Trust Sponsored Professional Liability Insurance

Insuring psychologists like me and you.

As an independent practitioner, I benefit from the professional liability coverage and risk management help I receive from The Trust. I believe the policy keeps pace with my evolving profession, and I have the assurance that when issues arise that might put me at risk of malpractice actions and disciplinary complaints, a free consultation with The Trust Advocate is just a phone call away.

With so much to do and so much at stake, it's good to know The Trust has me covered. I can spend more time focusing on what matters — helping others to help themselves.

Call The Trust at 1-877-637-9700 or visit www.apait.org to learn what they can do for you.

“Trust Sponsored Professional Liability Insurance provides the broad coverage and risk management resources I need.”

Sallie E. Hildebrandt, Ph.D.

Dr. Hildebrandt is in independent practice with a focus on the treatment of depression, sexual and marital therapy, and evaluation of bariatric surgery patients. She is also Past President of the California Psychological Association and Chair of the Committee of State Leaders.

www.apait.org • 1-877-637-9700

Trust Sponsored Professional Liability Insurance is underwritten by ACE American Insurance Company, Philadelphia, PA. ACE USA is the U.S.-based retail operating division of the ACE Group headed by ACE Limited (NYSE:ACE) and rated A+ (Superior) by A.M. Best and AA- (Very Strong) by Standard & Poor’s (ratings as of June 13, 2012). Administered by Trust Risk Management Services, Inc. Policy issuance is subject to underwriting.
# Table of Contents

**From the President** ........................................ 1  
Lane Ogden, PhD

**From the Executive Director** .......................... 3  
David White, CAE

**Have you heard the call?** .............................. 4  
Steve Schneider, PhD  
Rob Mehl, PhD

**The Year Ahead** ........................................... 5  
Ray H. Brown, PhD, PC

**The Roles for Psychologists in Civil Litigation:**  
**Not All Experts are Created Equal** ............... 7  
John P. Vincent, PhD, ABPP  
Scott A. Lemond, JD  
Tonya Inman, PhD

**Understanding the Texas State Board of Examiners of Psychologists: A Response**  ............... 13  
Tim F. Branaman, PhD

**Conflict in AG Opinions on Reporting Child Abuse** ........................................... 15  
J. Ray Hays, PhD, JD  
Floyd Jennings, PhD, JD  
Ollie Seay, PhD  
Karen A. Lawson, PhD

**A Snapshot of TPA Membership** .................... 16  
Brian H. Stagner, PhD

**What should be the focus of the Texas Psychological Association?** ............... 17  
A. Grace Jennings, PhD

**Psychology Students — The future of psychology** .................... 18  
Elizabeth L. Richeson, PhD, MS PsyPharm

*For information about articles or advertising in the *Texas Psychologist*, please contact Lauren Witt at (888) 872-3435 or tpa_lwitt@att.net

1464 E. Whitestone Blvd., Suite 401  
Cedar Park, TX 78613  
(888) 872-3435 • (888) 511-1305 fax  
www.texaspsycc.org
In my remarks at last year’s convention, which later were published in the Winter 2011 edition of this periodical, I attempted to urge members to prepare for and positively respond to anticipated change. I wrote things like…“These are challenging days in which to be a Texas psychologist”…“I find little to be optimistic about when I ponder the likely fate of psychologists in this state”…“We are in a threatened position today.” I warned that significant change is inevitable for us and that the practice of psychology is at risk for being redefined by persons other than psychologists.

I had as a goal to rally members to recognize and respond to challenges. I wanted to make you aware and believed that rational persons being made aware would move to act responsibly. As I prepare to end my term as president, I think back on the past year and want to use my final article to again urge you to act.

You may or may not have noticed, but at the end of each month’s “President’s Article” in our E-newsletter I included a statement at the very end that was set apart in a “box.” This information was not connected to the rest of the article. The note contained in the box was, in each case, a specific example of something that had come across my desk in that month demonstrating the validity of concerns about change and threat. My point was to illustrate with immediate, practical examples the state of our profession in hopes that such concrete data would create urgency and motivate us to move by making the abstract specific.

Here are the points as they originally appeared month by month in the E-newsletter:

- A Dallas psychologist recently confirmed that, without discussion, he was cut 25 percent on his allowable, billable time for exactly the same psychological assessment battery he’d been giving for 10+ years.
- On February 16, 2012 the TSBEP proposed a rule that would allow persons not licensable as psychologists to use the term “psychologist” as part of their credentials.
- A Houston psychologist recently reported that she was contacted by a managed care company about participating on their panel. In the information she received about reimbursement rates, there was no differentiation in reimbursement for psychologists and master’s-level providers.
- In an initial draft of suggested recommendations concerning the proposed revision of the Texas Mental Health Code, psychologists were referred to as “paraprofessionals.”
- The Medical Association of Alabama has added language to a bill that would remove from the scope of practice of federally-employed psychologists in that state the “diagnosis and treatment” of patients.
- The May/June issue of The National Psychologist reported that there is a disturbing trend occurring where insurance companies, such as BCBS and Humana, are partnering with a small managed care company called New Directions. In doing so, they are cancelling existing contracts with providers and slashing reimbursement rates for psychologists. For example, in March, Humana reduced reimbursement for a 90806 (45-50 minute psychotherapy) conducted by Illinois psychologists to $58.
- APA (along with nine state psychological associations including Texas) recently sent a letter of concern and protest to the United States Secretaries of Labor, Health and Human Services, and Treasury regarding Humana’s announced sudden, drastic, and unilateral slashing of reimbursement rates to psychologists to $56 for 90806.
- It appears that on September 1, all mental health coverage for employees of the state of Texas is switching to UHC/UBH from BCBS. Psychologists inquiring about getting on UBH panels so as to provide for continuity of care report being told they are not needed.

These were simply a smattering of the examples occurring around us that I chose to illuminate. They were not unique. They were not hard to find. They describe what we face. However, I believe that, thanks to the combined efforts of a number of hard-working volunteer psychologists in our organization, we are positioned more effectively than at last year’s convention in November. But there is still much to do.

I continue to believe that the biggest threat to our profession is complacency on the part of licensed psychologists. A scant one-fourth of us belong to the Texas Psychological Association, and TPA is the largest organization of psychologists in the state. In view of the challenges we face, the abject apathy and lack of personal concern continues to stun me. This organization simply cannot muster the resources needed if such a small percentage of those we seek to represent, support, and protect is willing to shoulder a fair share of the load in maintaining the viability and value of the licenses we worked so hard to attain. And if TPA as the largest organization is not robust enough to remain a powerful force in impacting legislation, policy, and the other concerns of our profession, then these won’t happen. Simply put, if present trends continue our influence will erode, and our significance in the field will decline—from my perspective, this is a given.

I continue to believe that it is not yet too late. At a minimum, however, we need four things, and we need them soon. We need more members in this organization—our voice is weak when we speak for only one fourth of those who should have the most vital interest. We need money—funds to allow us to be real players in the political arena through the
increased capacity to donate to the candidates who recognize and support our causes. We need money to allow us to seek legal remedy when clear violations of law and policy occur. Both these ventures seem somehow “dirty” to many psychologists who are naïve to the reality of how things truly transpire in the political/legal arenas—but, because we are a regulated profession, we cannot exist if we do not participate at this level. We need member psychologists to take personal responsibility for developing a relationship with their legislators. As in most things in life, personal relationships are hugely influential. We don’t have to out-spend others if we utilize other mechanisms of influence. Finally, we need increased participation in the Association by those who are already members. This is an all volunteer organization, and we need many more members who are willing to take an active part in the day-to-day business of their harried professional association. We have work that we know needs to be done but simply cannot be handled with the fractional number of members willing to take on a task personally.

As I said last November, I am proud to be called a psychologist. I am grateful as a fellow Texan that you prepared yourself so thoroughly for this career that you also can be called a psychologist—and that you practice here. I encourage you not to be discouraged by the current state of affairs or by the challenges we face, but to be energized, even inspired to reach a new level of zeal both in your participation in TPA affairs and in your personal quest for excellence.

I also opined in November that we are doing God’s work—psychology and psychologists exert a palliative effect on culture; we seek not only to relieve and ameliorate pain but even to facilitate hope, joy, and health. I continue to believe this and to see our work as a calling. As such, the value we add and the potential compensation we receive eclipse the mundane (money, notoriety, power) and, in better moments, can approach the spiritual (transcendence of physical limits, actualization, meaning). Never lose sight of this nor of the importance of what you do and the motivation to persevere becomes intrinsic, the locus of control internal.

I close with a quote from one of the many positive things that recently crossed my desk and with an apology to you if my leadership has seemed characterized by a focus on the negatives more than by a constant eye toward what is good. Long-time Business of Practice Committee member Dr. Rosalie Cripps is retiring and wrote a nice note of resignation from that group. She has given me permission to quote, “It has been a pleasure to collaborate with all of you in our efforts to deal with the increasingly difficult realities of sustaining a healthy clinical practice. After 39 years of practicing psychology, first in three different publicly funded agencies and the rest of the time in private practice, I feel very grateful for having a career that has been meaningful, challenging and interesting and that has allowed me to have terrific colleagues—psychologists, other mental health professionals, and addictions professionals—and an incredible array of clients who have challenged me to be the best psychologist and person I could be.”

