We once again find ourselves heading into a new legislative session. We are seeing many changes, starting with our newly elected Governor, Congresswoman Michelle Lujan Grisham. This year, NMPA will be putting our efforts into the PSYPACT legislation. For those of you not aware, the Association of State and Provincial Psychology Boards (ASPPB) has adopted model legislation to create an interstate compact (PSYPACT - the Psychology Interjurisdictional Compact) designed to facilitate the practice of telepsychology and the temporary in-person, face-to-face practice of psychology across state boundaries (PSYPACT website).

NMPA is focused on providing better access to behavioral health services in rural areas. Telepsychology is already used and is prevalent in many states. One of many concerns is that telepsychology is unregulated, which means people may be practicing in our state without credentials, potentially harming people. Because telepsychology often involves providing services across state lines, those of us who wish to do so, run into inter-state licensing barriers.

By joining PSYPACT, we hope to increase client/patient access to care, facilitate a continuity of care when the client relocates or travels, and help to ensure that participating psychologists meet expected standards of care. Many states are pushing forward in order to join the PSYPACT and there will likely be 15 to 20 states involved by 2020, including all our border states.

Representatives from the NMPA board and the NM licensing board attended a Legislative Health and Human Services Committee hearing in September to introduce legislators to PSYPACT and answer questions. The committee’s chair, Senator Jerry Ortiz y Pino, has agreed to sponsor the PSYPACT legislation in the 2019 session, which begins January 15 and runs through March 16.

In addition to the PSYPACT legislation, NMPA will be looking out for any bills that may arise during the session that could impact psychologists. We are currently developing policy parameters for reviewing tax-related bills, and our committee has been requested to review proposed Physicians Aid in Dying legislation. As a group, the legislative committee will review each bill that is presented and go through a rigorous process of discussion and analyzation before presenting it to the NMPA executive committee.

We will continue to keep you up-to-date throughout the legislative session. Please send any queries to the associations email: nmpaoffice@gmail.com.

The full text of PSYPACT can be read by clicking HERE.
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**The New Mexico Psychologist**

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**Newsletter Editor:** Julie Lockwood, PhD
Dear Colleagues and Friends,

I’m very happy to be writing my first column for inclusion in NMPA’s newsletter. First of all, heartfelt thanks to our immediate Past President, Dr. Brenda Wolfe for her selfless commitment to NMPA. Congratulations to her as well for the remarkable expansion of our membership and (very importantly) the increase in the number and participation of early-career members. In 2018 and for many years, NMPA has been exceptionally well-led and successful. I’m honored to take a turn and will do my best to build on past success.

NMPA owes much to our amazing Executive Director, Kevin Kinzie, who continues to provide insight, clear judgment and management enabling all of us to fulfill the mission and purposes of NMPA. We are an association of volunteers and NMPA has benefitted enormously from the creativity, commitment and energy of our members. As you read the other articles in our newsletter, please think of the dedication of our colleagues and thank them when you can.

I want to be sure to remind you of the many ways NMPA enhances the quality of life in NM and helps psychologists make a difference in the science and practice of psychology. We also work to improve the quality of life in our state and communities. As you read this, the 2019 NM Legislature is beginning work on its “Long Session,” a biennial opportunity for our house and senate to consider new legislation. The governor, senate and house all represent the same political party and there may be more money in the state budget than in recent years. Establishing priorities for spending and legislation is likely to be fast-paced and far-reaching.

NMPA’s past legislative successes include passing the New Mexico Mental Health Parity Law, the extension of prescriptive authority to psychologists, renewals and protection of the Licensing Act. We continue to work towards managed care/Medicaid reform, license fee reduction, gross receipts tax reform, patient rights, protection legislation, laws concerning end-of-life, the practice of telepsychology and federal efforts.

NMPA’s legislative committee and our lobbyist are fully engaged with the legislature and the NM Board of Psychologist Examiners. We will ensure that you are informed about legislative issues that impact psychologists in our state. Our individual and collective voices make a difference and I encourage you to read more on legislative activities in Dr. Taryn Goff’s article on the front page.

In addition to our efforts in Santa Fe and Washington, your dues provide other benefits. You receive discounts on every NMPA-sponsored CE program, both on-line and in-person. Our cultural diversity and ethics courses are especially well-received. You receive discounts from the National Register’s online courses, and access to the members-only listserv to facilitate peer-to-peer communication. The listserv is a great source of information, referrals, opinions, networking, and provides an opportunity to share news of value to psychologists in New Mexico.

