

## **Drug Companies and Clinical Psychology**

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*This article argues that the pharmaceutical industry uses psychological techniques focussing on shame and guilt to sell its concepts and products to an ever-widening group of health care professionals. Clinical psychology shows signs of both joining and resisting this process.*

Drug companies have always advertised their products to doctors. The extent of such advertising can hardly be overstated: in 1996 \$450m was spent on drug company advertising in US medical journals and in 1997 sales of SSRIs rose to \$3billion per annum (Los Angeles Times, 23 August, 1997). Double (2001) has noted that many psychiatrists and junior medical staff actually receive their so-called training in psychopharmacology from drug company salespeople. In a review of 16 studies of interactions between doctors and drug companies, Wazana (2000) found that meeting with company representatives led to both positive attitudes towards such interactions and non-rational prescribing. In particular, attending meals paid for by the pharmaceutical industry led to increased requests for the drug promoted and receiving gifts from drug companies was found to correlate with the belief that such gifts did not influence prescribing practice. This is of particular concern because behaviour may be most influenced in those who do not recognise their susceptibility (Katz, 2002). Respondents to Wazana's review indicated that without drug company sponsorship, funding for activities such as training and research would not be available and suggested that it should be the degree of the practice, rather than the practice itself which is questioned (Tenery, 2000; Vollman, 2000).

The aim of any drug company or representative is to get more prescriptions for their drug: representatives are highly trained in sales techniques. Huthwaite International train sales reps to achieve 'Effective Social Influencing' at corporate events. One of the techniques they learn is persuasion. Reps are also taught to employ commercial influencing skills in other circumstances where the explicit aim of the interaction might not appear to be persuasion, for example by funding social events. Here, 'developing the relationship' is seen as preferable to 'closing a sale,' as the former is shown to lead to more sales of expensive drugs in the long term, (Huthwaite International). Further, the more time doctors spend with drug company representatives, the more likely they are to prescribe the newer, more expensive drugs (Wysong, 1998). While there is no evidence available about the impact of such interactions on professions without prescribing

powers, Ashmore and Carver (2000) suggest that the pharmaceutical industry recognises the importance of mental health nurses in influencing prescribing decisions and as potentially acquiring prescribing powers in the future.

This position is not dissimilar to that of clinical psychologists: a survey of American psychologists has revealed that over 50% referred between 21% and 60% of their clients for medication in the last year and that 60% saw prescribing as a logical extension of their current practice (Ramirez, 2002). This might, in part, reflect the fact that drug company-sponsored sessions are increasingly to be found at American Psychological Association events. Ashmore and Carver discuss how mental health nurses are exposed to drug company seminars with free refreshments, promotional gifts, such as pens, diaries and mugs, and advertising in professional journals. They raise the concern that as a consequence, nurses may be the recipients of information that has been found to be inaccurate and biased. Research cited by drug companies, for example, is only a fraction of that carried out, and it is invariably only the results that suit the vested interests of researchers or sponsors which appear. Further, a UK government publication, *Effective Health Care*, in reviewing the newest so-called anti-psychotic medication concluded, "Most relevant trials are undertaken by those with clear pecuniary interest in the results" (December, 1999).

Promotional gifts may also trigger the social tendency to reciprocate and maintain the product in awareness through the constant presence of a logo in the work environment. Clients too may be influenced by the presence of such promotional materials, and Ashmore and Carver describe them as a subtle form of direct to consumer advertising (currently illegal in the UK). Another similar form of tacit endorsement more pertinent to clinical psychologists is the drug company sponsorship of educational materials. The Psychotherapy Division of the American Psychological Association is currently involved in a joint venture with one of the large pharmaceutical companies to produce and distribute brochures on mental disorders (Galves, personal communication, January 14, 2003). Such materials, while apparently useful, may place an undue emphasis on medical models of causation and pharmaceutical forms of treatment as well as conveying a subtle message to the client about the attitude of their mental health worker towards their medication. It seems unlikely that drug companies would invest in providing training and promotional material to non-prescribing professions if they did not anticipate a return (Tenery, 2000).

Ashmore and Carver suggest that there is a need for mental health nurses to re-evaluate the nature of their relationship with the pharmaceutical industry, but also identify that it is difficult to establish open and honest debate about the influence of promotional material, as this would seem to be questioning

the integrity of those professionals who accept it. It appears to us that these concerns are of increasing relevance to clinical psychologists.

