 published in 2013, spend significant time and energy considering every proposed disorder. They review relevant research and solicit feedback from practicing professionals and the public before they decide to include any new disorder or change the criteria for an existing disorder. Among other concerns, they want to minimize the chances that people struggling with mental illness fall through the cracks, so they want to create a diagnostic manual that captures all of them. Obviously, they believe that any disorder that “makes the cut” to appear on the pages of the DSM truly deserves to be there. But their decisions have caused significant controversy among those who believe that many of today’s disorders actually capture normal life experiences—unfortunate or unpleasant experiences, certainly, but nothing that warrants a label of mental disorder. This was particularly true with DSM-5, which introduced numerous new disorders and which changed the criteria for some existing disorders in such a way that they would include more people (to be covered in more detail in Chapter 7) (Paris, 2013b). Among the criticisms about overdiagnosis that were offered about DSM-5 were these:

- “There has been no real epidemic of mental illness, just a much looser definition of sickness, making it harder for people to be considered well. The people remain the same; the diagnostic labels have changed and are too elastic. Problems that used to be an expected and tolerated part of life are now diagnosed and treated as mental disorder.” (Frances, 2013a, p. 82)
- “The danger of DSM-5 ideology is that it extends the scope of mental disorder to a point where almost anyone can be diagnosed with one” (Paris, 2013a, p. 41)
- “The more that psychiatric diagnoses appear to encroach on the boundaries of normal behavior, the more psychiatry opens itself to criticisms that there is no validity to the concept of mental disorders (e.g., there’s no such thing as mental illness—it’s a ‘myth’)” (Pierre, 2013, p. 109)

Concerns about the expanding definition of mental illness were around long before DSM-5 (Dobbs, 2013; Frances, 2013b; Horwitz & Wakefield, 2007). For example, excessive shyness that interfered with a person’s life was once considered an unfortunate personality characteristic, but since 1980, it has been included in the DSM as social anxiety disorder (Barber, 2008; Horwitz & Wakefield, 2012). But with each edition of the DSM, the scope of mental illness has expanded, along with the controversy surrounding it.

**New Disorders and New Definitions of Old Disorders**

This expansion of the scope of mental disorders happens in at least two ways: introduction of new disorders to capture experiences once considered normal, and “lowering the bar” for existing disorders such that more people meet the criteria. As examples of new disorders, critics might point to premenstrual dysphoric disorder (severe versions
of the symptoms of premenstrual syndrome, very common among women) or binge eating disorder (out-of-control overeating at least once per week), both of which appear for the first time in DSM-5 and which have the potential to describe large numbers of people. As examples of “lowering the bar,” critics might point to changing the age by which symptoms of attention-deficit/hyperactivity disorder must appear from 7 to 12, or changing the required frequency of binges in bulimia nervosa from twice per week to once per week, both of which are also DSM-5 innovations.

Whether the risk of overdiagnosis comes from a new disorder or a new definition of an old disorder, the consequences can be very real. A diagnosis can help some people with problems get treatment they need, but a diagnosis can also help some people with problems get treatment they don’t need—medications that have harmful side effects, or unnecessary therapy that undermines a person’s ability to use their own coping skills and could have been offered to someone else. A mental illness diagnosis can have many other effects as well: it can affect a person’s self-image via the stigma that some people attach to mental illness (“I’m mentally ill”) and subsequently their self-efficacy and overall wellness; it can influence how health insurance companies consider the person as a potential enrollee; and it can affect how a court of law views the person in terms of guilt regarding a crime or suitability for child custody (Caplan, 2012, Frances, 2013a, 2013c).