Another great benefit for NMPA members is ethical consultation. Our ethics committee is chaired by Dr. Rex Swanda and includes several of our most experienced, thoughtful and helpful members. They are a great help when considering challenges that arise in the course of a busy career.

NMPA has local chapters (Santa Fe/Northern NM and Las Cruces/Southern NM) to facilitate networking and peer support outside greater Albuquerque. In 2019, we plan to offer NMPA-sponsored CE in both regions and I look forward to meeting members at those events. We also sponsor special interest divisions (RxP and School Psychology) and assist with networking and advocacy for those with these important specialties.

Finally, NMPA offers opportunities for service. When I was young, I sometimes viewed community service as a burden and an imposition. Reflecting on my life, I realize that volunteer service provided enormous personal and professional fulfillment. Barbara Bush wrote, “To say ‘No’ with a smile, you have to have a bigger ‘Yes’ in your heart.” I encourage you to find your big “Yes” and I hope it includes participation in NMPA.

I wish all of you a healthy, fulfilling and productive 2019. I look forward to working together to fulfill the mission of NMPA. I also you’ve renewed your membership for 2019. If that renewal is still on your to-do list, please renew today!

Tim Strongin, PhD, ABPP
What do these ten words have in common? BOODY, BUBBY, FART, FATSO, LES, LIBBER, NOOKY, POO, SPAZ, and TURD? They are all on “The POO List,” or words which can be played in Scrabble clubs and tournaments, but were excluded from the “Official Scrabble® Players Dictionary” (OSPD) since 1994. As Stefan Fatsis tells it (Word Freak, 2001), in 1993 Judith Grad, a Virginia art gallery owner, was having lunch with two elderly Jewish friends who shared her passion for Scrabble®. They took out their OSPD and showed her that “JEW” was defined as, “to bargain with – an offensive term.” Shocked and offended herself, Grad looked up other words: KIKE, HEBE, YID, NIGGER, DAGO, SPIC. They were all there.

Grad wrote to publisher Merriam-Webster and Scrabble® trademark owner Habro’s game division Milton Bradley. She felt such hateful words had no place in such a game. Milton Bradley’s president replied that while they did not condone the use of such words, were it up to them, none of those words would exist at all. Dissatisfied with that tepid reply, she contacted the Anti-Defamation League, NAACP, and other organizations. Finally, a letter-writing campaign by the National Council of Jewish Women led to the ADL accusing Hasbro of “literally playing games with hate,” and urged the “hateful and demeaning epithets be retired.” The Hasbro chairman grew up playing Scrabble® with his mother who admonished him, “No dirty words.”

So Hasbro relented to Ms. Grad’s concerns, and at the 1994 National Scrabble® Championship, where I was attending, it was announced that certain words would be removed from the OSPD. This caused the biggest brouhaha in my 38 years in tournament Scrabble®, with Hasbro caught between lexical hate-mongering and tournament players charging blatant censorship. The solution? The OSPD, with hundreds of thousands of copies sold to the public, would be purged, and a new edition published. However, only for the 5,000-10,000 rabid club and tournament players in North America, they would get to continue using all the words.

In 1988, I self-published “The Wordbook,” which provided such rabid players the keys to success at Scrabble®, namely, various lists of words which were “cost-effective” to study, i.e., the least amount of time to study with the biggest “payoff” on the board. It took probability of tile selection and other factors into account. In the ‘90s, publishers showed interest in my book, but Hasbro had its demand$ if it were to be called the “SCRABBLE Wordbook.” After the 1994 brouhaha about offensive words, while the OSPD became sanitized for the public’s use, the Official Club & Tournament Word List (OCTWL, later just called OWL for short) was produced just for the few thousand members of the National Scrabble® Association, and it retained all those nasty words.

When a publisher approached me with the doability of a “SCRABBLE® Wordbook,” with Scrabble® in the title, and which would be released in 2007, there was one caveat: No nasty words. I asked the publisher to send me what they believed the nasty words to be. I knew the serious tournament players would have a fit if SCRABBLE® Wordbook was similarly censored as the OSPD had been 13 years earlier. Solution: I coined the list I got from the publisher “The POO List,” and it became a bookmark, listing all approximately 300 nasty words, from ABO to YIDS. Yes, the F-bomb and C-word and others are on the list. But I find it ironic that while POO, FART, and FATSO were purged from the publicly available OSPD, they managed to keep BASTARD, BITCH, and SCHMUCK in there for innocents’ eyes.