Beautifully said, and I second the sentiment; it has been a privilege to serve as TPA President, a challenge which afforded me the opportunity to observe, meet and learn from many outstanding psychologists. I am a better person for it and will continue to fight to maintain the high standards of our profession.
From Your Executive Director

David White, CAE

As I write this column, I am humbled to have served this organization for over 20 years and honored to be able to be a part of TPA as it celebrates its 65th Birthday. We have come a LONG way since 1992 when I first came to TPA. Recently I was looking through some of our archives and found a special 50th Anniversary Edition of our Texas Psychologist. A special thanks goes to Dr. Tom Lowry who put together this incredible publication of TPA’s history. I think you will enjoy these snippets from that publication:

- TPA was conceived by a small group of psychologists, including Paul Young (TPA’s 1947 President) and Aaron Sartain (TPA’s 1948 President) in a car on the way back from Dallas from the APA 1946 convention in Detroit. By the time they reached Texas they had decided on the framework for the TPA and called the first meeting in a classroom at SMU.
- Paul Young was TPA’s first President in 1947. He was not elected to that office, but was selected by a group of younger psychologists because he was older and had a national reputation in hypnosis research.
- In 1947 TPA dues were $1 and were raised to $2 in 1951. Many members threatened to resign over this increase (some actually did).
- The first racial integration of an Austin hotel took place at a 1955 TPA convention. Thanks to the hard work of Wayne Holzman (TPA’s 1956 President) and the intervention of then Senator Lyndon Johnson, black delegates from outside the U.S. were permitted to stay in the Commodore Perry Hotel. At that time, Cactus Pryor conducted the first Texas TV interview of a black person, a distinguished-appearing psychologist named Huggins from Jamaica.
- 1959 marked the first time a concerted effort was made to wine and dine legislators to try to pass a licensing law. Prior to that time our idealistic (and naïve) TPA forefathers believed therightness of our cause would convince the legislators to vote for us (haha!).
- The first female TPA president was Ruth Hubbard in 1960. It was not until 1977 when TPA had another female president as Dr. Joan Anderson was convinced to run for TPA President by the “Original Old Guard” – those psychologists holding License number 1 though 10.
- Dr. Charles Cleland is the only person to have served more than one year as TPA president. Betty Cleland, the wife of Charles, was TPA’s first Administrative Secretary and also served in that capacity for the Southwestern Psychological Association and then as Administrative Director for the State Board.
- TPA’s first lobbyist, Judge William Bell, died suddenly of a heart attack while attending a TPA convention in San Antonio at the St. Anthony Hotel. At the time, some members thought he was just sleeping in the large over-stuffed lobby chair, as he often did. It was reported that he slept through many TPA meeting also. His assistant, Don Cavness was then employed as TPA’s lobbyist.
- 1972 TPA President Jack Wheeler invited Rollo May to speak at TPA’s Convention held in Houston. At that time, TPA had a record turnout of over a thousand delegates.
- TPA 1980 President June Gallessich moved the agenda along by promising the members of the Executive Committee (Board) in her home that they all could go for a swim in her lovely pool, “just as soon as you gentlemen finish your work.”
- New Cadillac’s were provided at the 1982 Convention by Lone Star Cadillac of Dallas to President Larry Abrams, Past President Bob Gordon, and President-elect Tom Lowry. The convention was a busy one, so the fancy cars were little used except for one night when the Lowrys and Abrams covered half of North Dallas looking for a non-existent restaurant.
- The upscale suites for the TPA officers at the St. Anthony Hotel at the 1983 convention were snatched away at the last minutes for the use by Nancy Reagan and her Secret Service detail. The TPA officers were moved into small rooms which were not in service. TPA was given free meeting rooms for this inconvenience.
- The band at the President’s Dinner Dance in San Antonio in 1987 was so bad that everyone, including President Karen Kamerschen left after the first number.
- TPA’s 1988 President Mike Gottleib promised his wife he would never be president of TPA if he had to do all the work of the Executive Director. TPA hired their first ED six months after Mike’s election.
- Slaughter Leftwich Cellars produced a special edition TPA bottling of Cabernet’ 95 with the EC members names embossed on the label. The presidential dinner for Kim McClanahan was held in the Laughter Leftwich Wine Cellar.
- Bob McPherson’s teenage twosome agreed that being TPA’s President would be “cool” if they could pick the music and food for the parties.

HAPPY BIRTHDAY TPA!
The Threat: Psychologists are a dying breed – UNLESS we are able to unite and expend our energy wisely and efficiently. We are the most highly trained mental health professionals that exist in this state, but lesser trained groups constantly attack our standing. These groups concoct derivative areas of ‘expertise’ and purport to be the ‘experts’ in those areas, seeking certificates or licenses or diplomas or badges or whatever they can obtain in order to establish some sort of credibility. They want to do what psychologists trained long and hard to do, but want to do it through legislation – not through exacting, professional training. If we stand idly by, the practice of Psychology will be carved up and assigned to those who are ‘dumbing down’ the science and the standards that psychologists represent.

As the best trained mental health professionals, we must go beyond repeating that mantra in a satisfied way. We must take responsibility for Mental Health in the state of Texas. We cannot hope that someone gives us that responsibility, we must assume that responsibility. It goes beyond practice issues and involves all of mental health care delivery in the state. With that comes the necessity and responsibility to work with the powers that influence the process. In the most major way, that is the legislature. We have much to do.

The Solution: TPA created The Grassroots Network as a dynamic and systemic outreach to every representative and senator in the state of Texas to effectively promote our profession. Those in other mental health professions outnumber and outspend us, but our message is compelling. We are relationship experts, and it is necessary and sufficient to form those relationships with legislators. Our experience with legislators proves that relationships always trump money and numbers (but remember that legislators DO need contributions to exist). The Grassroots Network identifies psychologists in all House and Senate Districts in Texas who are willing to establish a relationship with their legislators. Meetings for lunch or coffee serve as opportunities for psychologists to create an affiliation through which we can pass on critical information, educate legislators regarding our training relative to others, and be resources to assist legislators when they need information regarding any aspect of mental health.

The Process: When a psychologist accepts the challenge to become a Key Contact, then that psychologist can provide to TPA Staff possible times and places for a meeting and TPA Staff will contact the legislator’s office to coordinate the meeting. Psychologists – and legislators – are busy folks, so ‘our people’ get with ‘their people’ to iron out the specifics, leaving the psychologist to simply arrive and establish positive contact. TPA has created a multitude of materials – the TPA Legislative Agenda, Talking Points for Bills to be offered in the next session, Charts, and other professional handouts – to provide to legislators, making for productive, informative, and top-notch contacts.

The Ultimate Practice Networking: As we have developed the Grassroots Network, we have found that a number of psychologists already have relationships with their legislators. These relationships turned out to be critical in our efforts last session. Those psychologists were also very successful, connected to their community in general, were used as resources by their legislator, and seen as a valuable resources with important expertise. Legislators talk to constituents constantly. It is one invaluable way to be better known and respected in your community.

WILL YOU HELP? The future of Psychology is at stake! The more psychologists available to meet with legislators, the better our image and their understanding will be. The Grassroots Network can make a monumental difference in how we are perceived as a profession and in our effectiveness in preserving the integrity of Psychology for sake of the public and the many psychologists who have dedicated themselves to helping others. Call TPA today! Please answer the call!
Texas Psychological Association —

The Year Ahead

Ray H. Brown, PhD, PC
2012 President-Elect

In just a matter of days, many of us will gather once again to attend the annual convention of the Texas Psychological Association. For many of us this event is rich in tradition and is approached annually with great enthusiasm and anticipation. This is the time and the place where quality continuing education of a practical nature literally surrounds us, a place where old acquaintances are renewed, where new friendships are initiated, and where we collectively examine the status, whether good or bad, of our profession and then hopefully leave energized and redirected.

I attended my first TPA convention as an intern back in 1975. In all honesty, I never considered that membership in our professional organizations, particularly TPA, was an option. I knew immediately after one convention that the quality and practical nature of the continuing education was outstanding. Across time, essentially without exception, I returned annually from TPA with new ideas and new energy to put behind those ideas. What I learned next came much more slowly, requiring some years of experience and increased levels of professional maturity. This included my realization that the field of psychology, in terms of a recognized and viable profession, was young. Even licensure was a new thing, something that was offered for the first time to the generation of psychologists just before me. Still later, it became obvious to me in those early years that we were making great professional strides, gaining prominence, increasing opportunities, and growing in recognition as a real profession. Concurrently, however, there were battles to fight, obstacles to overcome, and worthy adversaries who had to be educated regarding the scope and nature of psychology, both what it is and what it is not. I learned early that this growth and forward movement did not just happen out of the benevolence of our legislature, nor from the demands of the public, not even from any groundswell movement of the mental health community at large. These positive changes came because early psychologists were also strong leaders and many worked tirelessly and wisely to found the Texas Psychological Association, the only organization in our state that truly has the interests of our profession at heart.

This upcoming convention in Austin brings with it a special celebration. This year, we will hear our President, Dr. Lane Ogden, lead a celebration of the 65th year of our existence. As with any birthday or anniversary event, celebration and recognition are in order and some of that is to be expected at this special convention. We will celebrate and then we will move forward in our work. In a sense, our annual convention serves to at least symbolically culminate one year and to usher in the next. The 2013 Board of Trustees will be introduced and plans which are already underway will be thrust into action as we anticipate yet another challenging legislative year before us. I can assure you that I consider my transition into the role of TPA President to be a special event, a special time, and I view this opportunity as an honor, as a privilege, and as a responsibility that I will not take lightly. Obviously, I move into this role because you, the members of TPA chose to give me your support in our election two years ago. It has been an honor and a valued learning opportunity to serve behind Drs. Mehl and Ogden during my year as President-Elect Designate and my year as President-Elect. No better mentors could be found for the preparation for these transitional years. Beyond merely being elected, however, I am in this position because I view the profession of psychology as far more than just a job, even more than just a profession. I view this work with great passion, and I take what we do as serious business, knowing that it has great potential impact on the lives of other people. I move into this role as TPA President because psychology has given much to me, and it is my hope and my plan to give something back. This legislative year will create both opportunities and obstacles for our profession, but perhaps you have heard that every legislative year before. We are met with many challenges—challenges that we must meet head on in spite of relatively small numbers and limited resources. In fact, we simply must grow our membership and increase our fiscal resources. Other recent articles published by TPA have communicated very real concerns and serious threats to our profession. Perhaps the most poignant one-liner that I have read recently appeared as a topic heading in the September 2012 TPA E-Newsletter. It said quite frankly and accurately that, “At TPA, we are fighting for the life of our profession in Texas.” We are doing this at a time when expenses for all of us are high, incomes are being threatened, professional memberships are down, and doubt and uncertainty cannot be fully ignored by any of us. I wrote in another article that, indeed, these may be the “worst of times” for our profession. These words are not, however, said to discourage nor to create panic, or for me to present as a pessimistic old-timer who is giving up on psychology. Rather, these are simply words that will hopefully help rally the psychologists in the state of Texas, awakening us from any illusion that we will be taken care of without fighting our own battles. This demands that we increase our membership, that we tolerate modest dues increases, that we volunteer with our time, that we make our presence known among our local legislators, and that we react with unparalleled professionalism to the threats that now haunt our profession.
It is my vision that this must be done through a multifaceted approach to our problems. In thinking this through, it reminded me of my most typical approach in dealing with seriously depressed individuals. I find that, more times than not, I recommend a trial of psychotropic medication while concurrently engaging the patient in the most appropriate type of psychotherapy. At the same time, I almost always recommend some personalized regime of lifestyle changes that affect daily habits of diet, exercise, social engagement, etc., always encouraging them to “do these things so that you will feel better” even as they argue that they will do these when they feel better. We, as the caretakers of our profession, must move now to do some things to protect our profession, and I suggest that these efforts must also include a multifaceted approach.

