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TEXAS psychologist

The Tragedy of the Virginia Tech Massacre: Legal and Ethical Considerations

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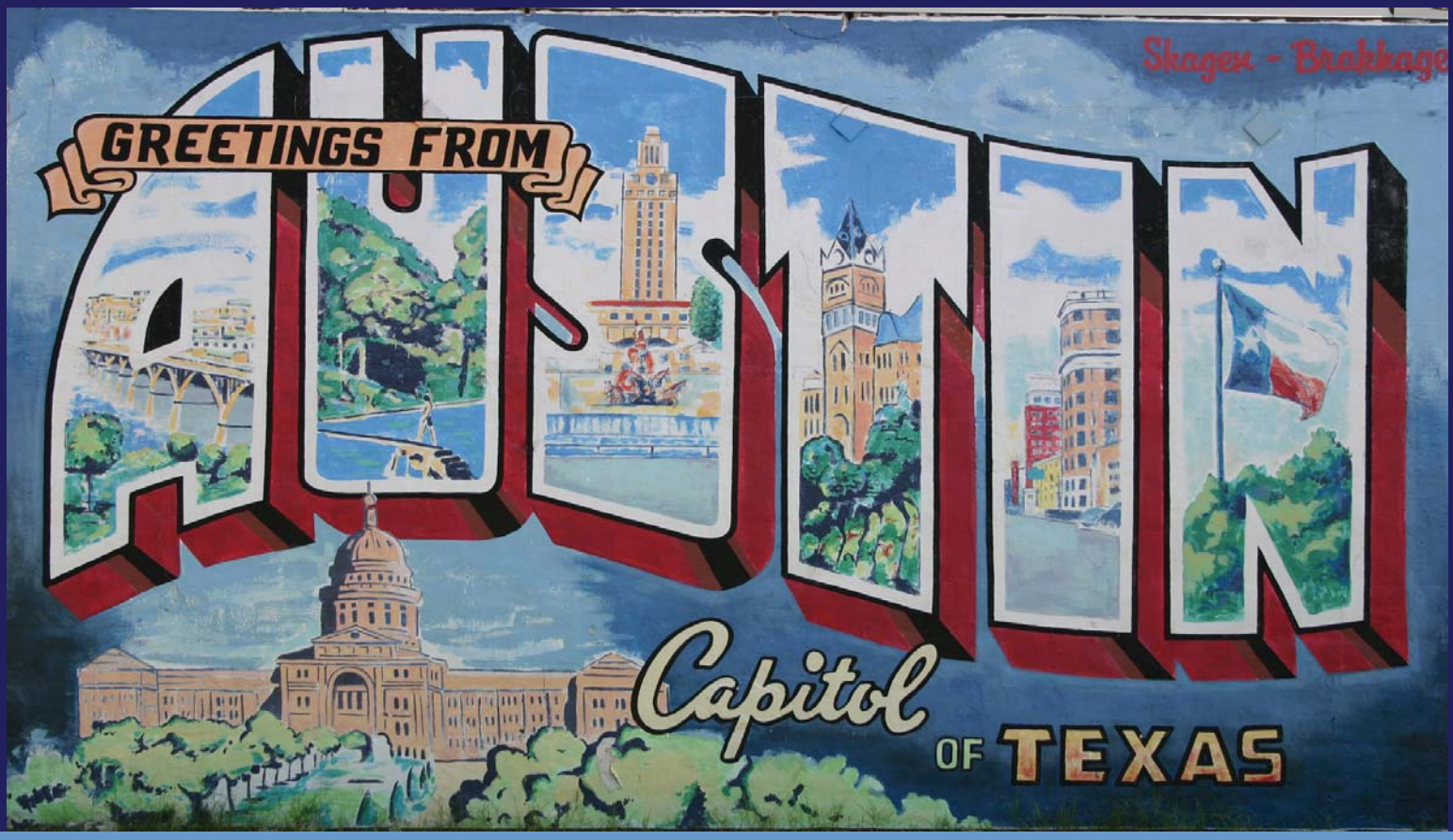
Texas Psychological Association Annual Convention



Texas Psychological Association Annual Convention

Maturing as a Profession

November 20-22, 2008
Hyatt Regency-Austin

Registration, programming, hotel reservations information will be posted online at www.texaspsyc.org as it becomes available (updated daily).

Invited speakers include: Drs. Glenn Ally (RxP), Judith Beck (personality disorders), Ira Iscoe (prevention), Nadine Kaslow (supervision), Katherine Nordal (APA), Doug Snyder (marital therapy), Melba Vasquez (ethics)

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FEATURES

DEPARTMENTS

TOP 10 List

The category is "The top 10 People who Influence your Practice and/or Profession". Who would be on your list? If you take some time and really think about this question, I am sure you could come up with more than 10 people. Therefore let's expand this list and allow you to list your top 50 people who have the most influence in your practice and/or profession. I am sure your list includes your colleagues or other medical health professionals that make referrals to your practice, the editors and reviewers who read your papers, or the referees who evaluate your grant proposals. I hope you had on your list your colleagues and individuals on TSBEP and your state and congressional legislators that represent you.

Did any of you put the following names on your lists? Shirley Higuchi, JD, David Ballard, PsyD, MBA, Randy Phelps, PhD, Daniel Abrahamson, PhD, Luana Bossolo, Marilyn Richmind, JD, Alan Nessman, JD, Peter Newbould Geoffrey Reed, PhD, Ron Palomares, PhD, Diane Pedulla, JD, Margie Schroeder. How about Paul Burney, PhD, Sanford Portnoy, PhD, Katherine Nordal, PhD, Ron Cohorn, PhD, Suzanne Mouton-Odum, PhD or Deanna Yates, PhD. These, and others, are individuals that have devoted their life either as their full time job or as a dedicated volunteer. All of them have sacrificed much of their time and energy to advocate and advance the profession of psychology.

Many of the names above are your colleagues that work in Washington DC at the APA Practice Directorate or serve on the Committee for the Advancement of Professional Psychology (CAPP). I hoped you recognized your own Texas colleagues Dr. Ron Cohorn, President of TPA; Dr. Suzanne Mouton-Odum, President of Texas Psychological Foundation and Dr. Deanna Yates, President of Association for the Advancement of Psychology in Texas. I would say that I if these people did not make your "top 50 list"; they should have.

These people shape how the future of psychology will be practiced in Texas. Think about this. The Practice Directorate has approximately 45 employees. You might belong to a couple of APA division that might employee 2-5 individuals. Assuming you belong to 1 or 2 specialty psychology organizations (2-15 staff). Add the TPA staff (2-3 staff); your local chapter (1- staff at most). Remember to add the volunteer leaders who do most of the heavy lifting to make these groups work (10-20 overextended individuals). My point is this: outside your direct contacts, if you really think about the individuals that "influence your practice and the direction that psychology is heading", many of them are individuals that work for non-profit psychological associations and/or volunteers.. And to further highlight the importance of these folks, I would venture to say that your list did not exceed 75 or 80 people. So, less than 80 people have the responsibility of advocating for your needs and desires and to shape the future for YOU.

AND THE # 1 PERSON...

Who is at the top of your list? I know that everyone's list is different, but the # 1 person MUST be the same on every list…..the # 1 person that influences your practice and or profession is….YOU! You, and only you, have the greatest influence on the future. My recent article in the Texas Psychologist asked if you were successful. I defined success as getting involved and making a difference. I encouraged you to get involved in TPA. The first, and perhaps most powerful means of getting involved is to ask questions. Look at your professional environment and ask why and why not. You have only 80 people that are going to determine your fate as a psychologist. Don't sit on the sidelines.Call anyone that influences you and your practice and find out what is going on. Your colleagues who have committed their time to volunteer are shaping tomorrow, they welcome your thoughts.

CAPP

I am so very fortunate to represent Texas and all the other state psychological associations on CAPP this year. As the only non-psychologist I have an unusual opportunity to learn what is being done for you at the national level. I have just returned from my first meeting and was overwhelmed by the incredible staff in Washington DC, that everyday with unwavering passion, advocates for you. Their talents and expertise open doors and opportunities for each one of you. Let me highlight some of their accomplishments.