(Cont’d on p.5)
Though an advocate for free speech and appalled at censorship, I concede to some self-imposed censorship when overseeing a school Scrabble® Club in Corrales about 20 years ago. I set up two racks and one board, and we’d play an “open rack game.” Students, 4th and 5th graders, would fill up their racks with tiles and I would ask what word they saw, where they would play it, then discuss alternative plays which might be better and the rationale or strategy behind the alternative plays. One time the rack had the letters CDEFKMU. I wasted no time in precluding discussion by immediately grabbing six of those letters, “Ooh! Here we go!” and forming “MUCKED” on the board on a triple word score for beaucoup points, and then turning our attention to the next rack and play choices. Obviously, I never mentioned the slighter higher scoring play as an option.

I bring up the issue of “What’s in a word?” because, as many pundits, especially in the past couple years, have reiterated, “words matter.” Particularly with the two-dimensionalization [1] of communication (emails, texts, Twitter), the nuance of words may be lost. Even with the benefit of being face-to-face with another, where nuance may be deciphered, when it comes to words, one person’s “acceptable” is another’s “nasty.”

For the most part, psychotherapy is an enterprise consisting of the exchange of words. There is a propensity in our field to, um, psychologize. Who better than a psychologist?! But the tendency to theorize about the underpinnings and motivations of behavior has the potential to lead the therapist and client down the rabbit hole to someplace between grandiloquence and psychobabble. We’ve certainly suffered through much of that in graduate school textbooks and professional conferences!

Clients are astute at ascertaining and conveying their mental anguish, and even “measuring” it. At an intake session, to establish a baseline, when asked, “On a 0-to-10 scale, 0 is saddest, 5 is neutral, and 10 is happiest, how sad or happy would you estimate yourself to have been on average over the past 30 days?” clients readily provide their estimates. I’ll then ask for their estimates over previous time frames as a history is acquired.

Some clients may include as their goal, “To understand my depression,” and let us say they provide a baseline of a Level “2” on the sad-happy scale. To that I will say, “If by therapy’s end we develop an ‘understanding’ or ‘theory’ of your depression and you’re still at a Level 2 or we may not develop a theory but you’ve achieved a Level “7,” which would you prefer?” Invariably, my clients choose the latter. That outcome may well be one of our client’s goals, and the means by which we try to assist our client in accomplishing that will vary, depending on our skillset, experience, and orientation. I simply advise we not let our “theoretical constructs,” should we have them, undermine our task.

At or near therapy’s end, I have queried my clients about his or her awareness of their newfound or restored level of happiness. And I will confirm their mindfulness or awareness of such. On more than one such occasion, I have then said, as if out of left field, “Is it time to clap your hands?” Some clients “get it” right away. If they give me a sort of Scooby-Doo “huh?” I reply, “If you’re happy and you know it, clap your hands.”

PS: The word POO recently got readmitted to the OSPD, for which I clapped my hands.
[1] Challenge this word if played in Scrabble because “dimensionalization” is not in the dictionary. Besides, it’s 18 letters long, the board’s only 15 letters wide, and it’ll just make such a mess.
Preparing for the Future: What Future, and When Does it Happen?

By Morgan T. Sammons, PhD, ABPP

Executive Officer of the National Register of Health Services Psychologists

Psychology is a growth profession. While this might be surprising to those of us who entered graduate school in the 1980s and 1990s, when gloomy prognostications about the demise of the profession seemed to be on every professor’s lips, it is incontrovertibly true that the past two decades have seen rapid expansion of the ranks of health service psychologists. Consider these facts: In 2003, the VA employed approximately 1,500 psychologists. Today, the VA employs over 5,300 psychologists, and this number continues to grow. When I stepped down from my role as Specialty Leader of Navy clinical psychology in 2008, we had 125 psychologists and psychology interns on active duty. Today that number is over 200, and similar increases exist in other branches of the military. Future projections of the psychology workforce predict a shortage of psychologists in many practice areas, principally in health organization-based settings, such as hospitals and multidisciplinary clinics. As psychologists gain expertise in providing integrated behavioral health care, another area of shortage is likely to be in facilities that provide integrated care platforms, such as Federally Qualified Health Centers and the like. With robust loan forgiveness programs for those providing services in mental health practitioner shortage areas being currently offered by the Health Resources and Services Administration (HRSA), it seems likely that a substantial proportion of newly minted psychologists will seek opportunities in these health delivery settings. Many practitioner shortage areas are located in stunningly beautiful rural settings, where the price of housing and overall cost of living is far lower than in more urban areas. When location is coupled with loan forgiveness programs that may represent hundreds of thousands of dollars of value, this makes a compelling opportunity for new psychologists.