Of course, our discussion of the controversy surrounding overdiagnosis must include not only the diagnoses themselves, but the way they are used in the real world. In other words, it hardly matters what the DSM authors label as a mental disorder, or how they define them, if those who diagnose and treat clients ignore such information. There is at least some truth to this notion that practicing clinicians make diagnoses without detailed consideration of the precise definition of a mental disorder, and in some cases, they offer treatments whether or not a diagnosis has been made at all (Greenberg, 2013; Paris, 2013b). For example, 72% of people who receive a prescription for an antidepressant medication do not receive any mental health diagnosis (Mojtabai & Olfson, 2011). Other surveys of mental health professionals indicate that many rely more on professional experience, intuition, and “gut feelings” than symptom checklists to guide diagnostic decisions (Mishara & Schwartz, 2013). In these cases, overdiagnosis is as likely to stem from decisions made by the mental health professional who sees the client as from the mental health professionals who wrote the diagnostic manual.

The Influence of the Pharmaceutical Industry?

Increasingly, the overexpansion of mental health diagnoses has been connected, at least by some experts in the field, to the possible influence of the pharmaceutical industry. To be sure, big drug companies have a stake in the way mental disorders are defined, and to them, the broader the better. The more disorders there are, and the more they overlap with
the unfortunate experiences of normal life, the more potential customers these companies have to target their advertising toward (Sadler, 2013; Barber, 2008; Paris, 2013b; Pierre, 2013; Frances, 2013a).

As such, pharmaceutical companies might be pleased if those who write the DSM—the prominent research psychiatrists and other professionals who decide what’s a mental disorder and what’s not—were on their payrolls. A series of recent studies by Lisa Cosgrove and her colleagues found that a majority of them are. Specifically, Cosgrove et al. (2006) found that of the 170 panel members of DSM-IV, 95 of them, or 57%, had financial ties to the major pharmaceutical companies. Interestingly, on the Work Groups for mood disorders (e.g., major depressive disorder, bipolar disorder) and psychotic disorders (e.g., schizophrenia), disorders for which medication is extremely common, the number was 100%. The numbers were also high for other Work Groups in which medication is common, such as anxiety disorders (81%), eating disorders (83%), and childhood disorders (62%), but lower for Work Groups in which medication is more uncommon, such as substance related disorders (17%). The most frequent types of financial ties were research funding, consultant fees, and speaking fees.

In 2012, Cosgrove and Krimsky repeated their research for those working on DSM-5. The results indicated that the relationship between industry and authors remained. Overall, the percentage with financial ties to the pharmaceutical companies was 69%. In terms of specific Work Groups, psychotic disorders was 83%, mood disorders was 67%, anxiety disorders was 57%, eating disorders was 50%, and ADHD and disruptive behavior disorders (which covered much of the same ground as childhood disorders in DSM-IV) was 78%. Cosgrove and Wheeler (2013) have since gone on to argue that the pharmaceutical industry is trying to “colonize” psychiatry—that is, it is attempting to control the mental health field, beginning with a deep connection between its core diagnostic manual and their financial interests.

Do financial connections with drug companies really influence mental health professionals? Couldn’t the DSM authors make whatever decisions they thought were right, with no regard for any payment they may have received or may soon receive from a particular drug company? One study suggests that the power of such a financial arrangement can be remarkable. Carey and Harris (2008) studied the prescribing habits of psychiatrists in Minnesota and found that those who had received at least $5000 from pharmaceutical companies had written three times as many prescriptions for antipsychotic medication than doctors who had received none. Of course, clinical psychologists are not going to be affected in a major way by prescription rates; as explained earlier in this chapter, only a small minority have the ability to prescribe at all at this point. But clinical psychologists (and most other mental health professionals) use the DSM, and the notion that its disorders
were defined by people under the influence of financial relationships with pharmaceutical companies whose profits may depend on their decisions is troubling to many.

It is important to note that those in charge of DSM-5 did place some limits on its authors’ financial links to drug companies, in terms of the amount of companies’ stock they could own, and the amount of payment they received from the companies; however, neither of these was required to be zero (Greenberg, 2013). In spite of the evidence that shows that many DSM authors have financial ties to drug companies, and the increasing breadth of DSM disorders that lead to drug treatments, any direct influence on the DSM revision process remains speculative.

In Chapter 7, we will explore possible reasons for overexpansion of mental disorders and other issues involving the DSM-5 in greater detail.