Geoffrey Reed, PhD, a former APA employee and now APA consultant, has been invited by the World Health Organization (WHO) to serve as the primary coordinating person for their core revision team which is tasked with revising the International Classification of Diseases and related Health Problems, Tenth edition (ICD-10). This is an unprecedented opportunity for psychology as such a role has been reserved for psychiatry.

Marilyn Richmond and Peter Newbould and their staff, lobbied congress to delay an across-the-board 10.1 percent cut in Medicare reimbursement scheduled for January 1, 2008.

Shirley Higuchi, JD and her staff help psychologists claim their share of the a 3.5 million nationwide class action lawsuit settlement by Humana. This settlement, along with the settlement with CIGNA has yielded $15 million in total settlement to date.

Randy Phelps, PhD along with the APA Practice Directorate co-sponsored the tenth annual Department of Veterans Affairs (VA) Psychology Leadership Conference, where participants focused on improving mental health services for veterans.

Marilyn Richmond and her staff were instrumental in negotiating successfully with insurance and business to pave the way for the Senate to successfully pass the Mental Health Parity Act of 2007.

To help serve the Hispanic population APAPO staff launched a new Spanish-language WEB site, Centrodeapoyoapa.org.

Luana Bossolo and her staff released the results of its 2007 "Stress in America" survey of attitudes and perception of stress among the general public. USA Today, The New York Times, NBC Nightly News, The Today Show were among the hundreds of media outlets that covered the survey finding.

Marilyn Richmond and her staff continue to work with CMS Centers for Medicare and Medicaid Services (CMS) to enhance psychology's opportunities to participate in Medicare's pay for reporting program. The Physician Quality Reporting Initiative (PQRI) offers eligible health care professionals a 1.5 % bonus in all Medicare claims for reporting on a set of identified measures. In addition, they have increased the measures that could be reported by psychologists under the PQRI from one in 2007 to eight in 2008.

Luana Bossolo and her staff has launched APA's 2008 Practice Education Campaign which focuses on Mind/Body Health. This effort teaches individuals to recognize the importance of caring for both their mind and body and take proactive steps to promote whole-body health. This effort has lead to the partnering with National Council of YMCA's of the USA (YMCA) to address health and wellness programs. Psychologists will be asked to collaborate with the YMCA to reach women and families with information about stress, lifestyle and behavior and disease prevention with the goal of improving health and well-being.

Shirley Higuchi, JD and her staff launched a Parenting Coordinator Program with the Family Court of the DC Superior Court. Parents and children attend a Saturday parent education class when entering the courts system with a custody dispute. If parents are not able to resolve their issues in a subsequent mediation, their case may be selected for more intense involvement with the Parenting Coordination Program.

[And we haven't even mentioned your state legislators and the often underpaid professionals at the many governmental agencies that facilitate or impede your practice.]

WELCOME NEW MEMBERS

January 1 – April 21, 2008

Members

Thomas Cook PhD
Samuel Dutton PhD
Michael Gilhousen PhD
Darielle Greenberg PsyD
Sherry Hess PhD
Shawn Jeffries PhD
Lynelle Lynn PsyD
Amite Milner PhD
Karen Nelson EdD
Noel Nick PsyD
Debra Quackenbush PhD
Barbara Sanford PhD
Julie Schmitt Gersch PhD
Keith Stirrup PhD
Barbara Yonan PhD

Associates

Karen Brochue MA, LMFT, LPC

Students

Vanessa Avina
Krystal Blankenship
Andrea Bradford MA
Nicolina Calfa MA
James Carter-Haith MS
Jill Chrisman PhD
Suzannah Creech PhD
Kelly Dardeen MS
Valerie Dunbardo
Denise Ellinger
Raquel Estrada Gonzalez MA
David Heckler MS
Amanda Hench
LaShondra Jackson MA
Ashley Jefferson
Lauren Jordan MS
Jessica Martin
Erin McCrory
Melaney McShan MEd
Alfonso Mercado
Rachael Phillips
Jacqueline Rosckes
Jennifer Rush
Syreeta Scudder MS
Randi Shreve
Amanda Smith MEd
Jacquelyn Strait MA
Bryce Summers MEd
Leana Talbott
Blythe TwoSisters
David Wilson
Matt Wolff
Jennifer Womack

Too often we focus on the short view, whether we fear immediate threats to our practice (such as sex offender treatment legislation, the encroachments of managed care, etc), or we hope for opportunities to improve services (programs for the disadvantaged, new innovations in science, or prescriptive authority). We're absorbed in foreground battles but occasionally we take a longer view. Pondering the future, we reflect on our roots.

This comes to mind because Jack Jernigan passed away. Many readers won't remember Jack--- Early Career Psychologists (ECPs) weren't born when Jack was president of TPA in 1973---but he was pivotal in building psychology's professional status in Texas.

Jack graduated from Whitewright High School just before WWII. Picture a 26-year old veteran, just back from military service, newly married, and (in his own words):

In April 1947, an enticing bulletin board announcement at the McKinney VA caught my attention..."Training Program for Clinical Psychologists Associated with Part Time Work in VA Stations where Neuropsychiatric Patients are Treated"…Students selected for the training program were hired by the VA and detailed to VA hospitals near an approved university. ….. First year Interns received 22/40 of the full time salary of $2644.80.

Uh, that salary works out to $1455 per year. Jack achieved his PhD in Clinical Psychology through the joint Veterans Administration - University of Kentucky program and returned to Texas in 1952. Over his career he trained and worked at four VA Hospitals and eventually he retired as the Chief Psychologist at Dallas VA Medical Center after 28 years of service.

Jack was president of TPA shortly after Texas established licensure for psychologists. His genial wisdom and enthusiasm were essential for the growth of TPA. Speaking to Tom Lowry, he recalled that "there was a kind of subtle but meaningful social interaction at the executive meetings that really served to unify the whole state of psychology when these people would go back and talk to their local people. In other words, they would bring the wealth of information and diversity to TPA, and then it would get kind of blended together and would get dispersed back to the local areas, So TPA was a unifying force in that respect."

Much changed since Jack's tenure. We have freedom of choice (ECPs: ask your elders how much this mattered) and expanded roles in many arenas. On the other hand, we no longer have the funded support for clinical training that Jack found, and our professional identity remains under siege from all sides. The public readily accepts the usefulness of mental health services but we struggle to find resources to extend services to areas of greatest need. As ever, TPA remains the only voice in Austin that advocates for a professionally sophisticated, scientifically grounded psychology. Jack's dreams flourish when we unite the many interests of psychologists to better serve our state and its citizens. Thanks for setting the bar, Jack.

Texas Psychological Foundation Contributors

Donations received January 1 – April 21, 2008

$500-$999
Manuel Ramirez

$250-$499
Elizabeth Richeson

$1-$100
Barbara Abrams
Keith Barton
Jo Ann Bradshaw
Ray Brown
Sam Buser
Gary Chase
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Jim Cox
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Catherine Matthews
Charles McDonald
Brenda Meeks
Joseph Moore
Karen Nelson
Manuel Ramirez
Ollie Seay
Vicky Spradling
Collen Walter
Richard Wheatley
Connie Wilson

What's in a name?

Most people take great pride in their family name and some spend years researching their ancestry. In our early history, a man's good name was often the only main source of family pride and was fiercely protected. In the miniseries, "Return to Lonesome Dove", the value of a man's name was expressed during the end of the series. Captain Call finally recognizes his illegitimate son, Newt, and gives him his name by saying, "Call, It's Irish and as far as I know has no marks against it".

Psychologist, alone or with modifiers such as Counseling, Clinical, Neuro, Rehabilitation, Forensic, Gero, Health, or Experimental is a source of pride for individuals who have attained the title. We have protected and guarded this title against dilution and modification. The leadership of TPA has made defense of this title the most significant priority in legislation and/or policy change. I have watched in the past as several attempts have been made to make our title available to those who are not doctorally trained. We have not stood in the way of others practicing according to their training, but have resolved to maintain the doctoral standard for psychologists and to keep the name free of any marks.

We are aware of a possible request for rule changes where the term Neuropsychologist could be used by non-doctoral practitioners. In researching this area I have found there are three generally recognized areas for using the term Neuropsychology. The first is by attending a Neuropsychology training program. The second is by completing an internship in Neuropsychology, or third, passing the ABPP Board Certification as a Neuropsychologist. This is an area where TPA is working to promote the interests of a specialty group and at the same time protecting the doctoral standard. The membership committee is actively recruiting a Neuropsychologist and I am personally inviting all qualified in this area to join TPA.