It is essential that we protect ourselves in a legislative sense. Your Board of Trustees has engaged a legislative advisor to assist us in this upcoming session. Your Legislative Committee has several bills that will be presented, this constituting an offensive effort to shore up some areas of practice issues, to increase public access to our services, and to protect us against the loss of those small areas of specialty service that we are trained to do and where further licensure/certification should not be a requirement. We will introduce legislation in hopes of regaining our authority to delegate, and among other things put some of those individuals in postdoctoral years on the payrolls of practicing psychologists. Likewise, we will be challenging licensure exemptions in state agencies, and we will work to protect the term “psychologist” by leaving it in the hands of doctoral-level, licensed individuals. Finally, we have plans to work toward expanding opportunities within the forensic arenas as related to involuntary commitments, competency evaluations, and the like. It is our wish and our promise to try to protect the doctoral standard for the field of psychology. That standard is at risk already, and there is little or no reason to believe that the attacks on the doctoral standard are going to go away. We will launch, as the legislative session opens, a concentrated effort to review all bills that appear to have relevance to our profession so that we can defensively ward off changes that may not be good for us, the providers, or for those whom we serve. Intense efforts are underway on a daily basis to protect our status/our reimbursement rates among insurance companies and while the battle is tough and the future is uncertain regarding health care reform, the Business of Practice Committee has worked tirelessly and effectively under outstanding leadership. This will continue as we move into the next year. All of this is good and all of this is indeed necessary. All of my colleagues are heavily vested in the notion of preserving psychology as we know it and making it viable in years to come. It is my belief, however, that while we must fight to maintain the traditional image and scope of our profession, another facet, this one involving creativity and entrepreneurial endeavors is a must. We are a creative body of people with unparalleled skills that, in my opinion, are yet not fully tapped in many areas. Many of us, already, are engaging in creative, nontraditional areas of service delivery within the medical community, the legal community, private business, and much more. Those changes in our profession that I have witnessed serve as a point of reference in my coming to realize that change is inevitable. However, it is our job to guide and control as much as possible the changes to our profession. My great-grandmother was a storyteller. I spent many an hour at her bedside, listening to poems, hearing her tell stories, and best of all hearing her account of her early life in Texas. As a young child, she traveled in a horse-drawn cart from New Hampshire to the San Angelo area where she lived for the remainder of her life. In later years of this woman’s life, she talked about the first walk on the moon as she, indeed, lived through both of those experiences — the wagon ride and the moon landing. She was not quite sure of the validity of the moonwalk, and she reached the point where she said that she had lived through too much change, that it was hard to process. I sense a little of this myself having known some of the first generation psychologists to be licensed in Texas and sharing in the joy and excitement of becoming third-party providers for the first time ever. Now, in one professional lifetime, I am seeing threats to our doctoral standard, displacement by master’s-
The Roles for Psychologists in Civil Litigation: Not All Experts are Created Equal

John P. Vincent, PhD, ABPP
Scott A. Lemond, JD
Tonya Inman, PhD

Editor’s note: This article was originally published in the Houston Lawyer to guide the legal profession about the different roles psychologists play in civil damages litigation. Psychologists become involved in courtroom proceedings with increasing frequency, both on purpose (in forensic expert roles) and when called under subpoena in their roles as treating providers. The authors graciously allowed us to present it here in somewhat condensed form as a succinct guide to the legal, professional, and methodological differences in the different roles psychologists can play in legal proceedings. Although the article focuses on civil litigation many of the principles apply equally well to psychologists’ activities in criminal court.

Psychologists are frequently called on to testify in court regarding the psychological adjustment of plaintiffs in civil litigation. These professionals can be qualified by courts as experts based on their knowledge, skill, experience, or education, and permitted to render “expert” opinions that go beyond their personal observations or knowledge of the actual facts of a case.

In most forensic cases serve in one of three expert roles: (a) forensic evaluator, (b) treatment provider or (c) consultant. Each role carries certain responsibilities to the client or court concerning the nature of the expert’s professional activities. Consider for example a plaintiff who has sued her employer for alleged sexual harassment. As part of her allegations, the plaintiff claims that her employer’s acts led to severe emotional problems involving symptoms of depression and post-traumatic stress disorder. The plaintiff may seek a psychologist to initiate appropriate treatment to alleviate her emotional problems. At the same time, in order to quantify the plaintiff’s emotional injuries in monetary terms, the plaintiff’s attorney would likely designate the psychologist as a treating expert and ask the provider to submit a report describing the plaintiff’s emotional problems and diagnosis, the nature of treatment provided, the plaintiff’s response to that treatment, the prognosis for recovery, and the nature and cost of treatment necessary to achieve maximum therapeutic benefit. The treating expert might then testify about his opinions in depositions and at trial.

Next, a psychologist also can serve in an evaluator role designated by a party or by the court to conduct a forensic mental health evaluation. In the role of forensic evaluator, the psychologist conducts in-depth clinical interviews, administers psychological tests, reviews medical records and other case documents, and obtains information from third-party collateral sources who ideally have knowledge of the plaintiff’s emotional state before, during and after the alleged cause of action. The psychologist typically prepares a report based on these findings and can testify in depositions and at trial. The psychologist designated as the forensic evaluator provides no type of treatment, however.

Finally, a psychologist can serve in a forensic context as a consultant hired by either side, usually outside the knowledge of opposing counsel and with no designation as an expert witness. Experts in a consulting role may participate in various activities, such as reviewing depositions, medical records, and reports prepared by other experts; reviewing scientific and professional literature regarding psycho-legal questions; assisting in preparation of questions for depositions and trial; and consulting with attorneys regarding trial strategy, voir dire or any other relevant aspect of the case.

While each of these three roles can fall under the rubric of “expert,” they vary in ways that bear on whether the work products of each are admissible in court and the extent to which the experts are vulnerable to challenge of the methodology they used to arrive at their opinions.

Legal backdrop
It is important to place any discussion about mental health experts in an appropriate historical context. Before the early 1990’s, courts typically allowed expert testimony to go before the jury if the experts’ theories and techniques were “generally accepted” by others in the field, often without scrutiny of the actual methodologies employed. Beginning with Daubert v. Merrell Dow Pharmaceuticals, Inc., however, federal judges began to function as gatekeepers of the admissibility of expert testimony based on “evidentiary reliability.” Thus, trial judges were tasked with ensuring both the relevance and reliability of the expert evidence before allowing it to be admitted. Under Daubert, if the expert evidence was initially determined to be relevant and reliable, the court decided whether the probative value of the evidence outweighed its prejudicial impact. Texas courts followed suit, with slight modifications.

Daubert and its progeny counseled that an expert’s opinion must not be a bare conclusion, mere surmise or speculation. Such testimony is, on its face, inadmissible. Instead, the psychologist must first demonstrate that some rational connection exists between the expert’s opinion and the data he or she relied upon. Consequently, there cannot be too great an analytical gap between the expert’s methodology and his or her conclusions. An important restriction placed upon the courts is that they must never seek “to determine the truth or falsity of the expert’s opinion.” That job is left solely to the jury. Rather, the court’s responsibility remains only
to make the initial assessment of the relevance and reliability of the expert’s opinion.17

**Methodological and procedural considerations in evaluating emotional injuries**

**Overarching questions**

In typical civil cases the work of the three different expert roles varies across several procedural and methodological dimensions, including (a) the extent of plaintiff vs. defendant advocacy biases, (b) assessment methods and their susceptibility to response biases and potential malingering, (c) temporal considerations, (d) the importance of diagnosis, and (e) establishing causation and possible pre-existing conditions.

**Advocacy biases**

The three types of psychological experts vary in the nature of any advocacy provided to the client and/or the subject of the evaluation. These multiple loyalties often create real, sometimes serious, ethical conflicts, where allegiance to one party comes at the expense of another.18

Take the forensic evaluator. Regardless of who retains this psychologist, he or she should remain objective, impartial, and not favor either the defendant or plaintiff. The proper role of the psychologist as forensic evaluator is to assist the trier of fact by providing expert testimony to be considered in deliberations.

Treat the forensic evaluator as an expert witness and seek his or her objectivity, and do not actually exist. While self-reports can be intertwined with the forensic evaluator’s attitude is one of skepticism, given that plaintiffs often have powerful financial incentives to report significant emotional distress.27 Other incentives also may be present, such as vindication, sympathy, favorable treatment, consistency with prior disclosures, and protecting dignity and reputation. Such forces can lead to conscious and unconscious symptom exaggeration, where the severity of emotional distress claimed by the plaintiff exceeds the actual level of distress. The forensic evaluator must also be attuned to the possibility of outright malingering, where the plaintiff may fabricate psychological symptoms that do not actually exist. While self-reports by the plaintiff are sought in order to document his account of facts associated with the case, corroboration of those accounts through other assessment methods helps the forensic evaluator verify their accuracy and truthfulness.

**Forensic interviews.** The forensic evaluator uses a clinical interview and history to explore the plaintiff’s background and the events associated with the case. Forensic interviews can be structured or unstructured, but they are generally very involved and thorough.28 The goal of a forensic interview is to obtain information pertinent to an individual’s psychological adjustment at various points in time. The forensic interview is both comprehensive and probing, in that the evaluator tries to obtain detailed information about every aspect of a
plaintiff’s life that may bear on their past and current psychological adjustment. **Psychological testing.** Forensic evaluators employ testing with methods supported by empirical research, with sound psychometric properties, and well established reliability and validity. Psychological testing in forensic contexts requires stringent adherence to higher standards of validity/reliability than in treatment settings. In addition there is greater sensitivity to the appropriateness of the demographic characteristics of the individuals on which the test was normed. Plaintiffs’ reading levels and language preferences should first be assessed. (Non-English versions of some psychological tests are available for plaintiffs whose dominant language is not English but their use requires thoughtful evaluation of the psychometric properties of the instrument and its appropriateness for the case at hand.) While normative appropriateness is very desirable in evaluations done for treatment purposes, strict application of appropriate norms becomes an absolute necessity in forensic evaluations. The strength of an expert’s opinions must be moderated by information about the underlying psychometric properties of the assessment materials employed as well as the generalizability of supporting research to the particular case and psychological issues in question.39