Payment Methods: Third-Party Payment vs. Self-Payment

In the earliest days of psychotherapy, clients paid directly out of pocket. With time (and significant effort by professional psychologist organizations), health insurance companies increasingly recognized the worth of clinical psychologists’ practices and included them in their coverage. So today, although some clients still pay for therapy on their own, many use their health insurance/managed care benefits to pay for therapy at least partially. The presence of this third-party payer in the therapy relationship has numerous consequences (Reich & Kolbasovsky, 2006). Certainly, managed-care and insurance benefits bring therapy to many individuals who might not otherwise be able to pay for it. However, the companies who control these benefits are concerned about their financial bottom line as well as the health of their members, and at times, their priorities can strongly affect the work of clinical psychologists.

Effect on Therapy

It would be ideal if clients received the same treatment from psychologists regardless of how they pay, but a growing body of research suggests that this may not be true. Instead, it appears that managed care exerts quite an influence on the day-to-day practices of clinical psychologists. According to a survey by Murphy et al. (1998), psychologists in private practice describe managed care as having a negative impact on their practices and, more specifically, on the quality of therapy they provide. Most of these psychologists reported that their practices were affected by managed care, and, in general, they portrayed managed-care companies as exercising too much control over clinical decisions. Furthermore, their responses indicated that the managed-care companies’ emphasis on financial concerns
often made it difficult for them to provide appropriate, ethical psychological services. Confidentiality was specifically noted as an ethical concern. Psychologists can control firsthand the confidentiality of their own private files but not the clinical information they have been required to share with the insurance company. Additional surveys of psychologists have similarly concluded that most psychologists are affected by managed care and that the influences on their practices are generally negative (Rothbaum, Bernstein, Haller, Phelps, & Kohout, 1998; Rothstein, Haller, & Bernstein, 2000). From the psychologists’ point of view, the downside of working with managed-care companies can have many facets: lower pay than from clients who pay directly; taking time away from direct clinical work to spend on paperwork, phone calls, and other interaction with the managed-care company; denial of care that the psychologist believes is necessary; and numerous other frustrations (Reich & Kolbasovsky, 2006).

Should clients be informed about the negative influence of managed care? Put yourself in the client’s role: If you were seeking therapy and were considering using your insurance benefits or possibly paying out of pocket, would you want to know how your method of payment might influence your treatment? Of course, psychologists are required by the ethical code (American Psychological Association, 2002) to inform therapy clients about the therapy process as early as possible in the process, but the guidelines are vague about exactly what information they should include. An empirical study on the topic indicated that when they learned about psychologists’ negative reactions to managed care, many individuals thought more negatively about therapy than they had before. These individuals also felt entitled to know this information before beginning therapy (Pomerantz, 2000).

Of course, paying for psychotherapy without using insurance or managed-care benefits has its own drawbacks. First and foremost, many individuals would struggle to pay for therapy out of pocket, at least without reduced fees or services from low-cost community clinics. For a large segment of the population, self-pay is simply an unaffordable option (and the health insurance/managed-care option is what makes therapy attainable). For those who can afford it, self-pay therapy does allow the therapist and client to make important decisions—such as establishing the goals of therapy, agreeing on a treatment method, and determining when therapy should end—without the intervention of a third party with a financial interest.

**Effect on Diagnosis**

Although it should not, how clients pay for therapy not only influences therapy but also influences the diagnostic process. It is worth noting first that most health insurance and managed-care companies require a *Diagnostic and Statistical Manual of Mental Disorders* diagnosis for treatment (Ackley, 1997; Chambliss, 2000; Kutchins & Kirk, 1997). Typically, they will not pay for the treatment of issues that a client brings to therapy if those issues
do not qualify for a diagnosis. Thus, clients whose symptoms are not severe enough to be diagnosable may find that treatment will not be covered.