The cornerstone of our legislative agenda will be protecting the doctoral standard. Since it serves as the foundation for our identity as psychologist, it is also of paramount importance for any future legislation involving hospital access, prescription privileges or other responsibilities involving the extensive training and experience implied by the title psychologist. David White, Dr. Dee Yates and Dr. Rob Mehl have been working on a quick response grassroots network and this system is now being put in place. We will be ready to react and respond to protect our good name. We can't do it without your active support, so please be ready to pitch in!

The cornerstone of our legislative agenda will be protecting the doctoral standard.

News from AAPT

Deanna F. Yates, PhD, AAPT President

Sometime in the next few months you may be receiving a phone call from TPA. The call will be from a regional grassroots coordinator asking you to help TPA in its legislative efforts. There are many different ways in which you could help. You may be asked to serve as a key contact to one of your state legislators. As a key contact you would be expected to do things such as: keep in contact with your legislator by visiting him/her in the district office, take him/her to lunch or help with his/her campaigns. Basically, you would be the psychologist that both apprises the legislator of TPA's legislative agenda and be the mental health representative for that legislator to go to when he/she has questions about mental health issues. You may be asked to host a function for one of the legislators in your area or you may be asked to participate in such a function. You may simply be asked to place a phone call or send an e-mail to your legislators. But in one way or another you will be asked to help.

David White, Rob Mehl and I have been working to get the legislative grassroots network up and running. We are now about to launch the program. Texas has been divided into seven regions made up of many senate and house districts. Regional coordinators have been identified and secured. Possible key contacts for the 31 senate districts and the 150 house districts have been identified. On May 2nd and May 3rd there will be a legislative retreat for the regional coordinators and the AAPT board. This will be a strategic planning retreat for the 2009 legislative session. Shortly after this retreat the coordinators will begin calling prospective key contacts. If you are asked to be a key contact please say yes. Say yes to your profession. Say yes to keeping the doctoral degree the standard for psychology. Say yes to protecting the practice of psychology from other professions encroaching on our practice. Say yes to increasing our scope of practice. Say yes to the best mental health services for Texas' citizens.

Please do not feel that you need to wait until you are contacted. If you presently have a relationship with a state legislator or if you are just anxious to get involved call David, Rob or myself and we will be happy to get you plugged into the network. Remember, psychology is your profession and you will determine the future of psychological practice in Texas.

One other note, the AAPT election has been completed and we now have two new members of the AAPT board of directors. Congratulations are in order for George Grimes and Michael Hand. George lives in Kema and works in Houston. Michael is in private practice in El Paso.

Say yes to your profession.

Say yes to keeping the doctoral degree the standard for psychology.

Say yes to protecting the practice of psychology from other professions encroaching on our practice.

Say yes to increasing our scope of practice.

Say yes to the best mental health services for Texas' citizens.

Association for the Advancement of Psychology in Texas Contributors

Donations received January 1 – April 21, 2008

$250-$500

Judith Andrews
Jev Sikes

$100-$249

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Paul Andrews
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The Tragedy of the Virginia Tech Massacre: Legal and Ethical Considerations

Jarrod Campbell BA, BSCJ, Texas State University-San Marcos
Mary Alice Conroy, PhD, ABPP, Sam Houston State University
Ollie J. Seay, PhD, Texas State University-San Marcos

Introduction

This is the last of two articles written about the various aspects of the tragedy of the Virginia Tech massacre.

Immediately following the shooting tragedy, the mass media helped spark a tumultuous debate concerning who was to take the responsibility for the incident. For once, law enforcement officials were not held entirely responsible for the safety and security of violence prevention. Similarly, social rearing by parents and peer influence were not factors in determining culpability. Unlike Columbine, mental health professionals quickly became the culpable party as the media began labeling Seung-Hui Cho as a "narcissistic exhibitionist" by airing recorded videos of him brandishing weapons, notably guns, as a reporter discussed Cho's history of mental instability (Gibbs, 2007). Such "sensationalistic" reporting would later only serve to fuel the anger and confusion felt by the grieving victims, families of victims, and compassionate viewers.

The confusion felt by many of those grieving manifested into questions and demands aimed at mental health professionals. Queries into preventative measures focused on how mental health professionals should have known Cho's capacity to commit such an atrocious act, their perceived hesitance to share information with law enforcement and college administrators, as well as psychiatric incapacitation. The role that mental health professionals play within the legal spectrum can be negligently misconstrued by the public, especially those who possess a modest understanding of the legal system itself.

This article will focus on the prediction of dangerousness, confidentiality, as well as the ethical and legal considerations of involuntary civil commitment.

Risk Assessment

Up through the early 1980s, the ability of mental health professionals to predict the likelihood someone would present a risk of violence to others was frequently decried as unreliable – in fact, wrong more often than right (American Psychiatric Association, 1983). However, over the last 25 years, research in the area has increased exponentially. Risk assessment has gained respectability as a science (Conroy & Murrie, 2007). Solid data on violence risk factors has been collected and a number of actuarial risk assessment instruments have been developed and validated. This would seem to offer great tools for predicting, and subsequently preventing, violent incidents such as those at Columbine and Virginia Tech.

Unfortunately, the current science of risk assessment has very limited utility in the arena of targeted school violence. This is due in great part to the extremely low base rate of such attacks. In an exhaustive study of targeted high school-based attacks, the U. S. Secret Service and the U. S. Department of Education (2004) could identify only 37 instances in this country between 1974 and 2000. This translates into the odds of a child dying in school by homicide or suicide as no greater than 1 in 1 million. With such extremely low base rates, any attempt to utilize the nomothetic data collected by risk researchers to predict this type of targeted violent behavior would be apt to result in high rates of false positives (Sewell & Mendelsohn, 2000). In such circumstances, the assessment with the greatest probability of accuracy would be that everyone is at extremely low risk. Such an assessment would be of no value.

Well researched risk factors, strongly associated with violence in general would also be of little help here. The single, most prominent risk factor validated in the literature is history of violent behavior (Andrews, Bonta, & Wormith, 2006; Conroy & Murrie, 2007; Monahan, 2003). Yet most targeted school attacks come as the individual's first violent incident (U. S. Secret Service & U. S. Department of Education, 2004). There is a developing body of evidence that the presence of mental illness has some association with violence and this association strengthens significantly when substance abuse is also a problem (Corrigan & Watson, 2005; Monahan, Steadman, Silver, Appelbaum, Robbins, Mulvey, Roth, Grisso, & Banks, 2001). However, "a history of having been the subject of a mental health evaluation, diagnosed with a mental disorder, or involved in substance abuse did not appear to be prevalent among attackers" (U. S. Secret Service & U. S. Department of Education, 2004).

Partly in response to its frequent portrayal on television, "profiling" has become a technique of interest in predicting violent behavior. A number of agencies have developed prospective profiles of "the school shooter" (Reddy, Borum, Berglund, Vossekuil, Fein, & Modzeleski, 2001). However, after careful analysis of the data collected between 1974 and 2000, the U. S. Secret Service and the U. S. Department of Education (2004) concluded: "There is no accurate or useful "profile" of students who

engaged in targeted school violence" (p. 19).

A final approach felt promising by some is so-called "Threat Assessment" (Borum, Fein, Vossekuil, & Berglund, 1999; Randazzo, Borum,, & Vossekuil, 2006; Reddy et al., 2001). This technique incorporates a deductive rather than inductive approach. It is more idiographic than nomothetic and focuses on an identified individual's patterns of thought and behavior in an effort to determine whether the person is progressing in the direction of targeted violence. Yet research in this area is in its infancy.

