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# Table of Contents

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

*From the Editor* ................................. 2  
Brian Stagner, PhD

*What Will Psychology Look Like in 2020?*  .......... 3  
Walter Erich Penk, PhD, ABPP  
Dolores Little, PhD

*What Do I Want for Psychology*  .................... 6  
Marcy Laviage, PhD

*The Future of Psychology as a Health Discipline*  .......... 8  
Melba J.T. Vasquez, PhD, ABPP

*Show Me the Data* ................................. 9  
Leslie Rosenstein, PhD

*The Future of Traditional Psychotherapy*  ............ 10  
Kim Arredondo, PhD

*The Future of Neuroscience and Psychotherapy*  .......... 12  
Rowland W. Folsenbee, PhD  
Ashley Acheson, PhD

*Get to Know the Texas State Board of Examiners of Psychologists*  .......... 14  
Paul Andrews, PhD

*Future of Psychology Practice in the Era of Health Care Reform*  .......... 15  
James H. Bray, PhD

*The Demise of the Generalist*  ...................... 16  
Mary Alice Conroy, PhD

*Whither Now?*  .................................. 19  
Brian Stagner, PhD

*Texas State Board of Examiners of Psychologists*  .......... 22  
Paul Andrews, PhD
From Your President:

Lane Ogden, PhD

Texas Psychologist editor Dr. Brian Stagner came up with a wonderful idea that has produced this outstanding edition. Dr. Stagner has invited various distinguished Texas psychologists to comment on their vision of the future, specifically how they see the field of psychology evolving in the next 5-10 years. You too have probably thought about the future of your profession. What is your vision?

Perhaps not coincidentally, the Texas Psychological Association is celebrating 65 years in existence right now, and there are some fun and exciting related events to take place honoring this anniversary at our annual convention in Austin Nov. 1-3. Please make plans now to be there!

Though I have no special skills as a prognosticator (Indeed, I am not yet recovered from a self-diagnosed Acute Stress Disorder incurred during last year’s Rangers World Series debacle—though I know my four weeks are up,) I will include some ideas I’ve had as well.

Let me share my own thoughts. I believe we may be entering a period in world history where events occurring on that large stage may have significant impact in such distant corners as the practice of psychology. I am concerned that factors other than science, other than “best practice” policies, and even other than what is simply and clearly best for people will begin to strongly impact the practice of psychology. Things seem “fragile” on the vista of international politics right now to an unusual degree.

As I write this in late May, we have one middle-eastern nation vowing openly to destroy another as they apparently pursue the development of the same nuclear weapons the “target” nation already possesses—and has promised to use if survival is jeopardized. We have a new Premier in an Asian country whose leadership has been recently characterized by saber-rattling and bellicose defiance—also apparently pursuing the development of nuclear weapons. And these are just “known unknowns” leaving to imagination what other crises may be impending unimagined on us.

We have direct economic threat from a number of well known and potentially devastating sources both foreign and domestic: the European Union, especially Greece; weak dollar; more and more foreclosures; war dragging on; scary sized part of the GNP for debt relief; disproportionate health care costs which are ever rising; seemingly unrelenting dependence on foreign oil. And of course there’s the additional destabilizing stress on economies that would go with the outbreak one of the “new” wars I mentioned above. I am uneasy about the possibility of a significant shift in zeitgeist such economic pressures might bring to bear on our current practice of psychology both in Texas and throughout the USA.

At present, we define a good psychological outcome as some sort of improvement, such as increased adaptive functioning, better health, or more desired subjective states. When I am looking at the glass as being half empty, I am concerned that as world events unfold and the ripple reaches us, good outcome might become synonymous with “cheaper,” and that the criterion of cost will outweigh any other variable when assessing what constitutes a good outcome. Thus, if there is a way for something to happen more cheaply, it would be, by definition, better. Psychologists, who by training demand expertise and clinically validated methods and quality, could feel a financial pinch as a result of those who practice similarly to us but with less of these limiting restrictions and who are willing to work more cheaply.

I believe the day when third-party payers for psychological services will homogenize reimbursement rates is imminent. Indeed, in some cases this is already happening, and in others our fees have simply been cut. On this pessimistic side, I fear that any practical incentive to attain the level of competency a doctorate provides will disappear and so the term “Psychologist” will be absorbed and consequently redefined by market rather than scientific or competence based forces.

But, when I am looking at the glass as being half full, which is my tendency, I see infinite possibilities. I believe we are likely entering a period of rapid change but that we can influence the trajectory of that change by using our skills as psychologists. Physics tells us it is much easier to direct the movement of a body in motion than to overcome the inertia that prevents movement from starting. Systems theorists tell us that a crisis can be seen as good, as motivational, even as requisite for change to truly take place. In shifting markets, there is much opportunity; it is truly an ill wind which blows no good. I see the possibilities as unlimited for us to come to apply our expertise and unique blend of skills in ways or arenas of service delivery that are new, unique and infinitely more valuable. We must confidently and without fear embrace challenges and competition as shifts take place. We must remind ourselves that what we produce has high value in any way that term is defined. We must strive to find new ways to use our talents and abilities, creativity, and energy in serving emerging, expansive, exciting client bases. We must continue to adapt or risk practical extinction. Simply put, we must use the same psychological principles we share with others on ourselves.

There remains plenty of work and plenty of discovery to be done. I believe we still have time to educate the public and influence the political powers that control much of how licensed professions are defined. We need as never before to become personally involved in this educational process. And we need as never before to actively support and engage in the tasks initiated by professional organizations who seek to represent us as a group.

I hope you too see the glass as being half full and enjoy this edition of the Texas Psychologist. Let your imagination run free and come join us for stimulating conversation and predictions of future possibilities in Austin this Nov. 1.
From the Editor:

Brian Stagner, PhD

TPA is busy with many projects on behalf of its members, but central to many of these is the need for advocacy: helping APA lobby for mental health legislation in Washington, or having the grassroots network lobby our Texas Legislature, or engaging in legal battles over scope of practice, or negotiating with fee-setting policymakers in the public or private sector. These efforts may be critical to our survival in the immediate future, but it is useful to have a broader perspective about where psychology is headed.

Psychology will look very different in ten years, and TPA will have to adapt or fail. Contributors to this issue of the Texas Psychologist were asked to forecast the challenges that psychology will face in the next 5-10 years. What do you think should be in our long-term vision? By promoting a bit of forecasting we can mobilize the membership, particularly the ECPs, to lead TPA forward to be in a leadership position in the future of our discipline and profession.

Several folks who were invited did not choose to respond, but not because they were ducking the opportunity to embarrass themselves with predictions that might look fatuous in hindsight. Rather, they declined because they are discouraged. One individual called in some distress saying, “I’d like to write something, but I am so discouraged by all the attacks on our profession and the dwindling reimbursements that I would have nothing encouraging to say.” Fear is rational when change is thrust upon us. Hopefully these contributors will stimulate your plans for adapting to the future.

—Brian Stagner

*Reference lists for these articles will be available on the TPA website at www.texaspsyc.org.
What Will Psychology Look Like in 2020?

Walter Erich Penk, PhD, ABPP
Dolores Little, PhD

Introduction
In 2006, a group of psychologists speculated about how Psychology in the Public Sector will look in 2020 (Miller, DeLeon, Morgan, Penk, and Magaletta, 2006). We hoped to initiate strategic planning for the future. Our answers were written by those who grew up when President John Kennedy had challenged us all by saying, “Ask not what your country can do for you, but what you can do for your country.”