A few recent surveys have suggested that psychologists diagnose clients differently depending on how the clients pay for therapy. When psychologists considered clients with mild symptoms of depression or anxiety, they were much more likely to assign a diagnosis when these clients paid via managed care rather than out of pocket. The specific choice of diagnosis depended somewhat on payment method as well (Kielbasa, Pomerantz, Krohn, & Sullivan, 2004). Additional studies have suggested that for a wider range of problems, including symptoms of inattention/hyperactivity and social phobia (Lowe, Pomerantz, & Pettibone, 2007) or for symptoms that are clearly below diagnosable levels (Pomerantz & Segrist, 2006), psychologists’ diagnostic decisions depend on whether the client or the client’s insurance company pays for therapy.

The Influence of Technology: Cybertherapy and More

Like many other professions, especially in the health care field, clinical psychology has been significantly affected by technological advances in recent years (Dimeff, Paves, Skutch, & Woodcock, 2011; Kraus, Zack, & Stricker, 2004; Marks & Cavanagh, 2009). Particularly groundbreaking—and controversial—is the use of technological tools in the direct delivery of psychological services. Contemporary clinical psychologists can perform assessments and treatments via computer or smartphone as a supplement to, or instead of, traditional in-person meetings with clients (Eonta et al., 2011). This use of technology, and particularly the Internet, by clinical psychologists often goes by the name cybertherapy but is also called telehealth and telemental health, among other labels (Mohr, 2009; Yuen, Goetter, Herbert, & Forman, 2012). Cybertherapy and other recent applications of technology in clinical psychology and related professions have generated both enthusiasm and skepticism (e.g., Baker & Ray, 2011). Let’s explore various facets of this issue, including specific uses of technology, how well it works, and professional issues surrounding it.

Applications of Technology in Clinical Psychology

Today, technologically savvy clinical psychologists can use

- videoconferencing (such as Skype) to interview or treat a client;
- e-mail or text (in chat-room or one-on-one formats) to provide psychotherapy to a client;
- interactive Internet sites to educate the public by responding to questions about mental health concerns;
• online psychotherapy programs to diagnose and treat specific diagnoses, such as www.fearfighter.com for individuals with panic disorder or specific phobias;
• virtual reality techniques in which clients undergo therapeutic experiences, such as virtual exposure to feared objects;
• computer-based self-instructional programs designed as specific components of a treatment that is otherwise face-to-face; and
• hand-held devices (e.g., cell phones, iPhones, Blackberries, Droids) to monitor clients and interact with them on a regular or random basis between meetings with the psychologist (as described in Dimeff et al., 2011; Hsiung, 2002; Marks & Cavanagh, 2009; Yuen et al., 2012).

The applications of emerging technologies represent an exciting new horizon to many clinical psychologists. They promise to provide services to populations that have been underserved by clinical psychologists, including people living in poverty, in rural areas, or in war-torn/violent regions (Kraus, 2004; Nelson & Bui, 2010; Reger & Gahm, 2009). Maheu, Pulier, Wilhelm, McMenamin, and Brown-Connolly (2005) summarize the benefits of these technologies as “accessibility, affordability, anonymity, acceptability, and adaptability” (p. 10).

How Well Do Cybertherapy and Other Applications of Technology Work?

Because cybertherapy and other applications of technology are recent developments, the amount of data on their benefits to clients is quite small, and the methodology used to collect the data may be imperfect to some extent (Richardson, Frueh, Grubaugh, Egede, & Elhai, 2009). But the data we have are promising: Cybertherapy appears to work as well as more traditional, in-person forms of psychotherapy for a variety of disorders. Some studies have reached this conclusion regarding particular treatments for particular disorders. For example, Reger and Gahm (2009) found that cognitive-behavioral treatment of anxiety disorders was equally effective whether the treatment was delivered in person or via computer. Similarly, Spence et al. (2011) found that online delivery of cognitive-behavioral therapy to adolescents with anxiety disorders was as effective as face-to-face delivery. Numerous cybertherapy interventions focusing on health psychology are available (Castelnuovo & Simpson, 2011), and a review of the benefits of cybertherapies in this area found that effectiveness of interventions targeting pain and
headache were comparable to that of in-person interventions, but some other health psychology interventions were not as effective when implemented via computer as when implemented in person. Other researchers have come to broader conclusions about the relative equality of computer-based and in-person treatments of a wide range of disorders (e.g., Emmelkamp, 2011; Kraus, 2011).