Local experiences In Shropshire pharmaceutical company reps had, until recently, been limited, within psychiatry at least, to sponsoring psychiatrist and junior doctor training. The past few years have seen a gradual infiltration of CMHTs. Away days and one off training events have been sponsored, as have been two consultation exercises on psychological therapy and primary care mental health strategy development. Indeed a draft proposal for a primary care mental health strategy includes the aim of partnership with drug companies to continue sponsorship. The rationale for such ventures is little different from that found for many years in primary care: "it does no harm", "it doesn't make us prescribe more", "nurses can't prescribe anyway", "why shouldn't we have some freebies - the doctors have had them for ages", "we can't afford training otherwise", "we can't afford lunches like these" and so on.

There is little argument against despite the weakness of these positions (can we really not afford Marks and Spencer sandwiches and a cup of coffee?) and the acute embarrassment shrouding the whole endeavour. Shame and embarrassment are key here. Drug companies carefully select young, clearly quite nice, salespeople who are hard to turn down, impossible to argue with and have an air of quiet solicitude that dis-empowers those who might not want their money or favours. They are often discreet (the psychological therapies' consultation event had a small, easily ignored, advertising stand), happy to join in with banter about the corrupting influence of Big Pharma and offer gifts that have little monetary value. This last has the paradoxical effect that it would appear churlish to turn down the proffered diary or, in one recent example, electrical extension cable (with logo).

Turning down gifts is immediately uncomfortable; it goes against a lifetime's conditioning for many. To quietly resist gifts is seen as rude. To publicly advocate avoiding drug sponsorship is seen as high-minded or just mad. A local qualitative survey of experiences within teams has resulted in some fairly self-explanatory categories of response: money talks, gifts gladly received, they're in each others' pockets, exceptions to the rule and more. It was noted that salespeople would find out the team secretary's name and then falsely claim to have a meeting to gain entry into the building. If the psychiatrists are not keen, then nurses are approached. Few team members of the team openly disagree with drug company sponsorship but those that do often do not reflect their views in their conduct, e.g., eating cake provided by the drug rep whilst protesting at the ideology behind the free food.

One psychologist reported that the team asked challenging questions of the drug reps, seeing the lunches as an opportunity to do this. The survey also revealed hypotheses of why gifts were more readily acceptable to non-

psychologists including the possibility that psychologists are perceived as affluent enough to refuse gifts and a question about the extent to which team members feel valued: are other staff so undervalued by their managers that they have to accept these gifts as an ego-boost?

Within another service, a record was kept by the first author of the degree to which drug company merchandise and involvement was present in the everyday functioning of the service. Over the course of a month examples of such involvement included: ~ The offer of four diaries, a computer mouse and two mouse-mats and a set of weighing scales from drug reps and colleagues with spares ~ Only drug company mugs being available to both staff and visitors to the service ~ A predominance of drug company stationery, including pens, desk organizers, post it notes, staplers, rulers and hole punches. Some items (such as post it notes and pens) were not available without drug company logos ~ If new stationery items were needed drug reps were approached to provide them as money was not available in the service budget ~ A conference on DSPD funded entirely by a drug company ~ Free snacks and sandwiches provided by a visiting drug rep ~ Offers by drug reps to fund team lunches out at possible conference venues or for special occasions ~ The suggestion that as money was not available from elsewhere that an away day could be funded by a drug company. This involvement occurred in the context of financial difficulties within the trust and a climate in which any expenditure was scrutinized and, where possible, avoided.

It seemed that drug company involvement was accepted as it provided a source of funding and resources that would not have been otherwise available, an argument that is often offered in defence of drug company involvement (Tenery, 2000). It is clear that in some services there is now confusion as to what might reasonably be expected from employers (e.g. stationery, training and so on) and what has never been provided as of right (lunch, coffee, mugs and pens). Choosing not to accept items that are provided by drug companies is difficult under such circumstances. The reactions of other staff to this position are unpredictable, as it carries implied criticism of their acceptance of the items. Other staff also often construe rejection of drug companies as a rejection of the use of drug treatments, not just the way that they are marketed.

**The future** Drug companies and their alliance with the psychiatric industry will continue to be profitable. The tricks of the trade are well known and highly successful. For example, promoting the positive benefits of medication in excess of the negative in the early years of production is replaced by emphasis on the search for better alternatives as the manufacturing license runs out. Inventing curable maladies for the essentially incurable condition of being human will continue to appeal to public and profit combined. Healy (1991), for example, has suggested that so-called panic disorder was over-

promoted by Upjohn in order to sell alprazolam. Similarly, the idea of preventable psychosis is heavily sold with drug company support for early intervention. And, of course, the industry is not beyond simple bribery (Braithwaite, 1984). There are, however, some signs that the industry is not having it all its own way: a review by Jorm (2000) remarks, "The public's view of psychotropic medication is almost uniformly negative, contrary to the views of clinicians and to evidence from RCTs."