Many of us have answered by dedicating our careers as psychologists to practice in public service, medical schools, VA medical centers, prisons, universities, and federal, state and legislative agencies. We speculated on the driving forces that would change our profession as psychologists, like changes in health care delivery paradigms, technology and information systems, professional accountability, economic infrastructures that impact contracting to deliver services, shifts in clinical populations and points of intervention, credentialing and licensing, and prescription privileges.

That was six years ago. But it’s worth repeating the question, not just for psychologists in public service, but also for those who practice in private sectors. We find ourselves confronting great changes that are happening so fast and changing so much.

Shortly after 2006, the U.S. economy collapsed and fears persist today for economic deterioration in the USA and elsewhere. Austerity was the first answer to cope with economic collapse but now is being questioned. The U.S. housing bubble burst. U.S. banks may not have become too big to fail, as new anxieties arise from recent stumbles at JPMorgan Chase. An Arab Spring started to bud, but no one knows whether it is a weed or a flower and whether it will wither or bloom. New forms of health care insurance (e.g. Affordable Health Care Act of 2010) were passed but it’s not clear whether health care reforms are weeds or flowers and whether health care will bloom or dry up. The fate of health care now depends in part upon forthcoming decisions from the U.S. Supreme Court and results from the November elections. U.S. political parties are splintering, and factions are fracturing to both the right and the left, stalling the U.S. Congress. Citizens are growing in body mass indices (BMIs), walking less and driving more, and driving up gasoline prices. Wars started as revenge for 9/11 are decreasing, but the threats of terrorism still stress us all. The times, they are “a-changin,” and changes listed above are just a few of the many sectors where change has, and is, taking place so profoundly and so quickly. Uncertainties persist. Strategies for coping remain unknown and untested.

Given so many changes, we repeat the question from six years ago: In a world of enormous change, what will psychology look like in 2020? It is a question that the Texas Psychological Association (TPA) must address, as we strategize to cope with many forces influencing public policies that shape contributions from psychologists for citizens and institutions in the state of Texas. Answers will come from us all, for all of us together can strengthen our profession for its future. We hope to hear from others about what each intends to do for the profession.

Looking at the article from 2006, we are surprised that much of what was anticipated indeed now has started to occur. We are astounded by how much was not anticipated. Mainly, we underestimated how quickly changes would take place that transform the delivery of services by psychologists working in the public sector and delivering private services — changes in education, health care delivery, prevention, behavioral health for chronic diseases, executive coaching, telehealth, training psychologists and other clinicians, changes in private and public policies, and investments for, by, and with all psychologists in general.

What we did not predict, in 2006, was the failure of the U.S. economy and its impact on the delivery of health care services, including psychologists. The U.S. economy collapsed in 2007 into the worst recession since the Great Depression of 1929-1939. Firms thought too big to fail teetered toward bankruptcy. U.S. industries decreased production, went deep into debt, and were bailed out by taxpayers. Taxes increased for the poor and decreased for the rich. The federal deficit rose from $3 trillion in 2001 to $13 trillion by 2009, and deficits have not, as yet, been stopped, despite strenuous efforts by many politicians for the past several years. Federal deficits are now climbing to $15 trillion. One of the biggest surprises was that the U.S. borrowed more money from U.S. citizens to survive (e.g., $2.5 trillion from Social Security funds and $1 trillion from federal employee retirement accounts) than from the Chinese ($1.3 trillion) and the Japanese ($1 trillion).

Consequent reductions in financial support from federal and state taxpayers’ resources have negatively impacted those practicing psychology. The number of psychologists working for state health care systems, along with those teaching in secondary, undergraduate and graduate schools, has leveled and may be decreasing. Support is dwindling in economic aid to educate students, while tuition and other costs are escalating. Financial support for internship and postdoctoral fellows are declining. Health care insurance is reducing reimbursements for psychologists. PhDs delivering psychological services are replaced by practitioners with bachelor’s and master’s degrees. State psychology licensing boards question requiring PhD for credentialing. Threats to psychology are growing!

Despite declines in the number of psychologists, economic forecasts predict that more psychologists will be needed by 2020. The U.S. Department of Labor is predicting growth for psychologists over the next decade. While some sectors may reduce psychologists (as in states), others are already hiring more psychologists (such as federal agencies). After counting gains and losses by types of sectors where psychologists work, U.S. Bureau of Labor Statistics is predicting that well over 20 percent more psychologists will be needed by 2020.

Such predictions influence our prediction about what psychology will look like in 2020. Part of the answer
Psychologists must change from what we expect psychology to be to what we want psychology to become. A metaphor to guide us is the investment strategy of Warren Buffett: Invest when the market is down, not when it is high. “Stocks” in psychology are down right now, so now is the time to invest. Recently (5 May 2012), some investors in Omaha asked Mr. Buffett why prices for Berkshire Hathaway stock had not grown. Mr. Buffett answered that those stocks had collapsed and were still low, so it was time to buy. This meant the price of Berkshire Hathaway remained about the same for last year because he was investing. It was time to buy. It was not time to worry about returns.

Psychology’s stock is down, so we need to invest. We can’t worry whether or not we are profiting, but rather we should focus on investing in our profession to produce gains commensurate with improvements in our sciences and our practices. Rather than complain about our losses we should reinvest in our scientific discoveries about how the mind and body work, as well as in providing interventions and services that will produce gains in functioning.

Increasing Training and Continuing Education
First, we need to reinvest in our training and in continuing our education in psychology. It’s not time to decrease PhD qualifications to practice as psychologists. Practitioners with doctorates should not be replaced by those with bachelor’s or master’s degrees. Discoveries in psychology are multiplying, demonstrating that mental health is far too complicated for undergraduate degrees alone to suffice. Not having enough money is no excuse for lowering our standards for psychologists with PhDs.

This is the time for more education and going beyond the doctorate to require postdoctoral training. It is time to require even more continuing education across the board for those conducting research and teaching, as well as licensed practitioners. Boarding for specialties must continue through professional organizations like the American Board of Professional Psychology (ABPP). Psychologists should continue to develop and advance new benchmark standards for practice (e.g., ABPP). TPA is doing much to extend expertise for psychologists in practice through continuing education and collaborations with other licensed professions (See www.texaspsyc.org). All psychologists in Texas should be joining TPA, and using it and other local professional societies to increase their education.

Psychology as a science must be united with psychology as a practice. APA and APS need more collaboration rather than continue to operate separately. Gains from uniting scientists with practitioners in the late 1930s produced a well-organized discipline to confront swift changes that took place as the Great Depression ended and World War II concluded. Now APA and APS must join to combat the anxieties and trauma from terrorism that threaten us all in the 21st century. This is when we all must be about the business of creating the next Greatest Generation.

Changes in Health Care Delivery
Sciences, including psychology, are growing. There is particular growth in genetics and neuro-imaging, and in other bio-physical investigations. This has created a demand for new forms of learning, as well as classification of disorders and treatments. Such growth will change how psychology is practiced, particularly in health care delivery and its interaction with changes being created by whatever parts of the Affordable Health Care Act of 2010 survive. Clinical psychology is expanding by integrating behavioral health into primary care.