While many psychologists believe that they can determine symptom fabrication and malingering based on a patient’s interview responses, research suggests that interviewers are generally poor at identifying feigning. Forensic evaluators often use standardized self-report inventories such as the MMPI-2 or the PAI which include validity scales that help identify possible response biases that might distort (minimize or magnify) the symptoms. In addition, forensic assessments frequently include psychological measures specifically designed to assess malingering or exaggeration of psychological symptoms, including the Structured Inventory of Reported Symptoms (SIRS) and the Miller Forensic Assessment of Symptoms Test (M-FAST).31 While useful in many forensic evaluations, these two measures are best suited to assessing fabrication of psychoses and other forms of serious psychopathology. As such, they are more useful with detecting symptom magnification among relatively unsophisticated plaintiffs who have little knowledge of psychological disorders as opposed to the more subtle and sophisticated attempts to portray exaggerated symptomatology. Validity patterns among psychological tests also can shed light on the possibility of coaching, and corroborating information from other sources can be helpful in ruling out or confirming this possibility. **Collateral information.** To further corroborate a plaintiff’s self-reports, forensic evaluators gather information from case documents (e.g. medical records, affidavits, complaints, depositions, expert reports). Third-party informants are also a useful source of information. The ideal informant has extensive first-hand information about a plaintiff’s functioning before, during and after the events in a case and is arm’s-length in that they have no vested interest in the outcome of the case. Information from informants who do not satisfy these ideal requirements also may be obtained, but the evaluator must be attuned to the possibility that the information obtained is incomplete or biased in some way out of loyalty or the possibility that the informant hopes to benefit from the outcome of the case. Information may also be biased in the opposite direction, as in the case where an informant minimizes any bona fide psychological dysfunction from the defendant’s conduct. Both types of response biases among informants must be weighed carefully by the evaluator to rule out the possibility that an informant’s reports are inaccurate. **Aggregation and interpretation of forensic information.** Because the goals of a forensic evaluation are to obtain thorough, accurate, hopefully unbiased information about a plaintiff’s psychological adjustment, consistencies and discrepancies across information sources are critical. In light of Daubert, subjectivity in an expert’s opinions must be avoided or minimized. Experts are advised to acknowledge when their opinions are based on limited data or subjective impressions, and this fact should be considered by the court when placing confidence in such opinions.34 Convergence of information both within and across sources is regarded as support for the validity of the information provided by plaintiffs; the greater the degree of convergence, the more confidence can be placed in the expert’s resulting opinions. On the other hand, significant discrepancies across information sources are subject to less benign interpretations, including raising questions about the veracity of the plaintiff’s story.

**Clinical approaches to gathering information.** Clinical assessment methods, response biases and malingering. The treatment provider’s methods of gathering information differ in several important ways when compared to the forensic evaluator. While issues of reliability and validity of clinical reports are relevant to the treatment provider, the patient’s self-reports are typically taken at face value. In fact, treating clinicians generally believe that the patient’s perceptions are of primary importance for treatment and that legitimate differences of opinion might exist between the patient and other people in his or her life. Possible issues of secondary gain and bias in the patient’s self-presentation are acknowledged, but those possibilities are typically overridden by the assumption that anyone seeking treatment would be candid in the hopes of getting the best possible and most effective treatment. In some cases possible secondary gain and bias are seen as clinical issues and are incorporated into the conceptualization of the patient’s difficulties and their treatment plan.

While any history of past psychological difficulties and treatment is of some interest if it helps to formulate the basis of the patient’s current psychological symptoms and direct the course of treatment, most treatment providers focus on the patient’s current life circumstances and symptoms. Thus, it is unlikely that most treatment providers would conduct a comprehensive history of the individual’s life, risk factors and protective factors as well as other events that may impact his or her current emotional state.

**Clinical interviews and psychological testing.** Treatment providers rely almost exclusively on interview methods to gather information and implement treatment. Patient perceptions are the primary focus and self reports are treated as the principal source of data. Treating psychologists often don’t employ psychological testing on a routine basis to augment information gleaned from interviews. Symptom checklists, which do not include validity scales, are more commonly employed than in forensic settings to determine whether self-reported symptom severity is clinically significant.35 Furthermore, while these measures do not directly assess malingering and symptom exaggeration, response styles reflected by extreme responding to most or all items would certainly warrant attention and can be interpreted as a “cry for help,” or
purposeful or nonpurposeful symptom magnification when a patient claims emotional injuries in civil litigation. It also is unlikely that a treatment provider will administer measures designed to detect malingering.

**Collateral information.** In most treatment settings, clinicians seldom review collateral information from case documents and medical records, unless there is potential therapeutic benefit from such inquiry. It also is unlikely that they will obtain systematic information from third parties. When such information is obtained, it is usually from spouses or other family members, and seldom for the purpose of evaluating the veracity of the patient’s self-reports. Rather, such information is obtained incidentally in order to enlist support from nonclients to assist in the therapeutic process. Further, the issues of response biases that may impact the validity of third-party reports generally would not be addressed. Consequently, it is difficult to identify bias in those reports given that the informant may have a vested interest in the outcome of the case.

**Aggregation and interpretation of clinical information.** Inconsistencies across information sources or the plaintiff’s own self-reports is noted by treating psychologists, but the significance of those inconsistencies differs from those obtained in the context of forensic evaluation. Treatment providers might consider many explanations for such inconsistencies. For example, a client may be inherently conflicted about how she sees a particular situation; hence, differing perspectives may be reflective of the patient’s ambivalence and considered part of the clinical case conceptualization. Clinicians may also subscribe to the notion that certain information is blocked from conscious retrieval for psychologically defensive reasons. Treatment takes place over time, and it often takes time for certain psychologically painful thoughts and feelings to emerge. Consequently, inconsistencies of information at various points in time may be seen as clinically significant rather than being an indication of response biases that undermine the truthfulness of the information obtained. Subjective interpretation and clinical judgment is common among treatment providers and there is an explicit effort to place those observations in a theoretically or clinically relevant context. Thus, treating psychologists often go well beyond the data of their observations to make sense out of the patient’s clinical presentation, even though there is extensive research that underscores the inaccuracies of clinical judgment when compared to more objective, actuarial methods of interpretation. Information obtained over the course of treatment will ultimately determine whether observations and hypotheses obtained through the course of treatment are supported. Given the hypothesis generating purpose of information gathering in clinical practice, considerable latitude is afforded in the validity/reliability of assessment data for most common applications.

**Information gathering by consulting experts**

As with forensic evaluators, consulting experts place great importance on methodological factors that may bias information obtained from plaintiffs. The consulting expert is limited to information obtained during the discovery process. In some instances consulting experts can help direct the discovery process by requesting access to records and case documents or by posing questions that attorneys can use in interrogatories and depositions to help address issues of relevance to the case. Consulting experts provide a thorough methodological critique of the work performed by other experts and assist attorneys in gathering or understanding evidence. These critiques are used to prepare damages models or draft motions to exclude opposing expert reports and testimony based on a Daubert motion, and in depositions or at trial to help impeach the credibility of the plaintiff and other witnesses, including expert witnesses.

**Temporal considerations**

Forensic evaluators typically conduct evaluations after a lawsuit has been initiated. These evaluations typically involve a snapshot of the plaintiff’s psychological adjustment at the time of the evaluation, even though questions often must be addressed retrospectively about a plaintiff’s adjustment at some earlier point in time. Further, forensic evaluators seldom have access to plaintiffs at a later point in time in order to assess any improvement, deterioration or lack of change in their psychological adjustment. The forensic evaluator may have difficulty in obtaining valid documentation of the plaintiff’s pre-incident level of functioning as well as prognostic estimates about the future course of the plaintiff’s emotional adjustment. Plaintiff’s self-reports about prior psychological symptoms or treatment may be obtained, but a plaintiff may be motivated to withhold, downplay or distort such information if he or she believes it will hurt the case.

Given that treatment typically extends over time, treatment providers are thought by some to be in the best position to render opinions about the temporal course of a plaintiff’s emotional symptoms. Opinions about a plaintiff’s psychological adjustment are generally more convincing where the treatment provider initiates treatment before the accrual of the cause of action. A pre-incident baseline is therefore available to compare the plaintiff’s post-incident emotional adjustment. Opinions from treatment providers based on observations during the delivery of services provided after an alleged cause of action accrues are vulnerable to challenge that the plaintiff presented biased information to the provider in order to support his or her legal position.

As with the forensic evaluators, consulting experts generally become involved after a lawsuit is filed. Depending on the nature of information to which they have access, consulting experts may be able to construct a timeline of events and psychological symptoms that are juxtaposed with those events. Unlike the forensic evaluator and treatment provider, the consultant - except when he or she participates in the plaintiff’s deposition - has no direct access to the plaintiff and must rely on information based on others’ observations.

"Given that treatment typically extends over time, treatment providers are thought by some to be in the best position to render opinions about the temporal course of a plaintiff’s emotional symptoms."

**Importance of diagnosis**

When arriving at expert opinions, forensic evaluators may assign a diagnosis based on strict application of the criteria spelled out in the Diagnostic and Statistical Manual-IV-TR. While the DSM-IV-TR warns that the diagnostic guidelines may not be appropriate in forensic settings, the guidelines are still
commonly used by forensic evaluators to indicate that a plaintiff’s emotional problems are of sufficient clinical significance to constitute compensable emotional damages.

Though treatment providers also may assign a diagnosis for one or more purposes, such as for third-party insurance reimbursement purposes, diagnoses are intended to help guide treatment. When testifying as a treating expert, diagnoses may be somewhat more important than in a typical clinical setting in order to document the nature and severity of a plaintiff’s symptoms. If a psychologist has worked with a plaintiff clinically before being designated as an expert, the diagnosis rendered at the outset of treatment in a clinical context may not have been formulated with the same level of rigor as would be the case in a forensic context, and would not likely be substantiated by collateral information or multiple sources as is the standard of practice for forensic evaluators.

Consulting experts also are interested in diagnostic issues, but they are seldom in a position to actually assign a diagnosis because they have not directly evaluated the plaintiff. Psychologists are ethically prohibited from diagnosing an individual they have never met, but this ethical standard would typically apply only to forensic evaluators and treatment providers who actually testify in court as opposed to consulting experts who typically do not testify in depositions or in court.49 In a consulting context, “unofficial” diagnoses might be made for purpose of case theory development or in evaluating the conclusions of another expert’s forensic report.