Confidentiality, Privileged Communication, and Privacy

In the beginning and ongoing training of psychologists and other therapists, warnings abound regarding ethical standards of protection of confidential information. Confidentiality, privileged communication, and privacy are the concepts related to the ethics of trust in psychotherapeutic relationships. Confidentiality refers to the psychotherapist's prohibition from disclosing personal information about their clients. Privileged communication is a legal concept that prohibits disclosure of certain confidential communications within legal proceedings. The privilege of disclosure of the information belongs to the client. This is a protection for the client rather than for the mental health professional. Privacy, another legal term, refers to the individual's constitutional right to decide when, where, how, and to what extent to share information about him/herself with others. The presumption of confidentiality is central to the provision of mental health services. Within this deeply personal relationship, clients expect what they share with their mental health services provider to remain private. No genuine therapy can truly occur if clients do not trust that what they say will remain confidential (Corey, Corey, & Callanan, 2007).

The principle federal laws regarding privacy are the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Pub. L. No. 104-191 §264; 45 C.F.R. Part 160 and subparts A and E of Part 164) which addresses medical information, and the Family Education Rights and Privacy Act ("FERPA") (20 U.S.C. §1232(g)) and the implementing regulations contained in 34 C.F.R. Part 99 which governs govern educational records. In addition, each state has a set of laws that affect these and other related records. These privacy laws are designed to balance the needs of client protection and the need for protection of the public, so they contain several exceptions or situations under which confidential information may be shared (Report of the Virginia Tech Review Panel, 2007).

Therapists are ethically and legally bound to inform clients of the specific types of instances under which their private information may be shared with others (American Psychological Association, 2002; Corey, Corey, & Callanan, 2007, Pope & Vasquez, 2007). Exceptions to release of confidential information generally fall within the following areas: a.) the client provides written consent to release such information; b.) there is a legal requirement to release the information as is the case with suspected abuse, neglect, or exploitation of a child, elder, or person with a disability; c.) there is a concern for the imminent safety of the individual or others (Note: states vary on whom may be contacted when this arises); d.) the court orders the release of the information; e.) the client files a complaint about the therapist; f.) the client sues the therapist; g.) civil commitment proceedings are begun; h.) third party reimbursement requires disclosure; i.) clerical assistants handle the information; j.) the therapist is working under supervision; and k.) the client is being treated by a treatment team of professionals. Each law has its own requirements and, sometimes, the requirements of each are in conflict with the others. For example, HIPAA requirements can preempt state law if the state law is not as protective as HIPAA, and vice versa. HIPAA allows for release of information to coordinate treatment, but FERPA does not. In university settings, disclosure of information contained in student records is governed by FERPA, and the health and counseling center records are not covered by HIPAA. In determining whether students' medical records can be released, university officials must consult both FERPA and state laws on confidentiality. Since FERPA was primarily designed to regulate the release of educational records, it does not have many provisions or exceptions about the release of medical records, but it does authorize release of information to parents if the student has violated drug or alcohol laws and the student is under 21 years of age. In addition, FERPA allows for release of information about the student in an emergency if the information is needed to protect the health or safety of the student or others. Also, because FERPA deals with student records, it does not address observations and oral communications, so university personnel may share these with law enforcement, parents, or others (Report of the Virginia Tech Review Panel, 2007).

Yet, despite these exceptions provided by laws, sharing of such information is rare. The Virginia Tech Review Panel (2007) blamed this on lack of definition of boundaries of emergency situations and therapists' and others' lack of knowledge about the laws and their exceptions. However, the socialization of professionals may actually work toward their conservatism toward the release of confidential information in any context. Ethics texts and articles are rife with reports of violations of confidentiality and potential repercussions for the therapist and the client (Corey, Corey, & Callanan 2007; Pope & Vasquez, 2007). Given these cautions, and the lack of precision that is currently the state of the art in risk assessment of targeted school violence, perhaps it is no wonder that most therapists and others in possession of private information default on the side of nondisclosure even in situations in which laws allow disclosure.

In considering ways to overcome barriers

toward appropriate disclosure of confidential information in university settings when there may be a concern for the welfare of an individual or others, it may be beneficial to explore at least a few avenues. The extent of confidentiality of student/client records must be understood and respected if mental health professionals and agencies are going to function effectively, yet disclosure and information sharing among those with a legitimate need to know can be helpful to the individual and others in reducing risk of harm (Frost, Gerbasi, Merelman & Redding, 2003). Appropriate sharing of information can promote public safety (Frost, 2000). Providing more flexibility with regard to boundaries of sharing of information in emergencies should be investigated, though formal information sharing may be preferable to informal sharing within most other contexts. HIPAA and FERPA (and state law) requirements on release of information should be coordinated so that treatment can be adequately followed through when students move between service providers governed by the separate provisions. Safe harbor provisions in laws can protect those who disclose information in good faith from liability when there are concerns for health and safety of individuals.

Civil Commitment – Legal & Ethical Considerations

Since the inception of mental hospitals, involuntary civil commitment has continued to be a controversial topic among both legal scholars and behavioral scientists alike. As originally conceptualized, the medical model of civil commitment granted too much deference to physicians to make the essentially legal determination of when fundamental liberty can be taken away. However, the socio-political climate evolved during the early to mid-20th century to emphasize the legal rights of persons with mental disabilities, thus shifting to a legal model of civil commitment. Indeed, the legal model of commitment took power away from clinicians who might have abused it, by transferring it to lawyers and judges who often failed to understand the clinical needs of the patient (Winick, 2005). Involuntary civil commitment laws have changed dramatically since the mid-20th century, from emphasizing patients' rights to more recently calling attention to community security (La Fond, 1994). Emerging out these changes was the therapeutic jurisprudence model for civil commitment.

Wexler (2001) defines therapeutic jurisprudence as the study of the law as a therapeutic agent. Therapeutic jurisprudence "proposes the exploration of ways in which, consistent with principles of justice and other constitutional values, the knowledge, theories, and insights of the mental health and related disciplines can help shape the development of law" (Winick, 1997). Winick (2005) suggests that therapeutic jurisprudence would raise the following questions in regards to civil commitment:

What kinds of mental illness or abnormality should justify civil commitment?

Should we permit preventive outpatient commitment, mandating court-imposed treatment in the community for those whose mental disability does not satisfy the criteria for involuntary hospitalization?

How broadly should police power commitments—those authorized to preserve community safety—be defined?

The Virginia Tech tragedy rekindled issues seen in Tarasoff (1976), such as the balance between confidentiality in the treatment context and society's right to be protected from dangerous persons. Retrospectively speaking, the mass media began to speculate about the various measures that mental health professionals and school officials could have taken to prevent the incident. Generally, an individual must present a danger to self or others to justify involuntary civil commitment. Indeed, concern over Cho's pestering behavior towards female peers, as well as isolation from peers and material contained in completed class assignments had caught the attention of his professors and several school officials. However, one could not have accurately estimated the magnitude of the potential violence that Cho exhibited based solely on these past observed behaviors. Such behavior, alone, would not likely be sufficient to render an individual as potentially violent, so as to warrant severe restrictions on their liberty. The U. S. Supreme Court specifically ruled that clear and convincing evidence was essential to deprive persons of their civil liberties through involuntary commitment (Addington v. Texas, 1979). Some would champion the use of preventive outpatient commitment. However, critics of preventive commitment suggest that it abandons the dangerousness criteria, and thus promotes "unwarranted" inpatient commitment for those who do not meet civil commitment criteria (Schopp, 2003).

In Foucha v. Louisiana (1992), the Court held that civil commitment deprives the individual of the fundamental liberty interest in being free from external restraint, and imposes other massive curtailments of liberty. At a minimum, such deprivation may not be arbitrary or purposeless (Winick, 2005). The state's authority to commit individuals involuntarily for psychiatric care is derived from parens patriae and police powers (Cornwell, 1998). The parens patriae justification for commitment is based on the state's duty to care for its citizens who are so disabled as to be incapable of caring for themselves. Police power justification, on the other hand, refers to the state's authority to protect public safety. In recent years, police power has become the much more common rationale for civil commitment for individuals who are not actively suicidal. However, Winick (2005) cautions that dangerousness alone, although a necessary condition for police power commitment, is not a sufficient condition for civil commitment. In that context, dangerousness must result from a mental disorder.

Concluding Remarks

This article was not an attempt to explain Cho's behavior, nor discredit concerns over preventive measures concerning public safety. Rather, this article is aimed at the audience of this publication, whom are gener-

ally prospective and seasoned mental health professionals, to inform them of the evolving legal and ethical issues inherent within professional practice. The media is an important source of public information on mental illness (Stark, et. al, 2004). We, as educators, may need to utilize the media to disseminate factual information concerning our profession and those that we serve in general situations rather than those that served as the focal point of this article.