Likewise, psychological health care delivery is expanding into the community. Changes in diagnostic criteria for DSM-IV-TR added criteria to all disorders in which community functioning is now an element for each diagnostic formulation (e.g., criterion B for schizophrenia and criterion F for PTSD). Applications of WHO’s International Classification of Functioning, Handicaps, and Impairments are increasing. Functional criteria require psychologists not only to reduce symptoms within the individual, but to develop assessment and interventions to improve functioning outside the person, in homes, with families, at work, during school, and for communities. Such changes will require additions to Current Procedural Terminology (CPT) codes that, in turn, will drive psychologists beyond psychotherapy to delivering psychosocial rehabilitation in the community.

Interventions like cognitive processing therapies and prolonged exposure must be integrated into psychosocial rehabilitation. Such integration of therapies with rehabilitation must no longer be practiced in offices, clinics, and hospitals, but must be redesigned to take place at work, during school, with families, and for communities. This is where all our people must live, and where we must practice.

Technology and Information Systems
Extensions of the practice of psychology will incorporate emerging technology. Information systems already are functioning in health care systems to measure client adherence to medical and psychological treatments, as well as symptom management. These systems are based upon techniques developed in mental health by the Veterans Health Administration in the 1980s and continue to this day. Recently added are measures of physical and psychological health promoting behaviors for health-related risky behaviors (See, for example, VA’s https://www.myhealth.va.gov/index.html).

It is the Age of Apps. And psychologists must master how elements of treatment can be delivered through apps (Cf. www. dcoe.mil, for list of apps to treat sleep disorders, manage pain, reduce PTSD symptoms, cope with TBI, assuage Depression, limit use of alcohol, nicotine, and illicit drugs). Facebook is one of many Internet-information systems that is changing teaching and treatment. Treatments for mental disorders (e.g., PTSD, Traumatic Brain Injury, and other combat-related conditions) are available online. Each person has access to courses to improve character and achievement. (See summary in Chade-Meng Tan, 2012; Also, Martin E. P. Seligman’s University of Pennsylvania Positive Psychology website at http://www.authentichappiness.com). Psychologists must develop technologies and information systems within their professional services and learn how to extend relationships with clients through such techniques as Facebook, Twitter and any new developments as the Cloud engulfs us all. Simultaneously, psychologists should lead the way in
teaching all of us how to avoid the behavioral pitfalls of the Internet, in keeping with procedures described so well in Larry Rosen’s (2012) iDisorder: Understanding Our Obsession with Technology and Overcoming its Hold on Us.

**Professional Accountability**

Additionally, accountability for psychologists will continue to change. Research is the strongest skill psychologists possess. We are skilled not only in designing theory-guided interventions but also validating outcomes. Psychologists already lead professions in empirically validating treatments. All interventions can be empirically validated — psychotherapy, mindfulness, psychosocial rehabilitation, chronic disease management and psychological services for medical disorders. Competency skills to practice psychology should include capacities to conduct clinical trials. Accreditation for training must include verifying that training itself is standardized and effective. Outcome effectiveness is essential in professional accountability. Education and treatment is comprised of many interventions but too few have been tested for efficacy.

In an age of health care reform, psychologists in private practice will need to develop teams and alliances among professions to assess outcomes. Psychologists will be expected to demonstrate that they are standardizing delivery and that outcomes are efficient and effective. Technology and Information Systems are being used in private practice: Networks must be formed to assess competency and efficacy. TPA and local area societies are well-situated to foster development of such networks for professional accountability. This is a role that TPA needs to examine to lead implementation — facilitating formation of outcome evaluation systems among psychologists in private practice to validate accountability.

**Economic Infrastructure**

Psychological services and accountability were not included in original Medicare/Medicaid legislation. APA’s Practice Directorate was, and remains to be, an active partner in the 2010 Affordable Health Care Act (www.apapracticecentral.org and www.my.apa.org for services and reimbursement for Medicare, 2011.). Health and Behavioral (H&B) Codes for assessment and intervention have been created by APA’s Practice Organization (See May, 2012, issue of the Monitor on Psychology) for Medicare and other public- or private-sector health insurance plans. Reimbursement for psychologists occurs more frequently for psychotherapy, but billing in behavioral health for integrated service delivery is less, though growing. Certainly, H&B codes are already fully operational within the Veterans Health Administration. Such changes document on-going developments in the economic infrastructures for reimbursing psychologists in delivering health care services. These changes must continue to expand cognitive and behavioral approaches beyond psychotherapy to include compliance with nutrition and exercise regimens, adherence to medical regimens, dispensing educational information about medical and psychological disorders, adding social support in disease management, creating networks of family support, and creating peer support (For recommendations about reimbursement for H&B codes, see www.ama-assn.org, www.cdc.gov/nchs/icd/icd9cm.htm).

For 2020, psychologists must devise new economic infrastructures for capitation and contracting on costs for psychological services. Cost-gain reckoning is needed as another way to demonstrate benefits of delivering psychological services: Clients need to know emotional and monetary benefits for services that they are about to receive. Psychologists will have to negotiate for reimbursement in new health care alliances, which are now required by the Affordable Health Care Act of 2010.

We might consider expanding the concept of the Cooperative in psychology: bringing the consumer together with the psychologist. 2012 is the International Year of the Cooperative (See www.coopyear/un.org). Cooperatives have long flourished in Texas (e.g., Pedernales Electric Cooperative, Guadalupe Valley Telecommunications Cooperative, The University of Texas Co-op). Psychologists must begin to consider developing new economic infrastructures, based upon operations of Co-ops, in which consumers contract in advance with psychologists to deliver psychological services. Cooperatives were formed to balance social responsibilities while sharing economic liabilities. Several thousand cooperatives exist throughout the United States to achieve many different objectives. In the turmoil about debates regarding health care reform, consumers of psychological services might create agreements with psychologists to create their own unique cooperative as another creative way to advance health care reforms.

**Clinical Populations and Points of Interventions**

Creating cooperatives would expand the boundaries of clinical populations served by psychologists. However, there are other influences driving who psychologists may serve, such as revisions currently underway for DSM-5. Clinical populations are likely to expand. Proposed revisions in DSM-5 may expand the scope of practice for psychiatrists but provide room for more collaboration with psychologists. Such expansions arise in part from the extent to which behavioral health techniques are being spread by psychologists from their offices for psychotherapy to the needs of citizens with chronic medical diseases to adhere to medical treatment requirements, to manage symptoms, to improve functioning, to promote health, and to prevent disorders and deteriorations of medical conditions. Such changes are opening up and expanding the frontiers of clinical populations that will be served by psychologists. Furthermore, such expansions are increasing the points of interventions, highlighting the needs for prevention of disorders, not merely concentrating on treating disorders. Additionally, changes in accountability, based upon cost-for-gain reckoning, further lengthen the span of time in which effectiveness for treatment is assessed, as well as increases the populations who are served, as prevention is added.

Moreover, the Internet is greatly changing clinical populations served by psychologists. Psychologists must master telehealth and its tools for classifying disorders, delivering treatment and assessing effectiveness. Within a short period of time, a notable portion of treatment and rehabilitation will take place on the Internet. This will happen not just through consumers using Apps, not only by manualized treatment approaches written to be taken by computer, but also by clinicians directly contacting clients and delivering services through computers (See Lifestreamonline.com, a private organization developing online techniques for therapy). However, Larry Rosen (2012) sounds the alarm in iDisorders that the Internet requires skills to manage.