*When testifying about the cause(s) of an emotional disorder, the three types of experts differ in how or whether to address the issue.*

**Causation and pre-existing conditions**

In civil actions, the issue of causation is of critical importance – causation determines liability.50 In most instances, emotional injuries are relevant only as a measure of damages.51 That is, the “cause” of the plaintiff’s emotional injury is proven if, in the first instance, the defendant is found to be at fault. Although the plaintiff’s emotional symptoms and their severity may, in fact, be affected by other forces, the defendant’s conduct is still “a” or “the” legal cause of the injuries and, therefore, other events impacting mental health are relevant only to the extent the fact finder uses them to decrease money damages.48 By contrast, psychologists generally apply a biopsychosocial perspective to causation, which assumes that psychological symptoms are multidetermined, and that only in unusual circumstances can a single, direct and proximate cause of a plaintiff’s emotional symptoms be identified. When testifying about the cause(s) of an emotional disorder, the three types of experts differ in how or whether to address the issue.

The forensic evaluator approaches the task by conducting a comprehensive clinical history of the plaintiff’s life, as well as a detailed description of the events associated with the case, during the time frame immediately preceding, during and following those events. During that process, one goal is to determine if there is indeed a temporal association between the defendant’s conduct and the onset or exacerbation of symptoms as well as any distal or proximal factors in the plaintiff’s life that could have caused or contributed to the plaintiff’s symptoms. In the absence of a significant history of risk factors and prior trauma or stress, it is easier to establish a causal link between the defendant’s conduct and the plaintiff’s symptoms. However, the presence of significant risk factors, prior trauma and stress in the absence of protective factors muddies the causal picture considerably and forensic evaluators are often faced with the daunting task of trying to partition the various causal and contributory factors in the hopes of isolating the causal influence of the specific events alleged in the plaintiff’s lawsuit.

Forensic evaluators also address issues of causation by review of the plaintiff’s medical records. Many medical conditions are associated with emotional symptoms, and scrutiny is given to those in close temporal proximity to the plaintiff’s emotional problems that are allegedly linked to the legal case. Likewise, medical records typically provide documentation about the medications that the plaintiff has been prescribed, including psychotropic medications for emotional problems. Given that many medications for medical and psychiatric conditions are associated with side effects that can mimic various emotional conditions, forensic evaluators must address potential medication side effects in the causal picture concerning a plaintiff’s emotional problems. It is especially difficult to separate proximate and nonproximate causes of an injury when a significant amount of time has elapsed.49 It also is likely that litigation stress interacts with the original harm from the relevant injury making this task even more difficult.

For treating psychologists the principal goal is remediation of dysfunction or distress regardless of the cause. In fact, treating professionals may not always be permitted to render in-court opinions about causation.50 The principal difference between a forensic evaluator and treating professional involves methodology, specifically with the comprehensiveness of information that is obtained. Treating psychologists vary considerably in the extent to which they explore a client’s background, but in most instances that assessment tends to be less thorough and comprehensive than would be expected in a forensic evaluation. Consequently, the treating psychologist may have insufficient information about a plaintiff’s background to provide a defensible opinion regarding possible alternative causal or contributory factors associated with the plaintiff’s emotional problems. Likewise, it is uncommon for a treating psychologist to obtain and review medical records and medication logs concerning a plaintiff seen in treatment, and it is difficult for a treating professional in an expert role to rule out the impact of pre-existing or concurrent medical or mental health symptoms as well as the potential emotional side effects of medications used to treat those symptoms.

The consulting expert may be explicitly asked to address issues of causation in order to help attorneys make a case for or against the defendant’s conduct being the cause of a plaintiff’s problems. The extent to which a consulting expert can do so depends on the nature and scope of information obtained during discovery. In most instances the consulting expert will have access to prior medical and mental health treatment records as well as pleadings, depositions, affidavits and other case documents that may help in formulating the causal picture. Consulting experts may review reports prepared by forensic evaluators and treating experts, and the underlying information in relation to other experts’ opinions can then be evaluated. Consulting experts also may help in formulating questions for
depositions or cross-examination for attorneys to use in examining the basis and methodological underpinnings of an expert’s opinions.

Related to the issue of causation is the presence or absence of prior mental health conditions or medical conditions that may impact the nature of a plaintiff’s alleged emotional problems. There are three possibilities. First, a plaintiff has no preexisting medical/mental health problems. Hence, any emotional problems that emerged in relation to the defendant’s actions or inactions are more likely to have been caused by that conduct. Second, a plaintiff has documented mental health problems similar to the ones claimed in the lawsuit which predated the events of a case. Unless the severity of those symptoms has been exacerbated following the events of a case, it is harder to argue that any emotional problems that were already present could have been caused by the alleged conduct of the defendant. The important question in claims of emotional distress often becomes whether the defendant’s unlawful behavior “aggravated,” “accelerated,” or contributed in any way to the severity or course of the mental injury, even if it was a preexisting disorder. Thus, preexisting emotional problems may contribute to the plaintiff’s vulnerability to future emotional harm, resulting in greater psychological impairment than otherwise would be the case. A plaintiff can be compensated for emotional injuries if the defendant’s conduct results in the exacerbation of a preexisting psychological injury, but may not recover for emotional damages caused by other events or circumstances. Third, it is possible that a plaintiff has prior mental health problems, but a different and distinct set of psychological symptoms emerged after the events associated with the case. For example, if a plaintiff had been treated for depression before an industrial accident, and later experienced post-traumatic stress disorder, one could more easily support the argument that the new emotional symptoms were related to the case. Given high co-morbidity between various emotional problems, however, such specificity of effect is often difficult to establish.

Further complicating matters, individuals with preexisting conditions often cope with idiosyncratic reactions to different external stimuli and some people are better at coping than others. When confronted with emotionally stressful situations some people may minimize their distress, while others “nurse” the distress and “build it up.” Thus, personality traits also impact the clinical symptomatology that emerges “under conditions of trauma or cumulative stress.” Moreover, “long-standing” personality traits or disorders may substantially impact the determination of causation. If such traits or the disorder caused significant impairment to functioning (i.e., occupational, academic, personal, social) before the injury, these traits become legally relevant.

Issues of diagnosis also can be important to disentangling the causal/contributory influence of a defendant’s conduct and a pre-existing emotional problem. In the diagnostic guidelines for some emotional disorders, the time frame of symptom presentation is an important consideration. For example, for someone to be diagnosed with dysthymia, which is a long standing mild to moderate form of depression, psychological symptoms that satisfy the diagnostic guidelines must have been present for at least two years. If a plaintiff was diagnosed with dysthymia by a mental health treatment provider six months following an alleged wrongful termination, by definition the condition must have predated the adverse events in the case that supposedly caused those symptoms. Likewise, certain diagnostic codes like adjustment disorders and acute/post-traumatic stress disorder are used when there are identifiable environmental events that are implicated in the emergence of psychological symptoms. On the other hand, many mood disorders and anxiety disorders tend to be more chronic. Thus, if a plaintiff was diagnosed with bipolar disorder (which is a mental disorder that can be both chronic and genetically predisposed) following an alleged sexual assault it would be more difficult to support the argument that the disorder was caused by the sexual assault. An increase in the severity of symptoms might indeed be caused by the actions for which the defendant is legally liable, but first time onset of a plaintiff’s bipolar disorder would be unusual.

Conclusion
Psychologists can be helpful in civil litigation involving emotional injuries, but the roles and functions of forensic evaluator, treatment provider, and consulting expert have important implications. For psychologists, it is important that they clearly acknowledge potential biases, limits on validity/reliability of information, role differences, potential ethical pitfalls and other considerations that are implicated when moving from a clinical to a forensic role. The TSBEP has held that “a licensee specifically avoids accepting appointment or engagement for both evaluation and therapeutic intervention for the same case,” given the complexities involved and the host of potential ethical and methodological problems. When unavoidable, the best approach is one of caution and forthright acknowledgement of the potential limitations associated with psychologists’ observations and the various influences that may undermine the usefulness of the resulting opinions.

Analysis of the role differences between treatment providers and forensic evaluators serving as expert witnesses also has important implications for attorneys who employ psychologists. Experts’ credentials and the methods they use should be given close scrutiny to help protect against uncritical acceptance of experts’ opinions and the unnecessary waste of the court’s time. Attorneys, like judges, are becoming more sophisticated in their ability to promote “good” science and purge “junk” science. Appreciation of the methodological requirements for consultants, treatment providers and forensic evaluators help determine if an expert’s opinions can withstand careful scrutiny demands of Daubert, and related state and federal rulings. A clear understanding and respect for the differences between clinical and forensic contexts, along with the proper use of expert testimony, all enhance the value of psychological science in the courtroom.

John P. Vincent, PhD, ABPP, is professor, former director of doctoral training in clinical psychology, director of the Center for Forensic Psychology at the University of Houston, and clinical faculty member at Baylor College of Medicine. He is board certified in clinical psychology, and past director of the forensic division of the Texas Psychological Association. He can be reached at 713-790-1330 or jvincent@uh.edu.

Scott Lemond, JD, is a trial and appellate attorney and partner with the firm of Lemond & Ross, LLC. A former member of The Houston Lawyer editorial board, he can be reached at 713-223-2500 or slemond@lemond-law.com.

Tonya Inman, PhD, is research assistant professor at the University of Houston and assistant director of the Center for Forensic Psychology. She can be reached at 713-743-1072 or at Tonya.Inman@mail.uh.edu.
Understanding the Texas State Board of Examiners of Psychologists: A Response

Tim F. Branaman, PhD

Editor’s note: Dr. Branaman currently serves as chair of our licensing board. As he makes clear, these remarks reflect only his own opinion and not board policy. This piece is a response to an article in the last issue of the Texas Psychologist. You may find that, and all back issues of the Texas Psychologist at http://www.texaspsyc.org/displaynewsletter.cfm. (Click the pull-down menu in the center of the page.)

In the last edition of the Texas Psychologist, Summer 2012, an article written by Dr. Paul Andrews appeared. As a good friend and professional colleague, Dr. Andrews gave me a “heads up” notification that the article would be published regarding concerns he has about the Texas State Board of Examiners of Psychologists (hereinafter referred to as Board or TSBEP). He noted that I might not agree with and might not like some of what he had written. He was correct on one account; I do not agree with most of what he shared although I do not disagree with all. “Liking” or “not liking” is not so much an issue for me. I am more concerned about accuracy and the perception of the Board that is communicated to its stakeholders.