Emerging Professional Issues

As clinical psychologists embrace new technologies and incorporate them into their practices, professional issues—including both the ethical and the practical—continue to arise (Koocher, 2009). In response, the profession is making efforts to ensure that the services provided are safe, effective, and ethical (Baker & Bufka, 2011). The American Psychological Association (2002) ethical code includes several updates designed to address the increasing use of new technological tools. Some experts in the field have also proposed ethical guidelines for psychologists practicing online, via videoconferencing, or through other similar means (e.g., Hsiung, 2002; Ragusea & VandeCreek, 2003).

Like the technologies themselves, guidelines regarding their use are continuously in the works. Some of these guidelines are simply extensions of the guidelines that govern traditional, face-to-face practice, whereas others are quite distinct. As the technology-based practice of clinical psychology evolves, those providing it should follow some fundamental suggestions (adapted from Barnett & Scheetz, 2003; Ragusea, 2012; Rummell & Joyce, 2010):

- Obtain informed consent from clients about the services they may receive, the technologies that may be used to provide them, and the confidentiality of the communication.
- Know and follow any applicable laws on telehealth and telemedicine.
- Know and follow the most recent version of the American Psychological Association ethical code, especially the portions that address technological issues.
- Ensure client confidentiality as much as possible by using encryption or similar methods. Keep updated on ways clinical information could be accessed by “hackers” and techniques for stopping them.
- Appreciate how issues of culture may be involved. As technological tools replace face-to-face meetings, psychologists may need to make special efforts to assess the cultural backgrounds of the clients they serve.
- Do not practice outside the scope of your expertise. Merely having a license may not be enough. Advanced training—either clinical or technological—may be necessary to use a particular technique.
• Be knowledgeable about emergency resources in any community from which your clients may seek services. A crisis related to suicide or psychosis, for example, may require an immediate face-to-face intervention that the psychologist is simply too far away to provide.

• Stay abreast of changes to the laws, ethical codes, or technology relevant to your practice.

As this list suggests, numerous specific ethical issues have arisen as the use of technology in clinical psychology has expanded (Fisher & Fried, 2003; Koocher, 2009; Kraus, 2004; Naglieri et al., 2004; Rummell & Joyce, 2010). These issues begin even before the assessment or therapy does, as the very identity of the client may be questionable. That is, how can the psychologist be sure that the client is in fact the person agreeing to the informed consent statement, responding to assessment items, or providing comments during online therapy? Even if identity is confirmed, the psychologist must be concerned with confidentiality across electronic transmission, making appropriate interpretations in the absence of ability to observe nonverbal cues that would be present face-to-face, and remaining competent regarding not only clinical but technical skills.

In spite of these ethical and pragmatic hurdles and a very short history, evidence is beginning to indicate that cybertherapy can be quite successful, and it is certainly becoming more widespread. However, it is important to remember that the effectiveness of a cybertherapy treatment can depend on a number of factors (adapted from Marks & Cavanagh, 2009):

• Which cybertherapy is being used for which disorder?

• On what device and via what means is the cybertherapy delivered? Computer, cell phone, smartphone, e-mail, text, videoconference, or something else?

• In what setting is the cybertherapy being delivered? Home, clinic, school, public setting (library, café, etc.), or somewhere else?

• How did clients find the cybertherapy? Did they receive a specific referral from a knowledgeable source or stumble across it on the Internet?

• Does the cybertherapy have live human support, and is that support monitored for quality?