Prescription privileges are another driving force to expand services delivered by psychologists. Training is already well developed, and psychologists are already licensed to prescribe in some states. Prescription privileges increase the kinds of clinical populations that psychologists serve. Psychologists bring a special advantage to prescribing drugs — the capacity to measure outcomes
unparalleled by any other mental health profession. Assessing outcomes, as well as effects, of drugs are complicated. Psychologists are demonstrating the capacity to prescribe, as well as the ability to evaluate outcomes that are key to treating with both drugs and psychological techniques.

**What Must We Make Psychology To Be in 2020?**

Asking what psychology will look like in 2020 must be rephrased: What can we make psychology be by 2020? Central to remaking psychology is asking what would each one of us like to be doing eight years from now. So, the answers, in part, are discovered by asking not what psychology can do for us as much as what we are willing to do for psychology. These are the times for all of us to continue to plan.

Walter Penk, PhD, ABPP, is a 1965 graduate in clinical psychology from The University of Houston. He worked for the Veterans Administration from 1962 until 2003, at VAs in Houston, Dallas, Boston, and Bedford. His clinical academic appointments have been at Southwestern Medical School, Tufts and Boston University School of Medicines, Harvard Medical School, and the University of Massachusetts Medical School. Currently, he is Professor in Psychiatry/Behavioral Sciences at Texas A&M College of Medicine. He consults with VA Rehabilitation Research and Development, VA VISN 17 Center of Excellence, and DoD’s STRONG STAR projects.

Dolores Little, PhD, is a 1973 graduate in counseling psychology from Texas A&M University. She served as Associate Chief of Staff in Education for the VA in Dallas, trained in VA Hospital Administration at the San Antonio VA, and was the Associate Hospital Director at VA medical centers in Big Spring, Texas; Bedford, Massachusetts; Providence, Rhode Island; and Loma Linda, California, with supplementary VA assignments in Boston and Brockton, Massachusetts.

### What Do I Want for Psychology

Marcy Laviage, PhD

Where will the field of psychology be in the next 10 years? Where will psychologists be in the next 10 years? Where will I be in the next 10 years? I…don’t…know. So, since I have been banging my head trying to answer these questions, I’ve decided to modify the questions a bit to now read – Where do I want the field of psychology to be in the next 10 years? Where do I want psychologists to be in the next 10 years? Where do I want to be in the next 10 years? Now, that I can answer.

The field of psychology is vast. At one point, even before the start of my professional career, those who practiced in the field of psychology were commonly referred to as psychologists. Now, however, those who practice in the field of psychology are therapists, psychotherapists, counselors, social workers, marriage and family therapists, psychiatrists, behavior analysts, and other titles with a varying range of degrees and expertise. This field is growing, and in the next decade I find myself wondering not if, but when and how many additional titles will be subsumed under this umbrella.

There is a huge need for mental health providers. And all of the various titles that now fall under the field of psychology are important and critical to meeting the vast needs of individuals in our country. Referring back to what I “want” to see in the next 10 years for our field, I want to see governments supporting mental health programs by showing commitment to finance them. I want physicians recognizing the role of mental health in their patients’ physical health and taking a collaborative and multi-disciplinary approach to their treatment. I want schools to better understand the stress our children are under and implement more frequent breaks, introduce yoga during the school day, and/or offer other creative outlets for our over-pressured, over-scheduled and over-tested children. Our field helps save lives in multiple ways and on multiple levels and, in the next 10 years, I want that to be stated as a fact by politicians, physicians, teachers, parents and children.

I think focusing on where psychologists will be in 10 years is the reason why I wanted…needed…to modify the way the question was originally framed. We have some challenges of which most psychologists are aware, but that will likely be focused on in other articles within this edition. I am going to stay focused on the positive.

In Texas, one must have a PhD in psychology to use the title psychologist. One must have an MD to use the title physician. One must have a JD to use the title attorney. See where I am going? In the next 10 years, as psychologists, we need to work hard to assert ourselves as deserving of a place at the doctoral level table among the other professions. We should not sit back and wait for our invitation at this proverbial table. We need to advocate for ourselves and what we, as psychologists, can offer that is separate and different from what others in the mental health field can offer. Again, this is not about being more important than any other mental health provider—anyone

**“We need to work hard to assert ourselves as deserving of a place at the doctoral-level table among the other professions.”**

We all know psychology has a lot to offer. Very few question the mental health needs of millions of Americans across gender, age, culture and SES level. No one is immune to the influence of genetics, trauma and/or environmental forces that allows one to become overwhelmed by his/her vulnerability. Psychology helps to identify, explain and treat these needs, offering insight, skills and hope to those struggling with mental illness.
and everyone in this field is critical to meet the needs of our society—it is about differentiating ourselves, our education, our approach, our conceptualization, our scientific reliance, our leadership, our professionalism, and all the other ways that we can stand apart from other mental health providers with different education backgrounds.

The problem, which has been stated over and over again, is that we, as a professional group, are notoriously terrible at advocating for ourselves. We seem to prefer a passive, conflict-avoidant manner rather than make our presence known. If there is one change I want to see for psychologists in the future it is that we recognize our own value! Imagine the improvement of an individual’s health when his/her general PCP, PhD, and specialized MDs are all working together to coordinate a physical and mental health plan for treatment!

We need to start marketing ourselves as psychologists. TPA is doing everything it can to advocate on a legislative level. As individuals, we need to reach out on a community level. We need to meet with local medical, dental and legal groups, as well as any and all others with whom we can collaborate and educate. Recently, I was invited to attend a meeting of the local chapter of the Texas Pain Society, a group consisting of pain management specialists such as anesthesiologists, neurologists and orthopedic surgeons. With the abuse of prescription pain meds at an all-time high, they recognize the need for psychologists to assist with pain management and provide their patients with alternative strategies to control their pain. This collaboration seems like a marriage made in heaven. In every community, imagine what an impact can be made if PhDs and MDs work together to control chronic pain and reduce the amount of substance use and abuse by individuals.

There are any number of connections that can be made with specialists in the medical community. Another example is the involvement of psychologists in the athletic world. I also recently presented at a conference entitled “The Athlete and the Brain.” The majority of the audience was athletic trainers and coaches with the first half of the day focusing on the impact of concussions and the latter half, on ADHD in the competitive athlete. Presenters were Sports Medicine physicians, neuropsychologists, psychologists and athletic trainers. The recent suicide of professional football linebacker, Junior Seau, is a perfect example of why and how all these disciplines coming together can benefit so many people. Psychologists should be at the forefront of decision-making policies and treatments for athletes.

No legislative decision affecting mental health should be made without psychologists sitting on the steering and investigative committees. There has been a group of professionals involved in updating the current Mental Health Code in Texas. It has not been updated in over 25 years whereas the practices, services and standards have changed dramatically. We know that leading the committee of this project is a psychiatrist, and the steering committee is made up of “judges, attorneys, law professors and clinicians” (TMHC Draft submitted 3/21/12). There may be a psychologist on this committee, but TPA is unaware of whom that person may be. Our state association is working to provide critical input to the Mental Health Code that will directly affect the role of psychologists, but we have had to react to this information rather than be a proactive part of the process.