As happened in the case of John Hinckley's attack on President Reagan, a tragic incident widely discussed in the media may be the precipitant for significant legal changes ranging from a serious restriction on civil liberties to significantly increasing the liability for those involved in providing patient care. Before contemplating support for such revisions, mental health professionals need to carefully consider three factors:

With the benefit of 20-20 hindsight it may seem that a certain individual evidenced all of the "signs" of impending violent behavior. However, current scientific data suggest that a very low base rate event cannot be predicted with any reasonable degree of clinical certainty. To identify individuals with a few known risk factors would be to create large numbers of false positive targets.

Confidentiality remains a key factor in providing psychological treatment and should not be sacrificed easily. It may make the difference for some individuals deciding to enter treatment at all.

Laws regarding civil commitment (both statutes and case law) are carefully crafted to balance civil liberties and society's right to protection. Revisions to such laws and the potential consequences should be very carefully considered.

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The Brain in Psychotherapy: Intervention

Rowland W. Folensbee, PhD

Most clinicians are limited in their understanding of brain function. They are also unlikely to apply knowledge of neuroscience during day-to-day psychological interventions. In the previous edition of Texas Psychologist a framework was offered within which connections between brain function and psychological processes can be better understood. The current article offers specific ways in which this framework and knowledge of neuroscience can be applied by clinicians not immersed in the field of neuroscience. (It will help to have read the previous article before reading this article.)

'Input-process-output' and 'neural networks' are two ways of conceptualizing the brain's processing of experiences. Figure One offers a visual representation of elements of these two broad processes. The four boxes across the top identify four basic elements of the cognitive input-process-output flow of information through the brain.

The Big Picture

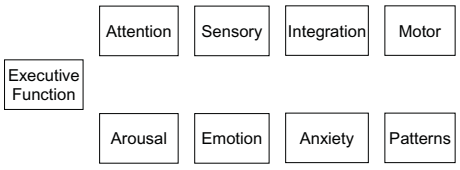

Figure One

The bottom four boxes represent more 'psychological' aspects of functioning. The 'Executive Function' box to the left highlights the role of frontal areas of the brain in decision-making, stop-and-think activities, and general management of activity in the rest of the brain.

Each experience a client has can be considered in light of the client's strengths and weaknesses in each of these areas. A given area may contribute to difficulties while another area may be relied upon to support positive change. Each intervention a therapist makes can be considered in light of which areas are relied upon for helping change occur, and which areas are most directly influenced by the intervention.

The cognitive elements of the input-process-output flow can be considered independent of psychological elements. A client could have weak verbal processing (specific Sensory and Integration areas) and strong non-verbal visual-spatial processing (different Sensory and Integration areas). This pattern of strength and weakness would not support successful verbal therapy, but could support successful therapy emphasizing graphic representations and roleplays of problem situations and their solutions. A stack of blocks representing escalating emotions would have more impact than a verbal discussion of changes in emotion.

Weak points in the cognitive flow can contribute to clients' psychological problems and can be targets of intervention. Consider a student with dyslexia. Repeated experiences of shame related to poor reading in class could result in development of anxiety associated with school in general. The client's dyslexia (visual verbal Integration weakness) could contribute to classroom failures that lead to shame (Emotion) as a student. Repeated experiences of shame would result in anxiety being triggered before the client enters situations requiring reading. Early interventions could improve the client's learning and help the client avoid shame. Reading could be done privately; learning and evaluation could emphasize oral language and nonverbal diagrams rather than written language. Different elements of processing (oral language integration as well as nonverbal visual-spatial reasoning) could be used rather than relying on the weak element (processing written symbols). Descriptions of associated brain processes could be part of treatment. The therapist could point out the small area of the brain contributing to dyslexia and the larger portion of the brain functioning effectively, providing a basis for new positive cognitive self-statements, behavioral coping strategies, and self-esteem. Shame would not be triggered and anxiety would not develop.

The series of 'input-process-output' events can be considered a chain of neural networks rather than a simple chain of cognitive events. Multiple elements in Figure One take part in each network underlying each moment of experience. Consider the client with a history of reading problems. If he were not treated, any sensory input previously associated with shame related to reading would begin to trigger the anxiety alarm before shame could occur. Anxiety could be triggered before the person was aware of connections between sensory triggers and anxiety, since sensory information can travel directly to the anxiety warning system without entering cortical systems underlying conscious awareness. This could result in comments such as, "I become

anxious for no reason." Sensory input and anxiety would both occur as part of the first neural networks in the input-process-output chain. Similar complex networks occur all along the input-process-output chain. In this client's case, anxiety would disrupt processing by activating diffuse arousal as well as specific, competing networks associated with anxiety, for example, thoughts about the consequences of being too nervous to think. Reading would become more difficult; avoidant behaviors that relieve anxiety would become entrenched. In fact, the client might avoid school completely because he feels 'uncomfortable'; he would forget reading was the basis for the distress. "I just hate school," might capture the extent of the clients' conscious awareness.

The neural network concept can guide exploration of presenting problems. Since networks contain elements from many areas of the brain, and since the neurons within a network are strongly connected due to a past history of firing together, activation of any area of Figure One can help turn on the network to be explored. Verbal self-statements, sensory images of past experience, similar voice tone, and recollection of emotions can stimulate neurons that activate a whole network. Assume our dyslexic student enters treatment years later complaining of disruptive anxiety while working on a contract designing libraries. He has become a successful architect and does not recall emotional difficulties related to reading. A therapist focused on managing anxiety could explore the anxiety event by asking, "What do you see? What do you hear? What thoughts pop into your head? What emotions come up inside you?" This could help both client and therapist identify connections between current experience and anxiety. Interventions could then be designed to address the various elements.

Clinical interventions activate multiple changes that affect neural networks. Activation of a neural network that includes stimulus-anxiety connections that are no longer reinforced by the environment can lead to habituation of the anxiety. For example, if the dyslexic client stands for an extended period at the door of the building that triggers anxiety, levels of anxiety will drop.

Positive neural networks that compete with maladaptive networks can be activated during treatment. Training in relaxation would allow relaxation-based networks to be attached to sensory networks associated with the initial stimuli (the building), adding to reductions in anxiety fostered by habituation. Networks pairing relaxation with the sensory pattern then compete for activation with networks pairing the same sensory pattern with anxiety.

The client could be taught thought substitution strategies that help activate competing networks. This would involve teaching the client to 'activate' networks related to architecture tasks whenever worry/anxiety networks begin to fire; this is more effective than saying, "Stop worrying about it," since stopping an action requires activation of what is to be stopped and does not activate a competing positive network. The client would be taught to identify anxiety, relax, and then focus on visual images, thoughts, behaviors, and sensations associated with architectural designing, which he enjoys. This would activate positive networks that support successful work completion. Weakening maladaptive networks and strengthening adaptive networks can allow the client to enter the building and complete visual-spatial architectural plans successfully. Details of the neural networks being manipulated would be discussed with the client, since such discussion provides the client with a clear rationale and a concrete focus of effort.

Sometimes the symptoms initially presented by a client are all that need to be treated, but sometimes resolution of initial anxiety is followed by signs that further concerns lie beneath the initial anxiety. For example, our dyslexic architect might continue to experience anxiety despite carrying out tasks inside the library that triggered his anxiety. Interventions would then rely on the fact that neural networks share neurons, and closely related networks are likely to trigger each other. The client could be encouraged to say whatever pops into his head, no matter how silly or bizarre, so connections between current anxiety and other networks can be identified. This description of the task seems more concrete and less threatening than 'exploring the unconscious'. Thoughts of stupidity, images of books in a library, and a dream about books being filled with blurry lines might prompt the client to admit to the therapist that he cannot read. Further connections might contain images of his father's angry face during reading practice, followed by memories of his father leaving home when his parents divorced. Such a string of thoughts, images, and feelings would allow interventions regarding other important issues in the client's life. Once underlying issues have been identified, the processes of exposure and habituation combined with development of new associations between old maladaptive networks and new adaptive networks can be initiated.