Independent practice remains among the most popular practice options for psychologists, but the number of independent practitioners is declining. This mirrors trends in other healthcare professions. Independent practitioner physicians are more likely to affiliate with groups, and those groups are more likely to be purchased by hospitals and other large providers of health care. Currently, less than half of licensed psychologists report a primary worksite that is independent practice, and over 20% report a primary worksite in a hospital setting. All independent practitioners know that survival in a fee-for-service world often entails multiple roles: Many independent practitioners are also consultants, contractors, or part-time educators. Despite the strains involved, this model can be an ideal combination that provides variety and the opportunity to serve the next generation of psychologists. But it is likely that, as integrated mental health becomes the standard of care, more of us will seek primary employment in institutional settings.

If this prediction is accurate, we do not seem to be preparing ourselves adequately for these demographic shifts. Our graduate programs continue to produce insufficient numbers of licensable psychologists to meet future demand. Average time to attainment of the doctoral degree in psychology is a whopping 7.1 years after completing an undergraduate degree, a number that has changed little with the passage of time. This is the same time it takes to produce a medical doctor graduating from a shorter residency program, such as in family medicine. Many graduate students in psychology maintain a tremendous student loan debt, sometimes exceeding $200,000, essentially buying a second mortgage on a house by the time they have finished graduate school (without the benefits of home ownership!).

So there are opportunities for intervention on a number of levels: Increasing the doctoral-level psychology workforce to meet future demand should be a bedrock agenda item for the educational community. Reducing student loan burden via loan repayment programs and expanding federal loan forgiveness programs for those working in mental health practitioner shortage areas would be a major step towards creating a more balanced system.

(Continued on page 8)
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stipends for graduate psychology education are already agenda items that the APA is tackling. But one area that has received relatively little attention to date is a systematic review of graduate curricula to ensure that we are equipping psychologists with the skillset necessary to work in expanding practice areas.

In the past year, the Register has convened a group of experts to examine what an ideal curriculum might look like for graduate education in health service psychology. This group is currently preparing a manuscript for publication, but I thought I'd give you a bit of a preview of what we think an optimal curriculum might be.

First, we believe that this can be accomplished within the confines of current accreditation standards as published by APA's Commission on Accreditation (CoA). We believed that the skills and discipline specific knowledge areas mandated by the CoA were sufficiently flexible to allow the development of a curriculum specific for psychologists working in what we called Organized Healthcare Delivery Settings (OHDS). But we believed that curricula could be optimized in two ways: 1) Making the graduate curriculum more efficient, so that the common core didactic and clinical knowledge could be imparted in no more than six semesters (this would include practica and scientific foundations), and 2) The systematic incorporation of a common knowledge core that is possessed by other professionals working in the same space. This is not to mean that we will be training junior nurses or physicians, it simply means that psychologists will learn the lingua franca and major concerns of other professions working in organized healthcare settings. So what, you ask, might this revamped curriculum look like? While I cannot go into detail in the space of one short column, here are some hints:

1. We must go beyond our current conceptualization of biological bases of behavior, as essential as this area is, to incorporate a broader understanding of the pathophysiology of a number of disease states. This will involve a sequence of courses, not a standalone class in bio bases, as is currently the norm. Medical psychology and clinical health psychology coursework will be needed to amplify the basics imparted in a biological bases course. What are the implications of greater involvement of psychologists in the management of chronic disease states?
2. Our courses in professional practice and the ethics of practice must look more closely at the standards upheld by other professions. There is much that other professions can learn from our robust ethical code, which is perhaps the most elaborate of any healthcare profession. Simultaneously, there is much that we can learn regarding the ethical foundations of other healthcare professions.
3. Supervision and consultation in interdisciplinary settings should be a more planful component of the curriculum. While psychologists' expertise is clearly valued in multidisciplinary planning, we often do not have the background in shared clinical decision-making that other healthcare professions bring to the table.
4. Just as coursework in healthcare management and administration is creeping into the medical and nursing curricula, we must simultaneously address these vital business of practice issues in the context of the graduate curricula. The postdoctoral apprenticeship type model that the profession currently utilizes needs to be standardized and a multidisciplinary syllabus developed for the graduate curriculum.
5. Healthcare planners are paying increased attention to social determinants of health, and how such social determinants affect health-seeking behavior. Psychology has much to offer in this arena, and the development of psychology-informed coursework will be of benefit.
Welcome New NMPA Members!