Speaking of TPA, in the near future (and I am really hoping that it is within 10 years), I would hope to see every psychologist practicing in Texas be a member of TPA. Whether in academia, VA, medical, school or private practice settings, the role of TPA is vital for each individual psychologist as well as our profession here in Texas. I have worked with the membership committee for the past five years and feel I have critically examined why TPA is relevant regardless of job position, job title or job setting. TPA has been in existence a long time and as an organization, it is maturing, growing, developing, and more importantly, learning. As an association representing many individuals, it has had to make tough decisions and tough stances that has thrilled some and perhaps, alienated others. The tide of TPA is turning. We are listening to the needs of each person that speaks up and the needs of each collective group – for example, with a recent expanse by the VA to hire a significant amount of mental health providers, TPA is keeping its pulse on how APA is managing the announcement. With the recent internship match resulting in a significant number of graduate students not being matched because of a disproportionate number of students to available internship slots, TPA is working to help create new programs. With the need for so many individuals to have neuropsychological evaluations whether because of congenital conditions or acquired brain injury, TPA is introducing legislation to allow use of extenders in testing. This bill would allow more individuals in the community to get needs met, more training positions available for our future psychologists, and more employment positions for our licensed psychological associates. I am concerned that there are those who feel the sole motivation behind this bill is to increase the profit margins for psychologists. I am not in a position where I would use extenders; however, I see the benefit to the community and to our own profession to be much greater than the benefit to any individual provider. If you have had or currently have concerns about the future of TPA, please speak up. I am open to talking further with each and every one of you who still question why TPA is relevant and critical to the life of our profession here in Texas.

As for me and where I want to be in 10 years, I hope I am continuing to do exactly what I want to be doing. It may or may not be what I am doing right now, but currently, I am doing exactly what I pictured myself doing when I was in graduate school. First and foremost, I am raising the two most wonderfully curious boys together with my wonderfully supportive and creative husband. Second, I am engaged in clinical work that I love and continue to have passion for. Third, I am involved in professional organizations such as TPA, local psychological associations, and other professional specialist groups that allow me to integrate my work with others in and outside of psychology. Finally, I can be involved in my community and continue to feel good about the work I do for them while making new friends (and I love teaching my boys that one is never too old to make new friends). These are the reasons I became a psychologist. And in 10 years (yikes, my kids will be 20 and 16...no way!), I plan on being wherever my pursuit of happiness and peace leads me. I hope the same for all of you.

Dr. Laviage is president-elect designate of TPA, having previously served as membership chair and member of the Board of Trustees. She is in private practice in Houston.
The Future of Psychology as a Health Discipline

Melba J.T. Vasquez, PhD, ABPP

Many of us are wondering about the implications of the changes of the health care reform act. In June 2012, we heard the Supreme Court’s decision about all or some of the provisions, especially whether the federal government can require individuals to purchase health care. Regardless of their decision, there are many questions about which no one has answers yet. How will health care reform change our practices? Are reimbursement rates going to change? Are we all going to be required to keep, store and transmit electronic records? What about telepsychology?

Over the next few months, more of this information will become clearer. In this article, I will focus on some of the basic concepts involved in integrated health care, and how it has been a key aspect of the evolution of the nation’s future health care system.

What is integrated health care?

Often referred to as interdisciplinary or collaborative care, integrated care brings together health care professionals who work in teams to treat the whole person (Novotney, 2010). Stress-related symptoms account for two-thirds of visits to family physicians, according to the American Academy of Family Physicians, and more than a third of Americans in a recent poll reported that they had an illness caused mostly by stress (APA, 2012). More than 300 studies have found that psychological distress can weaken the immune system; people with diabetes are twice as likely as those without the disease to experience serious psychological distress, and psychological interventions with heart patients can reduce the risk of further cardiac events by 75 percent compared with those who receive only medical care and medication (APA, 2012).

Psychologists’ work on interdisciplinary teams is already improving treatment outcomes and lowering costs, and there are many successful models for this work. Physicians, psychologists, nurses and other providers work together to diagnose physical and psychological health problems, plan and provide treatment, and evaluate whether that treatment is effective (Novotney, 2010). Studies are reporting that when patients receive mental health care services onsite, they reduce treatment time, need fewer appointments, and this results in lower costs compared with patients referred offsite to mental health centers or providers.

If this is the future of health care, what are the implications for our practices, both in private practice as well as in the various agencies where we work? What changes need to occur in our training programs and continuing education in order for us to remain up to date?

Since 1996, the American Psychological Association has produced several policies recognizing the importance of the inseparable relationship between mental and physical well being. APA has thus worked to ensure that behavioral health services are included in Health Care Reform. These efforts have been based on the belief that everyone should have coverage that provides affordable health care for all basic services, including psychological treatment to maximize rehabilitation of physical conditions, quality of life, and prevention that address the role that behavior plays in many of the leading causes of mortality and morbidity. We know that common health conditions often coexist with behavioral health problems, and unless those are treated, these conditions worsen. Psychologists have the skills and expertise to promote change of unhealthy behaviors of individuals, to improve quality of life, and to reduce the level of disability associated with illness. This results in dramatic reduction of costs in our health care system.

Most of us have integrated the evolving evidence of the role of behavior in the prevention and treatment of various chronic diseases caused by or mediated by behavior, e.g. heart disease, some cancers, diabetes, depression, suicide. However, the idea of moving one’s office to work in a hospital or clinic setting, in an office with physicians, or any of many other models may be intimidating to some of us; exciting to others.

Various models of integrated health care have been discussed in the literature and at conferences in the past decade or so. Several models or paradigms have evolved about how psychological services should be provided in health care settings. One is in family medicine settings, where psychologists and other mental health professionals literally work together and provide services in a primary care setting; another paradigm is working in a disease-specific setting. Psychologists who work for the Department of Veterans Affairs (VA) have worked under mandated integration of mental health services as the standard of care at all primary care clinics since 2009 (Novotney, 2010). In addition to working with geriatric health care, spinal and head injury treatment, primary and hospice care, and post traumatic stress of veterans, they guide, coach and consult with primary care physicians and other related staff. An example of speciality care may be someone who works with pediatric physicians and who provides help in an enureisis clinic, pediatric obesity treatment program and/or an ADHD treatment intervention program.

The goal is for comprehensive treatment to be provided by members of a team working together, and a long-term relationship is established between
Pat Smith, owner and CEO of a mid-size company is approached by employees who wish to purchase a new printer to replace their current printer. Before spending the money, Pat would like to know the cost of the new printer, how much it will cost to maintain, how this compares to the current printer, and what they will gain with the new printer. The insurance industry is no different, nor should it be. The insurance industry is a business. Insurance companies are able to fund health care for their clients with their earnings — earnings that would be lost if ineffective services are funded in lieu of effective ones. It is, thus, critical for the field of psychology to demonstrate the clinical utility of our services.

Just as we should not expect Pat to invest in a product that will not improve the company’s operations while expending excessive resources, it is not rational to demand insurance companies to underwrite services that have not been proven clinically beneficial and cost effective. Approaching third-party payers and government agencies requesting coverage for our services without “showing them the data” gives us the appearance of being nothing more than self-promoting. Rather than being self-promoting, we want to determine and demonstrate the services that will benefit our patients and clients and, based on those data, advocate for adequate coverage of those services.