It is useful to consider the unique contributions of each of the elements across the bottom row of Figure One. Elevated arousal, which derives from lower brain centers, can be triggered by top down influences from other areas of the brain. Arousal centers chemically 'turn on' all the brain at once, making it difficult for individual neural networks to compete successfully to be 'heard' and acted upon by the client. Neural networks related to active adaptive coping become ineffective. Our architect trying to apply newly learned coping skills would have difficulty turning on and applying necessary neural networks. Relaxation skills can help reduce arousal and make it more likely that old networks can be explored and new adaptive networks can be activated, including adaptive self-statements within executive functioning and new behaviors mediated by motor systems. Describing to the client the neural basis for becoming overwhelmed and describing relaxation in

terms of its influence on neural networks may help the client relax more effectively.

Anxiety, another element from the bottom row of Figure One, has the potential to turn on generalized arousal and disrupt thinking, but anxiety is also a valuable warning system that can alert a person to apply coping skills rapidly. Clients can be helped to use the experience of anxiety as a reminder to notice what thoughts, feelings, and images are popping into their heads. Relaxation may be the first skill to apply, thereby keeping anxiety and arousal at manageable levels. The person can then choose to employ strategies to initiate networks containing adaptive thoughts, images, and behaviors, thereby facilitating adaptive coping. For example, the dyslexic architect could realize the library triggers feelings of inadequacy and fears of abandonment due to connections with neural networks related to criticism and loss earlier in life. Each time this occurs, the architect could assess whether these past networks are relevant to the current setting. It is assumed the answer will be, "No." Rehearsing the same pattern of anxiety, calming, analysis, and generating adaptive coping networks will lead over time to the adaptive networks being triggered immediately by the same external stimuli that previously triggered only anxiety and incapacitating emotions.

Emotion, a third element on the bottom row, offers pathways to problematic elements of brain function during therapy. At the same time, emotions are difficult to define and seem to come 'out of the blue'. Clients define themselves by their emotions; "It's just who I am!" Clients fear their emotions, feeling out of control because they cannot explain emotions and because emotions often do not match value systems developed in the executive functioning areas of the brain. It can be explained to clients that emotions constitute an old memory system that provides valuable information that is often hard to interpret. It is therefore useful to listen to emotions rather than to run from them. It can be graphically demonstrated to clients that the amygdala, the primary seat of emotions, is quite small, that other parts of the brain are larger and are important in defining the 'self', and that the frontal parts of the brain can help manage the amygdala and its emotions. Such a demonstration helps clients experience themselves as more acceptable, since large parts of their brains have chosen to strive for better functioning. Clients also experience themselves as having a greater likelihood of managing their emotions.

A primary strategy for using emotions during therapy is to ask a client to notice what pops into her head when she immerses herself in a problematic emotion. This works because emotions have powerful connections within and between neural networks, so when the client maintains contact with an emotion, related networks that include the same emotion are likely to turn on. A current event includes a certain emotion, the client immerses herself in the emotion, other current and previously active networks begin to pop into consciousness, and the front of the brain, which is now taking time to attend to these connections, can begin to connect with, assess, and manage the emotions more effectively. Recall that our architect client allowed connected neural networks to emerge, leading to identification of images of criticism and abandonment by his father. Emotion likely was a primary connector leading to that unfolding of networks and images. Our architect might recognize that fear of criticism and abandonment are both strongly attached to problems reading and to the previously identified anxiety and avoidance that interfered with approaching certain buildings. Anxiety was previously warranted because the feelings were threatening and connected to real events, but now, as the client begins to accept dyslexia while recognizing strengths in other areas, he can see that abandonment is not part of the current experience. Life begins to calm down. The architect can work more effectively at his job. Finally, the architect can begin to explore whether the cognitive assumptions tied to strong emotions as a child are rational. That is, did dad (symbol of important, caring others) really reject the architect because he could not read? Addressing such a question can either help undo a previously mistaken concept or allow the architect to develop an adaptive way to respond within himself if the previous view was true. In either case, new, adaptive neural networks become strongly attached to and part of previously disruptive networks, thereby supporting better functioning.

The 'Patterns' element in Figure One incorporates the various elements described thus far. The architect identified a past memory that included images of a valued adult rejecting and abandoning him. This memory included images, cognitive assessments, self-statements, emotions, and subsequent warning anxiety: dad's angry face, the sounds of dad's voice, the car driving away, a child's helplessness, the child's self-blaming statements, loneliness and panic, fear of having the same experience and emotions again. The memory was the basis for a pattern of perception, experience, and behavior that disrupted the architect's functioning. Each element of the pattern provides an avenue for discovery of previously developed networks and connections between networks. Each also provides an avenue for establishing new networks and initiating change.

Executive functions located primarily in frontal areas of the brain include stop-and-think systems, evaluation systems, systems for directing activation of other brain systems, and, in combination with the hippocampus, systems for maintaining a coherent, conscious overview of experience. The architect decided to stop running from the anxiety, and instead focused on it. He evaluated whether current events warranted responses based on past experience. He chose to focus on specific emotions and

developed a new, conscious framework/narrative for his life that could allow for current success while acknowledging past loss and pain.

Explicit and implicit memory systems underlie activity and change in the brain. Explicit memory supports the psychodynamic 'Aha!' and the cognitive behavioral choice of more adaptive self-statements. Explicit systems integrate new information and use this information to guide selection of new behaviors. Implicit memory systems include direct connections between individual elements of the brain, with and without connection with explicit memory systems. Trauma and repeated painful interactions with the environment establish direct connections between sensory areas of the cortex, emotional response, and behavior. The hippocampus and frontal decision areas can be left out; perception, processing emotion, and behavior can occur without conscious awareness. The architect may escape the job site for no good reason. The process of therapy can involve the integration of explicit neural memory systems with implicit ones: new connections are made within the hippocampus. Establishing new connections can be sudden. But change also involves the slower processes of implicit memory. Repetition can lead slowly to habituation of old maladaptive responses and to strengthening of new adaptive neural connections. Explicit insight is far more rapid than implicit strengthening of new patterns. Often clients and therapists are dismayed that repetition of previous maladaptive behaviors follows recent adaptive insights. Both parties can maintain optimism if they understand that new explicit connections are not yet strong enough to supplant old patterns, but that repeated pairing of new and old neural networks is likely to lead to hoped-for change.

Viewing experience and psychotherapy as neural functioning has implications that can be labeled but not elaborated in two brief articles. Relationship patterns with the therapist become connected to the client's new neural networks whether the relationship is explicitly addressed or not. Various schools of psychotherapy emphasize change through different elements of brain functioning. For example, cognitive behavior therapy emphasizes frontal change in self-statements while psychodynamic interventions emphasize activation of connections between sensory systems, emotions, and past patterns. Therapists' and clients' intuitions change when brain processes and neural networks are considered. Clients' attitudes toward their psychological processes change when they conceive of problems as neural patterns: the frontal lobes are larger than the amygdala and have the power to guide change even though it feels as if emotions rule all. Clients can identify with areas of strength and work to change areas that do not work. Discussing the brain is a new way to communicate with clients: cognitive self-statements can include managing the affect system; identifying connections between networks is less threatening than uncovering the unconscious. Clients are empowered when they begin to manage specific neural systems.

The bottom line is, "The brain makes sense." We just have to hear what it is telling us. These two articles have only provided an introduction to using the brain in psychotherapy. It is hoped clinicians can integrate neuroscience concepts into interventions, thereby improving the quality of treatment.

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See previous article for further resources.

Disastrous Reflections

Judith Andrews PhD

I recently stepped down from my role as the TPA Disaster Response Network Co-chair, having served in that capacity since 2003 with my brighter and wiser (albeit older) psychologist sister, Dr. Rita Justice. Since she is unequivocally the wiser, calmer, and more patient of the two of us (and because she has endeavored to appease me since I was born), she stayed on to mentor my replacement, Dr. Rebecca Hamlin. With the blessing of our apt and long serving TPA DRN committee: Dr. Stephen Pierrel, Dr. Lisa Garmezy, Dr. Blair Justice, and Dr. Marilu Berry, Beckie graciously accepted the co-chairman role. Lest there be any ambiguity, this was a great gift to TPA. Being the TPA DRN chairman is an honor and privilege but it is also a daunting responsibility when disaster occurs. Having accepted that responsibility for several years now, I step down with confidence that under Beckie's leadership the TPA DRN will continue to evolve.