**Full Members**
- Rahima (Susan) Schmall, Ph.D.
- Reaume Mulry, Ph.D.

**Early Career Members**
- Kee (Jill) Straits, Ph.D.

**Members in Training**
- Evelyn Plumb
- Mortimer (Scott) LeCote, MA

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Save the Date!
**Friday, May 3, 2019**

**NMPA and the American Insurance Trust present:**

“*Ethics and the Law: Complications in Communication with Clinical and Forensic Clients*”

**Presenter**: Jeffrey N. Younggren, Ph.D., ABPP

6 Ethics Continuing Education Credits

(Continued from page 8)

5. To complete this abbreviated list, we must also systematically address the ethics and practicality of communication in an electronic health record environment. Most of us who have worked in OHSD settings learned long ago that a traditional psychological assessment report had little currency outside of our own field, and that we had to adapt our meticulous but often overlong reports for a medical audience. Now that the EHR has become the coin of the realm, we must learn how to communicate—and protect—sensitive psychological information within the context of the EHR.

Most graduate programs offer some of this curriculum already, if only in the form of individual courses. Some practitioner-oriented programs offer a great deal of it, but such programs have independently developed their curricula. Consider the benefits of a standardized curriculum that might be adopted by numerous educational institutions. That is the goal of our OHSD curriculum project. I hope this column has piqued your interest, and I look forward to sharing a more complete version with you in the near future.

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The Association of Family and Conciliation Courts (AFCC) recently held its annual conference on custody evaluations. The consistent message was that it is the process and integrity of the evaluation that holds the most importance. Workshops covered psychological testing, clinical consultation, expert testimony, recent case law, technology, and the progress and content of emerging guidelines.

There was a balance of workshops: introductory presentations about expert testimony; advanced meetings about psychological tests, emphasizing both Daubert criteria and the test results that Courts have found most persuasive in helping make decisions or clarify alternatives. The utility of determinative diagnoses was compared with how best to meet the needs of the children involved. The workshops reviewed the roles of mental health affiliates who advise the Court about the children while respecting the limits of their contributions.

“Move Aways” or “Re-Los” (relocations) received much attention, with special emphasis on the emerging frequency of military families whose situations become strained and who present special considerations due to complex circumstances. Several panels included judges who mused about what they found most compelling in crafting their decisions about maintaining family connections in the face of the brutal realities of military separations.

The burgeoning frequency of clinical consultations received attention and prompted much discussion. Parents dissatisfied with the recommendations of the custody evaluation are increasingly seeking 3rd party consultation by outside clinical experts on the integrity and the vulnerabilities of unfavorable custody recommendations. Receiving emphasis were the intricacies of scientific reliability of the evaluation, test internal and procedural complexities of the evaluation process, and consultation about the development of effective cross-examination. Custody evaluators were able to receive training in the practice of clinical consultation and in the construction and defense of their evaluations. Attorneys were exposed to information about using clinical consultations to develop litigation strategies and evaluate the extent to which such consultations were valuable to their litigant's position.

Available for review were videos and training programs on conflict resolution, anger management, parenting, and communication training. These can be recommended in the custody evaluation, extending the available especially in rural areas.

Technology assumed a topical presence. How far away are we from having custody interviews done by Skype? How close are we to working out the ethical issues involved in remote psychological testing? According to the technical experts present at the conference, about 11 minutes.

I have always found this a difficult and exhausting annual training to attend. The highlight for me this year was a workshop on non-parental custody matters. Since 2000, I have been hearing about Troxel v Granville, a case in the development of the grandparent's rights movement. The workshop featured an audio loop of “Mr. Blue” and “Come Softly To Me,” doo-wop hits by the 1950's group The Fleetwoods. The clever judge moderating the presentation tipped the audience to the connection. The Fleetwoods were led by Gary Troxel, the grandparent whose personal tragedy became Troxel v Glenville. Not a bad takeaway.

Troxel v Granville 530 U.S. 57

Kenneth C. Kenney, Ph.D., MSW, is a Ruidoso clinical psychologist who maintains a statewide practice in custody evaluations and parent coordination. Kkenney542@gmail.com.