Medicare and other third-party payers currently use medical necessity as the benchmark for determining whether a service will be covered (CMS, 2012). While medical necessity can be viewed as a somewhat vague term, concrete data demonstrating clinical benefit can be argued to illustrate the medical necessity of a service. This is particularly so when it can be further shown that the clinical benefit results in a decrease in utilization of other health care services (i.e., cost effectiveness) and improves quality of life.

Various medical academies regularly publish statements and standards underlining the medical necessity of services, including services provided by our own field. As an example, the American Academy of Neurology (AAN, 1996) published a report in which they rated neuropsychological assessments, generally, as Established, with class II evidence for specified conditions and a Type A recommendation with noted restrictions. The American Academy of Child and Adolescent Psychiatry (AACAP, 2007) addressed the use of neuropsychological assessment in the diagnosis of ADHD, stating that “Psychological and neuropsychological tests are not mandatory for the diagnosis for ADHD, but should be performed if the patient’s history suggests low general cognitive ability or low achievement in language or mathematics relative to the patient’s intellectual ability.” Unfortunately, AACAP did not extensively review studies addressing the utility of neuropsychological evaluations in guiding intervention or differentiating ADHD from their conditions. In their document, AAN conducted an extensive review of available studies assessing the utility of neuropsychological evaluations.

Importantly, third-party payers rely on these types of reports in determining the medical necessity of services. As an example, Aetna references the AACAP report in their clinical policy bulletin regarding psychological and neuropsychological testing (Aetna, 2012) in which they determine that neuropsychological testing is rarely considered medically necessary for uncomplicated cases of ADHD.

Serving as a potential model for all of psychology, the American Academy of Clinical Neuropsychology (ASCN, 2012) has developed a program to address outcome studies regarding
neuropsychological services as a means to determine and document the utility of those services. This program includes, among other efforts, a nationwide research consortium, presentations at their annual conference, and the establishment of a grant-funding organization, the American Academy of Clinical Neuropsychology Foundation, which funds studies addressing outcomes. These efforts are being combined with advocacy, which includes contacting and providing education and information to other organizations, third-party payers, and government agencies regarding the role of neuropsychologists and neuropsychological services.

In summary, to secure adequate coverage of our services for our patients and clients, it is incumbent that we demonstrate the medical necessity of those services. To do so, we must have data to show. There are currently data available for publication, as well as literature reviews, which can be carefully and exhaustively culled through. In addition, it is important for us to continue to encourage and support studies that determine, delineate and document the effectiveness of our services. We must also educate our members regarding the need for and methods to conduct outcome studies. Without data, we will not be effective in advocating for our services.

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The Future of Traditional Psychotherapy

Kim Arredondo, PhD

According to Yale University professor Alan E. Kazdin, “approximately 70 percent of individuals in need of psychological services do not receive them.” In his speech at the 2009 APA Presidential Summit on the Future of Psychology Practice, Tillman Farley, MD, stated that most people will not go to a free-standing mental health center and only about 15 percent of the people referred actually go. Only 50 percent of the clients who get an appointment show up to the appointment. Even with so few people receiving services, there are not enough psychologists or other mental health providers to provide the amount of services needed.

Psychologists must develop new methods to deliver services to those who need them. What will those services look like? How will they be delivered? Who will provide them? Where will the sessions take place?

Integrated Health Care
People with diabetes are two times more likely to develop depression, and people with depression are also more likely to develop diabetes. People with both disorders are at 2.3 times greater risk for mortality than people with either disorder alone. People with both diabetes and depression are less likely to follow diet, exercise and medication treatments than those who have only one of the conditions (de Groot et al., 2010). “If you take someone who is a diabetic and you don’t manage their depression, you can’t manage their diabetes,” said Frank deGruy, MD, during his speech at the 2009 APA Presidential Summit. Psychologists know the most about human behavior and how to change it. Clearly, psychologists must become full partners in the health care system to provide integrated health care.

Primary care psychology has emerged as a subfield that can be provided through a variety of models to coordinate mental health and medical issues for patients. “Models range from curbside consultation to fully integrated care in which psychologists work side by side with medical providers to provide consultations and treatment on a part- or full-time basis” (Gatchel & Oordt, 2003).

School-based health clinics are another model of coordinated mental health, medical services, and services related to school issues. The clinics are located on or close by school campuses so they are easily accessible. The schools, hospitals and other agencies combine staff and resources to provide a wide variety of services to the patients all in one place. At the same clinic, the client and their family receives therapy, medical exams and treatment, information and education, and collaboration with school personnel.

Technology and Service Delivery
David C. Mohr, PhD, is a professor of preventive medicine at Northwestern University and the director of the Center for Behavioral Intervention Technologies. Dr. Mohr’s research focus is to develop behavioral interventions that use technology to take the interventions into the client’s own environment. His research has shown that computer programs can effectively teach cognitive-behavioral therapy techniques to the client with depression and other disorders; especially when the interventions include emails or phone calls. He also found that a self-monitoring Internet website intervention for depression was very effective.

Dr. Mohr also is developing a program to increase the client’s compliance with treatment by using online social networks. The patient’s online social network of peers can see the patient’s goals and login activity and provide encouragement or correction as needed.

Yale psychologist and psychiatry professor Kathleen M. Carroll, PhD, and colleagues Samuel A. Ball, PhD, and Steve Martino, PhD, have developed a computer program called, Computer-based Training in Cognitive Behavioral Therapy (CBT4CBT). The modules feature film clips depicting people struggling with real-life situations where drug use is likely, with opportunities for patients to reflect on what they might do in the
A number of recent studies have shown that telephone-administered treatments are effective at reducing depression, well accepted by patients, and able to extend treatment to patients who experience significant barriers including disabilities.

2000 and 2008, with approximately 10 percent of providers using it weekly or more in 2008.

Telepsychology means to provide psychotherapy, psychological assessment, and testing using various electronic means such as videoconferencing, teleconferencing and telephone therapy; psychotherapy and counseling over the internet through various software packages with or without a video camera or webcam; counseling via email or internet chat; and using social networking sites like Facebook, etc. APA, the APA Insurance Trust and the Association of State and Provincial Psychology Boards launched a task force in 2011 to develop guidelines for telepsychology practice.

Administering psychotherapy over the telephone may overcome many barriers associated with failure to initiate treatment and attrition from treatment. A number of recent studies have shown that telephone-administered treatments are effective at reducing depression, well accepted by patients, and able to extend treatment to patients who experience significant barriers including disabilities. Furthermore, telephone-administered psychotherapies are likely associated with low rates of attrition, compared to treatments delivered face to face.

Evidence-Based Practice
Psychologists must integrate basic scientific evidence into their regular practice and choice of interventions and treatment. APA has developed a number of policies on evidence-based practice.