It occurred to me on my way out that the lessons I have learned in my role as chair are probably useful to the general population of disaster responding psychologists. So I offer these "disastrous reflections" to any interested:

Reflection #1: DISASTERS ARE EXCITING

Lest any of you construe that I am trying to sell you on responding during disasters, be assured that I do not mean that disasters are exciting in a positive way. They are not. They are exciting in a painful way. One need not be a direct victim of disaster to be affected. As soon as disaster strikes, everyone experiences some degree of disequilibrium which symptomatically is expressed as vigilance, anxiety, fear, stress, fatigue, grief and physical tension and pain in varying degrees. There is a strong need to restore equilibrium by doing something. So, disaster response is a natural response to all of us and most people feel compelled to help those most closely affected. Herein lies the catch for those of us (psychologists and others) who have gravitated toward and are professionally trained in helping others. We not only feel a personal urge to respond, but we may perceive that we are more obligated than others because by professional know-how we should be skilled in helping. That brings me to my second disastrous reflection:

Reflection #2: DISASTERS ARE TREATMENT RESISTANT

By this I mean that disaster response is so very different from clinical practice that most psychologists who are new to disaster response feel inept. All the fundamentals of treatment that we learn in pursuit of our degrees and licenses simply do not apply. The psychologist without disaster response experience can feel very insecure initially when "what to do" upon arrival is not well defined. The "identified" patient is not easily identifiable but rather spontaneously presents as a first responder, a shelter manager, another volunteer, or a person who is a direct victim seeking basic needs as well as emotional support. The disaster responding psychologist is challenged with offering professional expertise in a milieu outside of our usual treatment models. In that sense, when psychologists are part of a disaster response they need to understand that the effect of their efforts won't be easily measured and what treatment effect occurred will likely be unclear. In that sense, psychologists may feel their efforts were ineffective.

Reflection #3: DISASTERS ARE OFFENSIVE

By this, I mean disasters offend our sense of fairness, goodness and, health. Disasters put us on the defensive. The only way we can hope to level the playing field is to become offensive ourselves and this we do by being maximally prepared. The best way to combat a disaster that is naturally putting us on the "defense" is to have a good strategic response plan in place. That plan includes not only the community plans (city, state, and country) for disaster response, but the individual psychologist's professional plan of disaster response in place. There are several components of that plan: The psychological profession's statement of role and appropriateness of disaster participation (APA DRN and TPA DRN), an individual psychologist's professional preparation (training in disaster response), and affiliation with a response vehicle (i.e. How will an individual psychologist, trained and willing to respond, actually get into the arena?).

Reflection #4: DISASTERS ARE DISRESPECTED TEACHERS

After working several disasters I noticed how disasters leave people with very hard learned lessons. Disasters remind me of the meanest and most ruthless teacher ever encountered from whom you end up learning a lot from. You really never liked the teacher but you come away having some appreciation for what they taught you. Most disasters teach humans that they are resilient and cause them to examine their human existence at a deeper level. Most of the time immediately following a disaster we are justifiably angry at nature's wrath or human irresponsibility or evil. We do not immediately recognize how we grow in the face of a disaster. I do not

in any way welcome human adversity, but taking a bird's eye view of disaster response I see that humans are remarkably resilient. My perception is that disasters are unwanted teachers, they change us, but somehow we are stronger afterwards having participated in them. This leads me to my next reflection:

Reflection #5: DISASTERS ARE SELECTIVE

By this I mean, by their very "disastrous" nature, disaster response is not for everyone. And, by the way, that is also natural. I have ADHD and I am naturally stimulus seeking. Every fire truck that goes by holds great rapture for me. I am also, as most psychologists, a compassionate person drawn to helping and comforting others. But unlike many who are smarter and better trained psychologists, I am fine with disorder around me. Disaster response is very disorderly and folks who need lots of prediction and order in their lives are probably not suited for the front lines in disaster response. That's OK! I am all about getting psychologists to be a part of disaster response but I recognize that this environment is not for everyone, regardless of their professional expertise. Having said that, I would like to conclude with the following reflection and invitation to all psychologists:

Reflection #6: DISASTERS ARE BECKONING

Before the next disaster beckons you, please join the Disaster Response Network of the Texas Psychological Association. Go to TPA's website and enter yourself in the DRN database – there is no charge for doing so. You will then receive TPA DRN notices that are not sent to the general membership. At the time of a big disaster, you will receive communication from TPA's DRN as to how you might help.

Get trained! Check with your local emergency response entity. Each municipality has a disaster response plan and you can become a part of that plan in advance of a disaster. Red Cross, the federal government (DMAT teams), local government mental health teams, and others are poised for response during a disaster. You need to be trained and affiliated with an organization positioned to respond.

Consider your personal response plan. Disasters are not convenient and if psychologists want to respond, personal "absence" plans need to be in place.

Having said all of this, I do hope I have not disillusioned all of you from considering being disaster responding psychologists. This is very worthy work and I highly recommend it to those of you who feel so inclined. We are a good group and we have a lot to offer during disasters. I do hope that the above reflections help each of you to be disaster responders who are, as licensed psychologists always are, well educated models for the delivery of psychological health.

Prescription Authority for Appropriately Trained Psychologists: Doctoral School Psychology Students Debate the Issues

Stephanie Bieltz, BA
Patricia Reyes, MA
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Chana Adelman, MA
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Recognizing that psychologists were increasingly involved with clients/patients who were taking psychotropic drugs, the 1992 APA Task Force on Prescription Privileges for Psychologists recommended that a graduate course in psychopharmacology be included in all psychology doctoral training programs (Smyer et al., 1992). Although the APA Task Force was primarily focused on psychotropic drug treatment of adults, the rapid expansion over the last 15 years in the number and types of psychotropic drugs prescribed to children (Delate, 2004; Olfson et al., 2006; Zito et al., 2003) underscores the importance of providing current and future school and clinical child psychology doctoral students with greater exposure to psychopharmacology during their graduate training. This has been highlighted in recent years by the controversies surrounding recent U.S. Food and Drug Administration (FDA) pediatric antidepressant and stimulant drug warnings and public health advisories and by media attention such as a recent episode of the public television series Frontline, entitled "The Medicated Child" (Gaviria, 2008).

In spring 2007, doctoral school psychology students at the University of Houston were required to complete a newly developed graduate course in Pediatric Psychopharmacology taught by the last author. This course included four major components: (a) basic neurophysiology, pharmacokinetics, and pharmacodynamics, (b) the extant empirical support for drug, psychosocial and combined treatments for pediatric disorders, (c) ethical and legal issues, including emerging roles for psychologists in evaluating treatment outcomes and decision-making, and (d) professional and political controversies that characterize this area, including prescription authority for psychologists and especially for psychologists who practice with children and adolescents in schools and related settings.

Now that psychologists with appropriate postdoctoral training can prescribe in our neighboring states (New Mexico and Louisiana), prescription authority for psychologists is "close to home" for Texas psychologists, and psychology graduate students. One course requirement was for students to independently research and debate the issues relevant to prescription authority for psychologists with appropriate post-doctoral training. The debate was accepted for reenactment at the November 2007 Texas Psychological Association Convention. Positive feedback about the debate provided the impetus for the development of this article for The Texas Psychologist. The article will first review some of the arguments in favor of prescription authority for psychologists with appropriate postdoctoral training, followed by some of the arguments against prescription authority. Rebuttals of each position will follow, and the article will conclude with summaries and conclusions from each side. Although the arguments presented are not exhaustive, they provide examples of some of the most commonly cited issues.

Arguments for Prescription Authority

Psychologists with appropriate postdoctoral training (see APA Recommended Postdoctoral Training in Psychopharmacology for Prescription Privileges, adopted in principle as APA Policy on August 12, 2007) should be allowed to obtain prescription authority for several reasons. Psychologists are able to provide the most comprehensive and highest possible care before, during and after treatment. Before treatment, psychologists can assess for emotional and behavioral functioning to determine the type and scope of treatment that is needed (Phelps, Brown, & Power, 2002). Psychology training programs emphasize the importance of both the behaviors exhibited by a person and the emotional aspects that may result in or affect these behaviors. In addition, psychologists are trained to consider ecological and systemic issues. The environment and those around them reciprocally influence each person, which makes it essential to understand not only the individual, but also how the individual functions in his/her environment. Psychologists are also trained to utilize multiple methods from multiple sources when gathering information. One piece of information from one source (e.g., a clinical interview alone) may provide only a limited picture of the problem, especially for children and adolescents who may behave differently in home, at school, and in other settings. Therefore, school and child psychologists commonly employ

multiple, valid and reliable measures such as observations, rating scales, self-reports, interviews, and psychometric testing to assess the presenting problems and baseline functioning, and to inform intervention choices.