Having known Dr. Andrews for many years, I consider him not only a valued professional colleague and good friend, but also a man of principle and honor. While I value his opinion, I consider much of what he has expressed to be the product of frustration and misunderstanding of the mission and functions of TSBEP. I hope to shed some additional light on some of the points that were made in Dr. Andrews’ article. Before doing so, however, I would note that I am writing this article from a personal perspective. This article in no way represents any official position of the TSBEP, nor is it written in my official capacity as Chairperson for the Board. It represents my personal perspective as a psychologist who has served on the Board since 2008 and in the capacity of Chairperson since early 2010. This follows years of active involvement in local associations, as well as in various capacities with the Texas Psychological Association (TPA), and how it is different from the Board that TPA helped conceive. After having been founded in 1947, TPA had only come of age in 1964 when it was incorporated. Five years later, TPA engaged with the Legislature to accomplish passing the Psychologist’s Certification and Licensing Act that established the original six-member Board. The mission of the Board has been to protect the public; this is accomplished by implementing the statute in the form of regulatory procedures and rules to “provide qualified and competent practitioners who adhere to established professional standards.”

 Needless to say, much has changed since that time. During the late 1990s, changes in the Texas Education Code resulted in the practice of psychology in Texas public schools being placed under the oversight of the TSBEP. The TSBEP now has oversight of Licensed Psychologists, Provisionally Licensed Psychologists, Licensed Specialists in School Psychology, and Licensed Psychological Associates. The Board now consists of nine, rather than six, members comprised of four psychologists, three public members, and two licensed psychological associates. The Governor now appoints the Chair for the Board rather than it being an elected position as it was in the past. The Board relies heavily on an efficient staff consisting of its Executive Director, General Counsel, and other personnel. The work of the TSBEP is accomplished by the staff working with the Board. Determinations made by the Board on rules and policies require a general consensus in order to make decisions that require a majority vote. As with most boards and committees, this is more efficiently accomplished at some times than others.

From my perspective, it is within this context that the TSBEP carries out the mission with which it has been tasked by the state Legislature. With regard to concerns raised and opinions expressed by Dr. Andrews, I considered the article most misleading in its analysis of “services provided” in relationship to fees. While I do not disagree with the numbers as factual, I do disagree with the intimation that the Board is not providing services equitable to the amount charged for licensing fees. First, psychologist should remember, or be reminded, that more than half of the fee that is paid each year for a license is not for the license, per se, but $200 of the total amount is a “professional fee” that is levied on psychologists, physicians, dentists, optometrists, chiropractors, CPAs, and architects, among a few other professionals. This took place in 1991 as a product of HB 11. As I recall, we were told that it was the better alternative than being required to pay sales tax on fees received for service. As Dr. Andrews noted, that professional fee goes directly into the general revenue, as does the licensing fee received by the Board. The Board must justify its annual budget and request for funding from the Legislature each legislative session. Moreover, as with all state agencies, the Board has to carry out its mission and deliver services with less money allocated by the Legislature. The only means of being able to maintain services at the present level may be through a request for the Legislature to allow the fee for license renewal to be increased.

The TSBEP manages what is appropriated to it by the Legislature and considering the size of the Board’s staff and number of licensees, I believe a good job is done with that. As a practitioner, I understand the frustration with licensing fees that remain the same, while reimbursement rates go down. However, this is a statutory and legislative process that is driven by economic and fiscal considerations over which the TSBEP has no control. This is a matter that should not be attributed to Board operation. The TSBEP staff personnel should be congratulated for maintaining the high level of services that the Board has been able to provide in the short term. The
only way that the Board can continue to do that is by raising licensing fees.

Dr. Andrews suggests that “TPA support for any fee increase should be dependent on TSBEP making good on prior promises regarding such support, addressing with us ways to challenge the $200 per license surcharge, and exploration of projects that can be mutually beneficial to both organizations.” However, psychologists should keep in mind that TPA is the legislative advocate for psychology. It is not the mission of the TSBEP to advocate for how the state Legislature chooses to fund the Board or to implement professional fees. The Board may only serve to inform the Legislature in response to specific issues. It is our mission to seek sufficient funds to do what we need to do, and we carry out that mission, although it may require asking the Legislature to increase our fees. One must also remember that TSBEP remains a free standing entity because of the Board’s effort, and the support of TPA, at the last Sunset Review, a process which we will soon be addressing once more.

With regard to psychologist stakeholder support of increased licensing fees, Dr. Andrews complained that the Board had not “honored” a quid pro quo agreement regarding a continuing education monitoring fee. Concerning such a monitoring agreement with TPA that was not followed through on, I would have to say that is categorically a misrepresentation, although I expect an unintended one. While a TPA representative may have had a discussion with a Board member about that topic, there was no Board agenda regarding implementation of a continuing education monitoring system that the Board did not follow through on. No conversation with a single Board member or a staff member binds the Board to any action.

With regard to Dr. Andrews’ complaint that Board rules are characterized by a “moralistic” versus “ethical” approach, I would note that “moralism” is an ethical approach most generally equated with deontological models rather than situational models. Situational models do not lend themselves to legal enforcement. Legislation, statutes, and regulatory rules grow out of a value system and ethical paradigm. However, ethical standards are aspirational and aspirations are not enforceable, nor should they be. The mission of TSBEP is not to provide ethical or best practice guidelines but to provide rules that are regulatory and enforceable in nature, which are consistent with ethical practice that is founded on an acceptable standard of practice, which will not result in harm to the consumer. Any action that we take on these rules has to be defensible in a court of law, at the least an administrative law court, and potentially a state court if pursued to that level. That is inherently a legalistic process. I would say from my personal perspective that while rules need to be written in a manner that they can be enforced in a legal system, that ideally they must also be written in a manner that is not overly specific and does not have unintended consequences. Regulatory rules are also dynamic and may change with the developing trends in a profession or may be instituted at the direction of the Legislature to address general stakeholder concerns.

Dr. Andrews asks that TSBEP make better use of committee delegation to more carefully consider rule changes. I believe that input from stakeholders is useful. The TSBEP is responsible for multiple stakeholders with various needs and agendas. The ultimate stakeholder is the consumer of psychological services. With regard to soliciting input for rules to be considered, procedures are in place for consideration of possible rule changes to be brought to the Board by stakeholders. I know that in recent years during my tenure on the Board that professional input has been solicited from specialty groups regarding rule development, e.g., forensic practice. Additionally, an open meeting was held to solicit opinions from the public and various professional groups on one of our more recent rule modifications. Furthermore, rules that are drafted and brought to the Board for discussion and consideration are always submitted to the public for comment before a vote is taken on whether they will be implemented in their proposed form. I personally am interested in professional input for developing rules that address matters of concern with regard to licensing, maintenance of competent practice, and delivery of psychological services that provides the consumer with an acceptable standard of care or service. I will continue to look for practical ways in which such input can be solicited from our multiple stakeholders.

Dr. Andrews indicated that he believes that it is the Board’s responsibility to monitor and police the Internet as represented by his statement, “When insurance companies and mental health resource websites list non-psychologists under a heading of “Psychology” providers and TSBEP does nothing to confront this practice, this inaction neither protects the public nor upholds the integrity of the license TSBEP regulates.” I would note that in response to Dr. Andrews’ concern, as well as the Board’s recognition of emergent issues posed by the Internet and digital media, the TSBEP has proactively responded to such listings. This is not a new issue, but it was a more manageable one when we were dealing with local yellow pages. It is not so now. This is a matter that involves jurisdictional issues, servers located in various states and possibly countries, aggregators of web information, and lack of understanding of use of titles from state to state, as well as information that has been uploaded to the World Wide Web and remains frozen there in perpetuity. While I would expect to continue to be cognizant of this concern and address it as effectively as possible, I think that it is not a realistic representation of the Board’s mission, capabilities, or authority to suggest that it is tasked with this duty.

In closing, I want to reiterate that as Chair for the Board, I do value input and will seek to facilitate such input to the best of my ability in ways that are consistent with the Board’s mission, the size of our Board, the size of our budget, and the diversity of our multiple stakeholders. I would state again that all that I have shared here is my personal perspective and certainly does not represent an opinion or official position of the Board. It is only my personal response and perspective that has developed in the context of my role with the Board and in response to the issues brought up in Dr. Andrews’ opinion article. Any comments that I have made that might be construed as suggesting commitment on the part of the Board to act in particular fashion should be understood to be only a reflection of my personal commitment in my role with the Board and not a statement on behalf of the Board. I know that I certainly look forward to continued thought-provoking discussion and input from my friend, Dr. Andrews, and productive dialogue with fellow psychologists and the Texas Psychological Association, as well as other professional associations representing the various stakeholders of the TSBEP.
Conflict in AG Opinions on Reporting Child Abuse

J. Ray Hays, PhD, JD
Floyd Jennings, PhD, JD
Ollie Seay, PhD
Karen A. Lawson, PhD

Texas has had one of the broadest and best child abuse reporting statutes in the Nation; in Texas any person who has reason to suspect that a child has been abused or neglected is required to report that suspicion to appropriate authorities (Chapter 261, Texas Family Code). Many other states do not have such a broad reporting requirement, which has led to a failure to report suspected abuse to appropriate authorities, such as seen in Massachusetts with the serial abuse of children by priests and in Pennsylvania, in the abuse of children by Jerry Sandusky and the failure of reporting. The duty to report child abuse which occurred during the childhood of a now adult person is now at question, as there are conflicting attorney general opinions on that matter (DM-458 and GA-0944). This conflict threatens to dilute what was an excellent reporting statute.

Here is a synopsis of the two opinions:

Reporting dated and incomplete information
In response to a 1997 query from the Counsel on Sex Offender Treatment an attorney general’s opinion suggested that a report of abuse or neglect must be made even if the information was dated or incomplete (DM-458). The Opinion seemed to suggest that reporting must be done regardless of the present age of the abuse victim (“...a person who suspects that a child has been abused shall report the suspicion and shall do so immediately...”). Note the statement “a child has been abused...” Moreover the opinion states “...the reporting requirement expressly applies without exception to any individual whose personal communications are normally privileged.”

What if the child is now an adult?
A problem arises when the child who was allegedly abused is now an adult. Children have different privacy rights from adults. Does the full panoply of adult privacy rights prevail over the state interest in dealing with alleged abusers? A recent decision by the attorney general (GA-0944) has apparently limited a person’s duty to report when the abuse of a child occurred in a person who is now an adult. That opinion states “…that the term ‘child’ used in Chapter 261 refers to a person who at present...is under eighteen,” and further states “…a professional is not required to report abuse or neglect that the professional believes occurred during an adult patient’s childhood.” The effect is to relieve the professional of a duty to report and, by conflating other privacy provisions in the Texas Statutes, would suggest that to report abuse or neglect of that child where the child’s name is reported would be a violation of the privacy right of the now adult patient, thus also removing any immunity from liability of the professional for such reports that was provided by the Child Abuse Reporting Act to either the now adult patient or to the person implicated by the report. In other words the now adult patient could sue the professional for breach of confidentiality for the report, and the alleged abuser could sue the professional for a false accusation.