A recent longitudinal study was conducted using 165,958 men and women at least 30 years of age who received antidepressant medication in primary care for a depressive disorder. Moderate daily doses of antidepressants for 24 months or longer was associated with an 84 percent increased risk of diabetes (Andersohn, Schade, Suissa, & Garbe, 2009). Non-medication therapies are at least as effective as antidepressants relapse better than antidepressants (Babyak, et al., 2000). Stathopoulou, Powers, Berry, Smits, and Otto (2006) reviewed 11 studies investigating the effects of exercise on mental health and concluded that exercise should be included in the treatment plans for patients with depression. Merely making a recommendation to a client that they need to exercise is not enough as many clients would not know how to follow through or have the financial resources to join a gym. Some psychologists hold the therapy session outside while they walk with the client. Others have provided exercise equipment in the waiting room or office.

APA’s Mind-Body Health Campaign utilizes national and local outreach activities to educate the public about the connection between psychological and physical health. The campaign also promotes psychologists as the best-trained health care providers to support healthy lifestyle and behavioral change. Psychologists need to be informed about nutrition, relaxation, meditation, relaxation, sleep, and how to teach the client about a healthy lifestyle.

Traditional one-to-one psychotherapy will always be around for the clients who need it. However, the future of psychology as a profession depends upon its ability to work collaboratively with the medical community to provide integrated health care and to continue to evolve and develop new methods of delivery in order to overcome barriers to accessing services and meet the needs of the clients.
The Future of Neuroscience and Psychotherapy

Rowland W. Folensbee, PhD
Ashley Acheson, PhD

This consideration of the future of neuroscience and psychotherapy begins with a brief reflection on one of the author’s training as a psychologist. When I began taking psychology classes as an undergraduate in the early 1970s, behavior therapy and Skinner were at war with the humanists and Carl Rogers. The brain was nowhere to be found on the clinical battlefield. By the end of the ‘70s, when I began my graduate training, there was a ‘Brain and Behavior’ course to be taken, but consideration of cats that would keep walking into a wall forever if a certain portion of their brains was ablated seemed to have little relevance to clinical intervention. I encountered exciting courses regarding brain structure and function, as well as instruction in neuropsychological assessment, but as with that ‘Brain and Behavior’ course, the relevance to my psychotherapy training and future practice was never clear. Such is the context from which the neuroscience of psychological therapies now unfolds.

Clearly, since that time, neuroscience has worked its way out of an isolated cubbyhole in the psychological armamentarium to permeate all aspects of psychology as a whole and psychotherapy in particular. For example, in the late ‘90s, Kandel (1998) proposed a new framework for psychiatry based on a neuroscience foundation. More recently, Kazdin (2011), one of the deans of psychotherapy research, has called for mainstream psychotherapy research to identify the underlying brain mechanisms associated with change in psychotherapy. It now seems required to pay homage to ‘the neurobiology of...’ whenever one begins discussing a particular pathology or a particular type of psychotherapy intervention. Scholarly examination of the neuroscience underpinnings of all aspects of clinical intervention is underway. It is in light of this transformation in the field of psychology that the consideration of the future of neuroscience and psychotherapy is undertaken.

At the heart of the remarkable growth of neuroscience is rapid development of ways to identify connections between behavior and the brain. Prior to neural imaging, the behavioral effects of damage to specific areas of the brain could not be identified. For example, damage to Broca’s area interfered with production of language. Over the past thirty years, neural imaging techniques such as computerized tomography (CT), positron emission tomography (PET), and magnetic resonance imaging (MRI) have supported better identification of brain structures as well as revealing brain activity tied to behavior. This has supported better understanding of the effects on behavior of specific types of brain damage. Such techniques also have allowed identification of effects of experience on brain structure. For example, the size of the amygdala, which is associated with the processing of emotion, has been found to be smaller in victims of childhood neglect and abuse (Teicher et al., 2003). These techniques also have identified changes in brain functioning resulting from psychotherapy, as well as medical interventions. For example, changes in caudate metabolic activity have resulted from behavior therapy as well as from fluoxetine treatment during interventions with patients with obsessive compulsive disorder (Baxter, et al., 1992). Despite many contributions to understanding brain function and treatment, the effectiveness of neuroimaging techniques has been limited because their speed is limited compared to the speed of brain activity, and their locational specificity is limited compared to the small sizes of areas associated with discrete elements of brain functioning. Specifically, these characteristics of neural imaging have limited the ability to identify causal interactions between various areas of the brain associated with meaningful activities during psychotherapy and behavior change. In the future, improved neuroimaging hardware and improved statistical analyses will lead to identifying brain activity with increased specificity in time and location. In addition, new strategies such as diffusion tensor MRI and functional connectivity analyses are being developed and refined that allow investigators to examine the anatomy and functioning of collective neural circuits as opposed to individual brain regions. These approaches are currently being applied to studies involving patient populations to produce deeper insights into neurobiological mechanisms underlying various mental disorders. For instance, these techniques have identified global efficiency decreases in neural circuits in attention deficit hyperactivity disorder (ADHD), suggesting particularly impaired communication among distant brain regions in afflicted individuals (Konrad & Eickhoff, 2010). These approaches hold the promise of not only providing targets for intervention but also metrics for measuring treatment efficacy.

Other aspects of neuroscience and neuropsychology will contribute to advances in psychotherapy in coordination with, and independent of, neuroimaging. Specific neuropsychological tests such as verbal fluency tasks, memory tasks, set-shifting tasks, planning tasks and emotion identification tasks can assess levels of specific cognitive capacities within an individual at specific times and in specific circumstances. These capacities have been found to be associated with emotional states and psychological diagnoses (Christensen et al., 2006). In the future, integrating such assessment tasks within typical evaluations of psychological functioning will lead to improved understanding of the details of how psychological states and diagnoses affect our clients. This will guide research into the nature of psychopathology and the nature of intervention. For example, capacity for response inhibition can be a characteristic of a disorder, and change in capacity for response inhibition can serve as a dependent measure of improvement during treatment. On the other hand, a specific relevant neuropsychological process could be identified as a focus of training, and other clinical symptoms could be identified as dependent variables. For example, training in response inhibition could be initiated, and improvements in daily behavioral self-control could subsequently be
measured. Thus, the neuropsychology of the pathology can be a marker, and also an avenue, for intervention. This will be true for research, but clear identification of such patterns also will lead to improved assessment and intervention during clinical practice.

Increased understanding of the details of brain function associated with psychotherapy will lead to integrated understanding of how various versions or schools of psychotherapy relate to each other as they effect change. Isaac Marks’ “Common Language for Psychotherapy Procedures” (Marks, 2012) is a project that currently attempts to identify common activities of a wide range of psychotherapy interventions and techniques, thereby supporting understanding of brain function limited the specificity and completeness of the framework. The future holds the promise that increased understanding of specifics of neuropsychological processes will lead to effective integration of all forms of psychological intervention into an overarching intervention framework. This will allow all interventionists to better identify how their helping interventions relate to the details of clients’ pathological processes. It also will support interventionists’ selections of psychotherapy procedures. It will help practitioners recognize ways their strategies relate to the strategies of practitioners of other forms of therapeutic intervention. This identification of brain processes underlying pathology and intervention will support an inclusive rather than exclusive approach to viewing various ways of intervening to support clients.