Although many therapists remain wary of it and do not utilize it at all (McMinn, Bearse, Heyne, Smithberger, & Erb, 2011), the practice of technologically based therapy and diagnosis is undeniably on the rise and will probably remain so as technology improves and becomes more widespread. As it progresses, the current body of research
on cybertherapy’s effectiveness will certainly grow as well (Maheu et al., 2005), and the guidelines and training for its use will strengthen. Among the more interesting questions to be addressed will be the effect of technological tools on the client–therapist alliance (Rummell & Joyce, 2010). As we will see in later chapters, a strong professional relationship between client and therapist is crucial to any successful therapy. To the extent that therapy via e-mail, text, website, or videoconference can maintain or enhance that relationship, it stands to benefit the client.

CHAPTER SUMMARY

Several current issues and controversies dominate the contemporary field of clinical psychology. As a primary example, the issue of prescription privileges for clinical psychologists has emerged as a significant development in the profession. Those in favor of prescription privileges cite numerous justifications, including the shortage of psychiatrists in many geographic areas, other nonphysician professions that have obtained prescription privileges, convenience for clients, and autonomy for clinical psychologists. Opponents of prescription privileges cite difficulties related to training, medication as a threat to the practice of psychotherapy, identity confusion with the profession of clinical psychology, and the potentially negative influence of the pharmaceutical industry. The issue of evidence-based practice/manualized therapy has also stirred debate in recent years. Proponents point out that these treatments enhance the scientific legitimacy of psychotherapy, help establish standards of competence, and decrease reliance on therapists’ clinical judgment. Those who oppose evidence-based practice/manualized therapy emphasize that these therapies can threaten the therapeutic relationship, can overly restrict practice options, and may be based on empirical standards or specifically selected client populations that limit applicability to the broad field of psychotherapy. Overdiagnosis—also known as diagnostic inflation or the medicalization of everyday problems—has stirred significant controversy with each new edition of the DSM, especially DSM-5. Although the DSM authors follow a thorough process when deciding whether to label an experience as a mental disorder, critics argue that too often, they have included experiences that are unfortunate parts of normal life or have used criteria that set the bar so low that too many people qualify for the disorder. Consequences of an overly broad or loose definition of mental illness can include unnecessary treatment, stigma, and legal implications. How a client pays for psychotherapy—specifically, whether a managed-care/health insurance company pays the bill or the client pays independently—appears to have an impact on clinical psychologists and their work with clients. Especially in the private practice field, psychologists report
that their practices have been negatively affected by the increased involvement of managed-care companies. Evidence suggests that psychologists’ diagnostic decisions about clients can be significantly influenced by the presence or absence of a health insurance/managed-care company paying the bill. Recent technological innovations have expanded the range of tools that clinical psychologists can use to treat clients. Cybertherapy of various kinds, including videoconferencing, online therapies, e-mail–based therapeutic interventions, virtual-reality technology, and other forms of computer-aided treatment have all been successfully used. Initial outcome data are promising, but outcome may depend on a wide variety of factors related to the intervention, the delivery mode, and the setting in which it is used. Along with these new technologies have come corresponding ethical and professional issues, including informed consent, laws and ethics, confidentiality, and effectively managing client emergencies from a distance.

KEY TERMS AND NAMES

American Society for the Advancement of Pharmacotherapy (American Psychological Association, Division 55) 50
cybertherapy 68
dialectical behavior therapy 55
evidence-based practice 54
exposure plus response prevention 55
health insurance/managed care 66
manulized therapy 54
Morgan T. Sammons 50

Patrick H. DeLeon 50
prescription privileges 50
Robert McGrath 50
therapy manual 55
third-party payer 66

CRITICAL THINKING QUESTIONS

1. In your opinion, should clinical psychologists have prescription privileges? Why or why not?

2. In your opinion, is mental illness currently overdiagnosed?

3. In your opinion, to what extent should the use of evidence-based practice be required for clinical psychologists?

4. In your opinion, how much should clinical psychologists tell new clients about the impact that payment method (e.g., managed care/health insurance vs. out of pocket) might have on their diagnosis or treatment?

5. In your opinion, what are the most important advantages and disadvantages of recent forms of technology on the practice of clinical psychology?
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