What if the patient is just now an adult?
The real quandary for those who provide treatment to patients who report abuse or neglect comes when the patient is only recently an adult by reaching the age of 18 years. One day the professional is required to report suspected abuse or neglect and is immune from liability for good faith reporting; the next day after the patient’s 18th birthday that professional may no longer report such alleged abuse even in the presence of other children exposed to possible abuse. If a report is made the professional runs a risk of liability both from the patient and from the alleged abuser.

State has an interest in protecting children
It seems to us that the state has an interest in examining what might have been a criminal act toward a child even where the reporting is done by someone who is now an adult. We know from our experiences and from research that abusers seldom have a single victim; multiple victims are the norm, not the exception. Abuse of one person suggests abuse of others. We understand that a mental health professional does not have the job nor the knowledge, skills, or experience to investigate abuse or neglect; that is the job of the Texas Department of Family and Protective Services (CPS) and law enforcement agencies. However, CPS and law enforcement cannot investigate what they do not know. Having neither a report or some starting place, these agencies cannot investigate abuse or neglect.

Proposed resolution of the problem
There is a legislative change that may provide a resolution to this problem, a change that would require reporting of all suspected abuse, regardless of the current age of the alleged abused person, but which would protect the identity of the now adult patient. We can take guidance from the reporting requirement for sexual exploitation by a mental health provider contained in the Civil Practice and Remedies Code (Chapter 81.006). That code requires that a professional who “…has reasonable cause to suspect that a patient has been the victim of
sexual exploitation...shall report the alleged conduct...” and provides that the alleged victim be informed of the reporter’s duty to report with the option of the alleged victim to remain anonymous. Regardless of the alleged victim’s decision to remain anonymous the professional must still report the suspicion.

The reporting provision of the sexual exploitation statute provides for a limited immunity from liability for the professional who reports under that statute, so long as the report is made in good faith (Chapter 81.007). This liability protection is important to eliminate or reduce any negative legal consequences to the professional for reporting suspected abuse.

**Recommendation for TPA**

The dilemma presented in the two attorney general opinions deserves to have a solution in legislation so that any suspected abuse is investigated by appropriate agencies, but which respects an adult’s privacy rights, and provides immunity for professionals who report in good faith. TPA should propose legislation to amend the Family Code to track language found in the Civil Practice and Remedies Code regarding sexual exploitation by mental health service providers.

This change would resolve the conflict between these conflicting opinions, keep Texas child abuse reporting statues among the strongest in the nation, and perhaps avoid some of the problems experienced in other jurisdictions where a failure to report abuse or neglect resulted in a continuation of abuse that might have otherwise been prevented with timely reporting. Our children deserve this protection by the state.

---

**A Snapshot of TPA Membership**

Brian H. Stagner, PhD  
*Director of Professional Affairs*

We recently conducted a survey of TPA members. There were two purposes. First, the Legislative Committee had raised some specific questions about the nature of psychology practice in Texas. These questions had to do with how many psychologists were working with various special populations; it was felt that this sort of data might be useful next spring during the legislative session. Our second purpose was to sound out the respondents about the general perception of TPA among the members. We wanted to get a better sense of how the membership would like TPA to allocate its resources and what goals TPA should be pursuing on behalf of the profession and the TPA membership.

We sent out a bit over 100 surveys to a randomly selected sample of members representing several regions around the state and got 31 responses. Not a stellar return, but we did very little follow-up to increase response rate — this was a pilot project. Respondents were divided 50/50 male to female, with an average age of 56. On average they received their doctorates 18 years ago, but there was a wide range (3 to 39 years since graduation).

Virtually all of the respondents are involved to some extent in delivering clinical services. One section of the survey asked about the percentage of the clinical time that was spent on different activities. Table 1 lists the percentage of clinical time, the number and the percentage of respondents who reported any time in each activity. Not surprisingly, 90 percent of the respondents provide individual therapy and, on average, this mode consumes just under half of the respondent’s clinical workload.

---

**TABLE 1: How do you spend your clinical time?**

<table>
<thead>
<tr>
<th>Activity</th>
<th>% of clinical time</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual therapy</td>
<td>44</td>
<td>28</td>
<td>90</td>
</tr>
<tr>
<td>Couples therapy</td>
<td>13</td>
<td>21</td>
<td>67</td>
</tr>
<tr>
<td>Assessment</td>
<td>16</td>
<td>21</td>
<td>67</td>
</tr>
<tr>
<td>Group Therapy</td>
<td>5</td>
<td>7</td>
<td>22</td>
</tr>
</tbody>
</table>

We were very interested in learning about the populations that were being served. Table 2 lists the percentage of time that respondents spent with different populations. Only five individuals (16 percent of the sample) spend any time with criminal offenders. Those five respondents report that, on average, this work involves about 5 percent of their clinical time. Respondents may have endorsed more than 100 percent time in this section, as it is possible that a given clientele would be counted as members of several populations (e.g. health psychology services for geriatric substance abuse patients).

**TABLE 2: Who do you serve?**

<table>
<thead>
<tr>
<th>Population</th>
<th>% of clinical time</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric</td>
<td>13</td>
<td>26</td>
<td>84</td>
</tr>
<tr>
<td>Criminal offenders</td>
<td>5</td>
<td>5</td>
<td>16</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>9</td>
<td>21</td>
<td>67</td>
</tr>
<tr>
<td>Adult MR</td>
<td>6</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Autism</td>
<td>17</td>
<td>11</td>
<td>33</td>
</tr>
<tr>
<td>Other Spec. Ed. Populations</td>
<td>24</td>
<td>17</td>
<td>54</td>
</tr>
<tr>
<td>Trauma victims</td>
<td>14</td>
<td>13</td>
<td>44</td>
</tr>
<tr>
<td>Health Psychology</td>
<td>31</td>
<td>10</td>
<td>30</td>
</tr>
<tr>
<td>Ethnic minority</td>
<td>37</td>
<td>21</td>
<td>67</td>
</tr>
<tr>
<td>Poverty groups</td>
<td>19</td>
<td>12</td>
<td>39</td>
</tr>
<tr>
<td>Physical disability</td>
<td>8</td>
<td>13</td>
<td>44</td>
</tr>
</tbody>
</table>

While some of our sample are in full time, fee for service, cash up front practices, most are not. Table 3 lists the percentage and sources of income that our sample derives from clinical work. In this table, it probably makes sense to treat the Contract Referrals and Managed Care categories as one entity. These numbers testify to the diversity of employment settings for TPA members. A quarter of the sample derives the substantial majority of
clinical income from salaried positions. Three quarters of the sample depends on cash reimbursements, with the average person in this group receiving just under half their income from this source. Only about 30 percent of the sample are involved with Medicare and fewer of these are also participating in Medicaid.

<table>
<thead>
<tr>
<th>TABLE 3: How are you paid?</th>
<th>% of income</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash</td>
<td>45</td>
<td>23</td>
<td>74</td>
</tr>
<tr>
<td>Salary</td>
<td>87</td>
<td>8</td>
<td>25</td>
</tr>
<tr>
<td>Medicare</td>
<td>26</td>
<td>10</td>
<td>30</td>
</tr>
<tr>
<td>Medicaid</td>
<td>18</td>
<td>7</td>
<td>22</td>
</tr>
<tr>
<td>EAP</td>
<td>7</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Contract referrals</td>
<td>24</td>
<td>7</td>
<td>22</td>
</tr>
<tr>
<td>Managed Care</td>
<td>39</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

We also asked where TPA should be spending its energy on behalf of the profession. Table 4 is fairly self-explanatory. The respondents are uniformly very concerned about the changes in the regulatory environment which threaten their professional identity.

<table>
<thead>
<tr>
<th>TABLE 4: What should TPA be doing for Psychology? (1= top priority, etc)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protecting the Title</td>
</tr>
<tr>
<td>Fight against carveouts</td>
</tr>
<tr>
<td>Fight against the deceptive practice of Managed Care</td>
</tr>
<tr>
<td>Work to increase fees in the public sector</td>
</tr>
<tr>
<td>Educate the public about psychology</td>
</tr>
<tr>
<td>Advocate for services for the chronically mentally ill</td>
</tr>
<tr>
<td>Protect/promote training programs</td>
</tr>
<tr>
<td>Fight for prescriptive authority</td>
</tr>
</tbody>
</table>

These numbers are from a small sample. We made an effort to elicit responses from all the major cities in Texas plus a scattershot sample of rural areas, but the response rate was too small to permit more nuanced analyses of patterns in the data. We will leave you to your own conclusions about these largely descriptive data. The descriptive data demonstrate that TPA members work with a broad range of patient populations, and they provide a wide range of services. Although the majority of respondents derive some income from direct services, the sources of income are actually very diverse. Despite this diversity, the respondents were remarkably uniform in their perceptions of the major priorities for TPA. Many of these challenges in the regulatory environment will be on the table in the coming legislative session, and TPA leadership will be carrying these priorities to Austin to advocate for the protection of the profession.

In short, your colleagues are coalescing around a consensus agenda to preserve the highest standard of psychological care. There will be 70 new politicians in the next legislative session, and TPA will need all members to step up and build relationships with these freshman legislators. Without your involvement, our agenda will be very difficult to pursue. Contact Dr. Mehl and Dr. Schneider (see article on page 4) about helping, and plan to attend TPA’s legislative day to help with advocacy this spring.

What should be the focus of the Texas Psychological Association?

A. Grace Jennings, PhD
President, Houston Psychological Association

Editor's note: We are asking leaders in our Local Area Societies to offer their perspectives on what TPA should or could be doing to help promote their profession. Dr. Jennings graciously answered the call first.

What should be the focus of the Texas Psychological Association? This question was recently posed to members of the Houston Psychological Association (HPA). Although it is difficult to determine how most HPA members would respond, the following information was gleaned from the responses of the members who shared their perspectives.

The most frequent HPA responses concerning TPA were related to the legislature. These responses indicated that TPA should continue to advocate and lobby in the legislature for all psychologists to protect the title and practice of psychology in the state of Texas. This is especially critical considering that each year there appears to be another group of practitioners attempting to limit or infringe on the practice of psychology in Texas. A case in point is the most recent group claiming that psychologists don't know how to
conduct behavioral analyses. In addition to protecting the title and practice of psychology, pursuing prescription privileges and fighting to have the $200 special assessment fee on psychology licenses rescinded were also suggested as important areas of focus. Apparently, psychologists are the only professionals still paying this fee.