Psychologists also can utilize their measurement skills to assess the effectiveness of both pharmacological treatments and psychosocial treatments (Lavoie & Barone, 2006). In addition, non-psychologist prescribers may be unaware of evidence-based psychosocial treatments that are specific to certain pediatric disorders (Brown, Antonuccio, DuPaul, Fristad, King, Leslie, et al., 2007). In many cases psychosocial interventions are preferable as first-line treatments since they do not have potentially deleterious side-effects that often accompany psychotropic treatment (Kubiszyn, Carlson & DeHay, 2005). Because prescribing psychologists will be trained in both psychosocial and pharmacological treatments they will be best suited to identify the most appropriate interventions for the presenting problem.

Frequently, consumers of medication remain on medication or increase the number of medications they take without the medications and dosages ever being accurately evaluated to determine their progress (DeLeon & Wiggins, 1996; Lavoie & Barone, 2006). Appropriately trained psychologists have the tools and the knowledge to prescribe and monitor medication that is most effective for the presenting problem(s), while also assessing for adverse events.

Appropriately trained psychologists with prescription authority can address the pressing need for prescribers with knowledge of psychological and psychiatric conditions (Lavoie & Barone, 2006). Currently, there is a shortage of such prescribers and appropriately trained psychologists can help remedy this shortage by providing greater access and continuity of care for psychosocial and medication management.

Arguments Against Prescription Authority

There are ethical and professional arguments against granting psychologists the privilege to prescribe medications. In terms of professional issues, having the added responsibility of prescribing medication could detract from the ability of psychologists to effectively practice psychology. Psychologists may be spreading themselves "too thin" in terms of their expertise; keeping up with evidence-based practices in psychology as well as literature regarding all psychotropic medications would be difficult to accomplish. Psychologists may begin to abandon psychosocial treatments and replace them with a prescription pad, because providing psychotherapy often takes much more time and effort on the part of both the psychologist and the client (Hayes & Heiby, 1996). Because medication management appointments generally last about fifteen minutes each in the "real world," and each psychotherapy session lasts about an hour, financial and case load considerations may encourage psychologists to forego psychosocial treatment in favor of drug treatment. Malpractice insurance premiums are likely to increase, even for non-prescribing psychologists, due to the increased potential to harm associated with prescribing psychotropic medications.

Lastly, there are the ethical considerations. A postdoctoral "crash course" in medical training should not be a substitute for the extensive training medical doctors receive in order to practice medicine in medical school and during the internship and residency. (Lavoie & Barone, 2006). When treating mental health disorders, it is not uncommon for psychotropic medications to be prescribed "off-label" and in combination with other drugs ("medication cocktails"), which increases the risks associated with prescribing them, especially for children. In addition, psychologists would have less training in terms of differential diagnosis to determine the difference between mental health disorders and physiological factors which could be causing the client's presenting symptoms. Because many clients with a mental illness also have co-morbid medical conditions, the potential for medication error is increased when the prescriber is not adequately trained to take all factors into consideration, again increasing potential harm to the client (Lavoie & Barone, 2006). Thus, it is clear that, if granted prescriptive authority, psychologists are likely to face allegations that they are practicing outside their professional expertise.

Rebuttal: Arguments Against Prescription Authority

Opponents argue that prescription authority will move psychology into a narrow medical model. To some extent this may be true but the medical model and the psychological model (consideration of the cognitive, affective and behavioral as well as systems, and ecology) do not have to be mutually exclusive. Combining both of these models can help provide for the most comprehensive treatment. In addition, if psychologists were only interested in practicing medicine, they would have attended medical school. However, many psychologists entered the profession because they believe in the importance and the effectiveness of psychosocial interventions first and foremost, especially with children. Many of these psychologists will acknowledge that in cases where psychosocial interventions are not having the desired effect, pharmacotherapy may be necessary. Appropriately trained psychologists with prescription authority will have the knowledge and the authority to make this treatment decision.

Currently, there are a variety of prescibers in the medical field; doctors, nurse practitioners (NP), and physician assistants (PA) all have psychotropic prescription privileges. This has increased accessibility to prescribers, although neither NPs nor PAs attend medical school. However, there continues to be a shortage of prescribers trained in psychiatric diagnosis and psychopharmacology,

particularly with pediatric patients (Lavoie, & Barone, S. 2006). The medical field made adjustments to their training/continuing education programs to include more prescribing professionals who are not trained as physicians to accommodate need. Are psychologists with comparable training, or even more psychopharmacological training, not as qualified as these other non-physician professionals? Because they will be trained as psychologists first and prescribers second, they may be more qualified to provide comprehensive, integrated treatment. Psychologists with prescription privileges will be able to provide the highest possible care that addresses multiple areas. Because psychologists have a repertory of treatment tools, with the power to prescribe also comes the power not to prescribe (DeLeon, Fox & Graham, 1991).

Rebuttal: Arguments For Prescription Authority

Proponents of prescriptive privileges assert that they will be able to provide a superior standard of care for clients and address the need for more prescribers trained in psychiatric diagnosis and psychopharmacology. While that is ambitious, general physicians will continue to remain the "frontline service providers," because health-care consumers will visit their practices first (Lavoie & Barone, 2006). Moreover, even if psychologists had prescriptive privileges, there would still be other medical professionals providing psychopharmacological treatment which is still not addressing the comprehensive mental health care issue for the public. Instead, general physicians should receive greater training in mental health and psychopharmacology, and increased collaboration should be promoted among psychologists and medical professionals to ensure that everyone has access to the best mental health care possible, rather than grant prescriptive privileges to psychologists. The public would best be served by professionals with high competence in their respective areas of practice rather than those with minimal competence. For those psychologists interested in practicing medicine, they should do so by undergoing the extensive preparation that medical school provides. Lastly, there is no evidence that having prescriptive authority would solve the need for more competent prescribers (Lavoie & Barone, 2006).

Summary and Conclusions: Arguments Against Prescription Authority

Two main concerns arise in granting prescription privileges to psychologists, professional and ethical. A professional concern is that prescribing psychologists will compromise their practice of psychology due to the demands of practicing medicine. Another concern is that even psychologists without prescription privileges will incur additional costs in acquiring and maintaining liability and malpractice insurance. Ethically, the training provided by psychology training programs will not be comparable to the medical training other prescribing professionals receive. This places the public at risk for harm from psychologists who have prescriptive authority. In conclusion, psychology's professional identity and heritage is at stake if psychologists are granted prescriptive authority. Providing alternative nonmedical interventions and increasing their efficacy would best serve the mental health needs of society rather than having more prescribers providing psychopharmacological treatments.

Summary and Conclusions: Arguments for Prescription Authority

Psychologists trained in research and evidence-based practice routinely employ multiple measures and techniques for diagnostic purposes. Many of these measures and techniques also can be used to objectively determine the efficacy of psychosocial and pharmacological treatments, enabling better informed decision-making regarding the selection of drug, psychosocial or combination treatments. Psychologists who obtain prescriptive authority will likely become involved in "studying the act of prescribing as a psychosocial event as well as a medical one" (McGrath, 2004, p. 644), potentially enabling these psychologists to address the problem of poor treatment adherence recently identified by Olfson, Marcus, Tedeschi & Wan (2006). Perhaps, the most important issue to consider in this debate is that giving appropriately trained psychologists the power to prescribe, also gives them the power not to prescribe and the ability to determine, provide, and monitor the best treatment, or combination of treatments available.

Closing Comments

Although we have taken opposing sides for this debate, we are in agreement that the field of psychopharmacology is expanding rapidly, and that all practicing psychologists would benefit from at least one formal course in psychopharmacology. We also agree that is especially true for those who plan to work with children, one of our most vulnerable populations.

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