Similarly, direct evidence from users is less positive than the industry might hope. Of 1400 people taking SSRIs surveyed on-line by the National Depression and Manic Depression Association 25% were still depressed, 40% lacked energy and 35% still didn't enjoy anything (NDMDA, 1999). Meanwhile the Agency for Health Care Policy and Research found in a meta-analysis of 338 SSRI trials that there was no difference between SSRIs (at \$66.41 per month) and tricyclics (at \$5.50 per month). Further, 32 % responded well to placebo alone. David Healy has achieved some notoriety for his work linking SSRI use to suicide (Healy, 2001). A local study (Grime et al, 2002) revealed that service users were sufficiently sceptical of drug company literature that they required information independent of industry influence.

There are notable critics of the power of the drug industry but they have tended to be psychiatrists (e.g., Breggin, 1991; Healy, 2002) and service survivors (e.g., Crepaz-Keay, 1999) rather than clinical psychologists (cf. Holmes and Newnes, 1996). Local resistance has included throwing drug company merchandise away and advertising the No Free Lunch website (actively promotes non-involvement of pharmaceutical companies and gives information on corruption in the industry). Managers and team members are regularly asked why they want the industry so closely involved when the industry has more than enough clout to ensure global advertising without being actively invited in. Team psychologists question the relationship between outcomes of pharmacological interventions and funding (in the same way that this is questioned of psychotherapy). People strive to be diplomatic about their views in order to maintain relationships with the rest of the team while not attending events funded by drug companies and explicitly stating this as the reason for absence. Such efforts are tiring and frequently swamped by the pro-drug lobby.

The whole is a good example of what David Smail has termed distal and proximal powers operating in tandem for the purpose of profit. Drug companies have sold the idea of depression as an illness to the extent that people rarely question that it might need treatment. The distal power of government lobbying and corporate marketing strategy results in people wanting the proximal power of medication to cure them. Similarly, the distal power of early socialization and the more proximal power of stressful working

lives make it unlikely that staff will resist the immediate power of persuasion and other techniques practiced by pharmaceutical company salespeople.

Clinical psychology needs to take note of these powers in the way it finds itself influenced by Big Pharma; from our approach to ideas like brain biochemical imbalances somehow causing distress relabelled as medical conditions to the more immediate dilemma of whether to accept pens and mugs.

## **References**

Ashmore, R., and Carver, N. (2001) The pharmaceutical industry and mental health nursing. *Mental Health Nursing*, 10, 1396-1402

Braithwaite, J. (1984) *Corporate Crime in the Pharmaceutical Industry*. London: RKP

Breggin, P. (1991) *Toxic Psychiatry*. New York. St. Martin's Press

Crepaz-Keay, D. (1999) Drugs. In C. Newnes, G. Holmes, and C. Dunn (eds) (1999) *This is Madness: A critical look at psychiatry and the future of mental health services*. Ross on Wye: PCCS Books

Double, D.B. (2001) Can psychiatry be retrieved from a biological approach? *The Journal of Critical Psychology, Counselling and Psychotherapy*, 1, 1, 27-30

Grime, J., Pollock, K., Newnes, C., Lillington, J., Hudson, M., Thomas, T., Mooniaruch, L, Baker, E., Mantala K., and Lewis, E. (2002) Medication Information Project. Shrewsbury: Shropshire PCT (see [www.shropsych.org](http://www.shropsych.org))

Healy, D. (2002) Conflicts of interest in Toronto. *Perspectives in Biology and Medicine*, 45, 2, 250-63

Healy, D. (2001) The SSRI suicides. In C. Newnes, G. Holmes, and C. Dunn, (eds) (2001) *This is Madness Too: A further critical look at mental health services*. Ross on Wye: PCCS Books

Healy, D. (1991) The ethics of psychopharmacology. *Changes: An International Journal of Psychology and Psychotherapy*, 9,4, 234-247

Jorm, A.F. (2000) Mental health literacy: Public knowledge and beliefs about mental disorders. *The British Journal of Psychiatry*, 177, 396-401

Katz, D. (2002) The agony and ecstasy of free lunch. The American Journal of Bioethics NHS Centre for Reviews and Dissemination (1999) Drug Treatment for Schizophrenia. *Effective Health Care* 5, 1-12

Ramirez, B. (2002). Dissertation submitted for Doctorate in Clinical Psychology, Wright State University, retrieved November 10, 2002 from the World Wide Web

Tenery, R. (2000). Interactions between physicians and the health care technology industry. *Journal of the American Medical Association*, 283, 391-393.

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

Wysong, P. (1998) Time with drug reps affects prescribing: study. *The Medical Post*.