One HPA member stated, “no one should be deprived of mental health services because of inability to pay.” Several members feel that TPA should focus more on the issue of mental health services for everyone and advocate for insurance reform that encourages more insurance companies in Texas to credential more psychologists and to pay claims at parity with medical claims. In Texas, even with Medicaid and Medicare, there is practically no safety net available for the elderly, disabled, and poor as well as the uninsured and under insured. Even an excellent insurance plan can be drained quickly for individuals with chronic mental health issues. It is felt that TPA should advocate for more mental health services in any way it can, including suggesting resources that are available so that practitioners know what to tell individuals or where to send them when they are unable to pay. It was also suggested that TPA provide support for training clinics and other resources that can provide sliding fee, low cost, or free care. One member suggested that

TPA provide free workshops or classes. Locally, Mental Health America of Greater Houston has a limited list of pro bono providers, so possibly promoting something similar at the state level would help in this area.

Several private practitioners indicated that TPA should focus more on providing direct benefits for psychologists. TPA’s past efforts in the past to provide a group health insurance contract for members were applauded, even though those efforts were not successful. It is felt that TPA should stay abreast of the national medical and psychological landscapes as to what may impact the practice of psychology and keep Texas psychologists apprised of anything coming down the road such as issues regarding ICD-10 codes, changes in the DSM-V, and the Affordable Care Act. It was suggested that TPA educate psychologists on how the Affordable Care Act will affect them, e.g., will electronic records be required in Texas, what does that entail, and what will be the cost?

Other areas in which TPA was considered a source of education for psychologists were in negotiating a Merchant’s Services Company contract (e.g., what is the going rate for handling credit card payments, etc.) and keeping psychologists informed of Medicaid/Medicare issues and changes, such as the formula for proposed reimbursement cuts, etc. Also, helping psychologists understand the paperwork and procedures required to keep one out of “hot water,” if one stops accepting Medicare but wants to see a Medicare-eligible patient. Changes in technology and legislative issues were also considered areas of focus for TPA. In terms of technology, educating psychologists about the pros and cons of a psychologist having a Facebook page was mentioned. What are the ramifications of budget cuts in higher education and student loan programs for the future of psychology? Is there really a psychology internship crisis for doctoral psychology students? If so, what can be done about it?

Overall, I think many view TPA as a source of education to provide guidance for members of local area societies (LAS). TPA could serve as a clearinghouse, connecting local area societies and sharing statewide what a LAS is doing that works to address various/ specific issues. Finally, other issues considered important enough for TPA involvement are a generational divide in the workplace, with older psychologists feeling alienated and unappreciated; preventing professional burnout; and psychologists dealing with depression and stress.

**Psychology Students — The future of psychology**

**Texas Psychological Foundation supporting their efforts — and having fun while doing so!**

Elizabeth L. Richeson, PhD, MS PsyPharm
TPF Board Member

No matter the years that have passed since you were that ever-hopeful graduate student, you probably well remember the trial and tribulations of the experience. Some of us remember the experience more fondly – but we all remember. The graduate students that are following in our footsteps today are the ones that we must hand hold as they complete their journey.

I wonder where I would be without the wonderful and often challenging mentors that I had throughout my graduate school days. Some of us are still mentoring in one form or another – some are standing on the sidelines as these younger versions of ourselves grow their grey matter. No matter – there are many ways to guide and help our students.

One of the most significant reasons I agreed to return to the Texas Psychological Foundation Board was the emphasis the foundation has in their outreach to this next generation of psychologists. Psychology students are our future – and I want to do my part to help them – to protect our profession especially at this time when there are so many detractors.

The Texas Psychological Foundation is the philanthropic entity within the Texas Psychological Association. It is a non-profit body that works to raise money to fund our many worthwhile graduate student grants. We endeavor to fund these grants through many diverse
means including fun ways at our annual convention. This year the foundation board has been particularly creative, and we have many surprises in store for our attendees.

Fun alert: For the first time ever at our convention we will have our creative right brains challenged at “Painting with a Purpose.” This three hour event – off site – provides all the materials and artistic direction needed to paint a pre-chosen object. To help lubricate our brains, refreshments including wine will be provided. You must register prior to convention. Adding to the fun, our president’s painting will be sold at a silent auction on Friday night.

Fun alert: The Big Giant Head, also known as the Texas State of Mind Head, will be for sale at the convention. This beautiful one-of-a-kind object d’art has been keeping the TPA staff company, but it is time for him to find a new home. We envision him in a office waiting room or entrance way, perhaps a university office, or even a home library. Where ever he goes, no doubt the TPA staff will miss him, and he will be a great conversation piece.

Fun alert: Mock Interviews will be held for our psychology students to help them prepare for their job searches. We have members of our board who have volunteered to be interviewers for this event. Come join us in supporting our students.

TPF, like many of us, fell on hard financial times, which necessitated closing down our grant giving for a couple of years. This has been a disappointment to those of us on the board, as well as to the many students that would have liked to apply for our grants. For some of us it was a personal disappointment because we were particularly invested in one or more grants. Each grant has a specific purpose and each deserves to be funded. But we cannot do that without your help. And if anyone doubts the value of any size tax-deductible donation – imagine if all of our members each donated $50 – we would have $63,450 and that would fund ALL of our grants at once. A $25 donation would yield $31,725 and put us well on our way to sustainable efforts. Please make your donation today at www.txpsychfoundation.org.

As a non-profit we do a reach-out to our members. But as we ask for money we want to give you information about each of our wonderful grants so that you can identify the one you’d like to help fund. Currently there are eight awards or grants, which focus on a variety of topics. Each of these grants has come into existence as a result of our members’ interests and concerns, and they are expected to encourage research design attending to the area delineated by the grant.

- **Alexander Award** – ORIGINALLY FUNDED AT $500 – WE NEED YOUR HELP TO FUND THIS AWARD. Provides an award for the best paper submitted by a graduate student in psychobiology, psychophysiology and related areas.

- **Bo and Sally Family Psychology Research Award** – ORIGINALLY FUNDED AT $1,500 – WE NEED YOUR HELP TO FUND THIS AWARD. Provides awards for research projects related to family psychology.

- **Jennifer Ann Crecente Memorial Grant** – ORIGINALLY FUNDED AT $5,000 – WE NEED YOUR HELP TO FUND THIS GRANT. Provides an award for a Texas graduate psychology student in good standing who is conducting research addressing potential causes and/or prevention of dating violence.

- **Manuel Ramirez III Dissertation Award for Ethnic Minority Research** – ORIGINALLY FUNDED AT $500 – WE NEED YOUR HELP TO FUND THIS AWARD. Provides awards for research projects related to Ethnic Minority Psychology.

- **Rose Costello Education Fund** – ORIGINALLY FUNDED AT $500 – WE NEED YOUR HELP TO FUND THIS GRANT. Provides funds for furthering education in psychology.

- **Roy Scrivner Gay, Lesbian, and Bisexual Issues Award** – ORIGINALLY FUNDED AT $1,500 - WE NEED YOUR HELP TO FUND THIS AWARD. Provides an annual award for the best student research paper on gay and Lesbian issues.

- **Schoenfeld-McCann-Schmidt-Ehrisman Fund for Ethics Education** – ORIGINALLY FUNDED AT $500 – WE NEED YOUR HELP TO FUND THIS AWARD. Provides funds for education in ethics in the field of psychology in the state of Texas.

- **TPA-TPF Student Merit Research Awards** – ORIGINALLY FUNDED AT $500- WE NEED OUR HELP TO FUND THIS AWARD. Given to one graduate and one undergraduate student to defray costs of meritorious research projects.

Please help us get our awards and grants funded again. Our students are counting on us.

Those of you that are affiliated with a university - we are profoundly interested in what your psychology graduate students are doing. Please contact me at elr@drricheson.com with that information, and we will be glad to put that information into our next newsletter.

Our first TPF Newsletter for this board was emailed out in April. If you did not receive it or want to review it again you can find it on the TPA website. (click on About TPA – scroll down to Texas Psychological Foundation – once there you’ll find the link to the newsletter at the bottom of the page). The new TPF brochure will be available for distribution at the convention.

We hope to meet all of you at the TPA annual convention, the best place for networking for psychologists in Texas.
Bring Harmony to Your Practice

At CPH & Associates, our dedicated consultants are committed to providing the most comprehensive, accessible Professional Liability Insurance featuring NEW HIGHER LIMITS* to protect your most important asset, your peace of mind.

Unlimited Defense Coverage
Covers you for legal fees and court costs involving claims or allegations at no additional cost.

State Licensing Board Defense
Automatically receive limits of $35,000 with options to increase up to $100,000 available.

Deposition Expense Coverage
Pays up to $10,000 per deposition.

Medical Expense Coverage
Pays up to $5,000 per incident regardless of fault.

Enhance Your Benefits with
• First Aid Coverage
• Assault Coverage
• Defendant’s Reimbursements
• Portable Coverage
• Professional Liability
• Supplemental Liability

Ask About Our Discounts**
• Newly Licensed
Receive up to 50% off your professional liability premium if you have been licensed within 24 months.

For Licensed Clinical Psychologist Only – Receive 15% off if licensed within 36 months.

• Risk Management Discount
Save 10% off your professional liability premium for completing your states Legal and Ethical CEU requirement for licensure renewal. Only applicable to fully licensed professionals.

CPH & Associates only provides Occurrence Insurance, protecting you from claims and damages made during the life of the policy, even after it expires. Plus, your premium stays the same year-to-year.

Trust CPH & Associates, leaders in insurance and risk management solutions for healthcare and social service fields.

APPLY ONLINE: www.cphins.com
Save 5% off your Professional Liability Insurance Premium and get your proof of coverage in minutes!

* Higher limits not applicable to all coverage benefits listed. **A combination of discounts cannot exceed 50% off the premium.
National Register of Health Service Providers in Psychology Continuing Education Seminar

The Impact of the Patient Protection and Affordable Care Act on Psychologists

November 29, 2012 • 4:00 pm - 6:00 pm • Hyatt Regency • Austin, TX

Open to All Psychologists and Psychology Doctoral Students

Reception Immediately Follows the Seminar • Meet the National Register Board of Directors and Staff

Learn about Licensure Mobility, Credentials Banking/Verification, and FindAPsychologist.org

RSVP Today at NationalRegister.org

About the Presenter

Ronald H. Resensky, PhD, ABPP is past chair of U.S. Department of Health & Human Services' Advisory Committee on Interdisciplinary, Community-Based Linkages and participated in making recommendations to Congress on healthcare reform including topics of interprofessional education and training and the importance of addressing health behaviors in integrated care.