The field also will see integration beyond individual processes associated with pathology and intervention. Research by Caspi et.al. (2003) provided the model whereby knowledge of the human genome will be tied directly to the unfolding of psychopathology and to subsequent interventions used to treat it (Fonagy, 2011). In Caspi’s research, a cohort was divided according to variation at a specific genetic site, and the functioning of the identified groups were assessed over subsequent years as a function of stressful life events. It was found that when there were fewer stressful events, cohort members carrying either variation developed successfully. However, in the presence of significant stressful life events, members carrying one genetic variant developed successfully while members carrying the other variant displayed more maladaptive functioning. The future will be characterized by combined progress in the areas of genomic assessment, identification of specific neuropsychological functioning associated with adaptation and psychopathology, identification of behaviors associated with adaptation and success, and identification of neuropsychological substrates of successful clinical intervention. Progress in these areas will lead to improved diagnosis, improved determination of what interventions work best for what type of person, and improved implementation and evaluation of treatment. Progress also may support the development of preventive rather than reactive intervention strategies.

The future holds the promise that increased understanding of specifics of neuropsychological processes will lead to effective integration of all forms of psychological intervention...

communication between proponents of the various techniques, and supporting better insight into how change occurs. However, the elements to which the project reduces psychotherapy interventions, for example, exposure, interpretation, and roleplay-rehearsal, do not identify underlying brain locations and activities comprising psychotherapy. Improved identification of brain processes comprising psychopathology and intervention will support systematic identification of the similarities and differences between various pathologies, psychotherapy procedures and psychotherapy outcomes. A neuroscience project similar in format to Marks’ integration will lead to improved understanding of unique and shared elements of various forms of psychotherapy intervention.

The current states of neuroscience and psychological intervention should support in the near future the development of a neuroscience framework within which all forms of psychological intervention can be considered. Such a framework has been presented previously by one of the current writers (Folensbee, 2007, 2008a,b), but the lack of detailed process of integration to be most effective. While it is likely there will be improved identification of elements of brain function and causal connections between them, the complexity of the brain and related psychopathology and intervention effects will prevent complete understanding. Research incorporating neurobiological processes will be vulnerable to problems encountered by current empirical research studies: studies will tend to be simpler than the complexities typically encountered by clinicians in daily practice. Findings based on neurobiological processes may suggest the presence of a more scientific foundation. However, limitations will consistently need to be identified and explained. It will be critical that researchers and clinicians maintain vigilant consciousness that individual causal relationships will not account for all critical elements of psychotherapy change, even though the evidence includes ‘neuroscience’. Overinvestment in a single relevant causal connection or in a single impactful intervention will have the potential to blind the researcher or intervener to broader, open-minded understanding of pathology and treatment.

In the future, specific new and informative causal connections between the brain and both psychopathology and intervention will be established. Significant causal links between intervention, improvement and related brain function will be clarified. However, a complete accounting of psychotherapy intervention and outcome will remain elusive despite such advances. It will therefore be critical for all researchers and interventionists to remain respectful of the value of understanding behavior. It will continue to be important that researchers and clinicians appreciate the direct ties that can be made between clients and therapists, and between client behaviors and interventions. Behavior analysis, clinical intuition, the psychotherapeutic relationship, cognitive reframing, and similar concepts must remain the context within which the imminent advances in understanding psychotherapy and its related neuroscience will be conceived.

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Get to Know the Texas State Board of Examiners of Psychologists

Paul Andrews, PhD

The Texas State Board of Examiners of Psychologists (TSBEP) is composed of nine members appointed by the Governor with the consent of the Texas Senate. These members serve staggered six year terms. Only four are psychologists; two others are psychological associates, and three are public members. Obviously, psychologists comprise a minority of the Board. Traditionally, the Chair, appointed by and serving at the pleasure of the Governor, is a psychologist although there is no statutory or regulatory rule requiring the Chair be a psychologist. Members receive no compensation although there is a per diem and travel allowance for attendance at the three or four board meetings each year. Day to day functioning, investigation of complaints, and processing of applications is conducted by the Executive Director (Ms. Sherry Lee) and her staff including the General Counsel (Mr. Darrel Spinks).

Below is a short profile of one of the new public members. Other members will be introduced in subsequent issues.

The newest Texas State Board of Examiners of Psychologists (TSBEP) member is Ms. Doris Couch who lives in Burleson. Ms. Couch has previously served on the Texas State Board of Podiatric Medical Examiners and was appointed to serve as chair of that board. She also has served the Governor by helping the Texas Supreme Court with two appointments, Guardianship Certification Board and Disciplining Review Committee.

Ms. Couch stated she founded the Burleson Insurance Agency in her hometown and helped found the local Chamber of Commerce. In her professional pursuit as accountant and tax expert, she became licensed as an “enrolled agent” meaning that she could represent cases before the Internal Revenue Service in the same manner as attorneys or certified public accountants. She has used her knowledge of tax laws, particularly as they relate to non-profit organizations, to start and nurture many religious non-profit corporations. An ordained minister, she founded Well Ministry Fellowship. She now serves on the board of directors of Garlock Ministries and her own Couch and Russell Financial Group.

In her previous professional and avocational interests, Ms. Couch has traveled nationally and internationally teaching tax law to churches and clergy, teaching IRS workshops, and working with ministry projects. She stated she enjoys helping others, does not like mediocrity, and “always gives 1000%.”
Future of Psychology Practice in the Era of Health Care Reform

James H. Bray, PhD

Introduction
The future of psychology practice is rapidly evolving due to economic and legislative changes during the past four years. During the health care reform debate mental health and the future of clinical practice was not a major issue, but due to the efforts of the American Psychological Association, psychology is well positioned in health care reform. “The Future of Psychology Practice Initiative” (Bray, 2010), examined the current status of psychology practice and developed a blueprint for the future (Bray, Goodheart, Heldring et al., 2009). The new opportunities outlined in the initiative and in the federal health care reform legislation will have a major and evolving impact in the way we train and practice as psychologists.

The Patient Protection and Affordable Care Act, H.R.3590 (ACA) was signed into law by President Barack Obama in March 2010 (P.L. 111-148) and is being rolled out through 2015. The ACA provides major changes to our health care systems to meet the emergent health needs of our population.

A major emphasis of the ACA is on creating integrated systems of care that include both behavioral and physical health. These changes provide new opportunities for the practice of psychology and behavioral health. The focus of this article is to discuss some of these changes that are likely to impact the practice of psychology. In this paper, references to specific aspects of the ACA are based on language and work reflected in the APA health care reform documents (APA, 2010). Additional discussion of these issues is elaborated by the author (Bray, 2010).

ACA and Health Care Reform
The ACA health care reform legislation included increased access for uninsured and under-insured people, reimbursement for preventive services, a modernized health care system and a greater emphasis on primary care (Clancy, 2009). These changes are supposed to decrease escalating health care costs through a variety of cost-containment strategies.

Increased Access to Health and Mental Health Care
The ACA authorized increased access to health care for millions of Americans who are currently uninsured or under insured. The essential benefits package in the ACA includes mental and behavioral health and substance abuse services, and psychologists are one of the named professions to provide these services. People will have greater access to behavioral health care through the combination of increased access, implementation of the mental health parity act, and the provisions that end discrimination against individuals with pre-existing conditions.

The 2008 Mental Parity and Addiction Equity Act, H.R. 6983 was strengthened in the ACA. This law specifies that services for mental and behavioral health problems will be treated and reimbursed with parity to other health problems. The rules and regulations of this law went into effect in July 2010. Many insurance companies are trying to work around and avoid the parity law. The APA Practice Directorate is monitoring the implementation of the law and if you experience problems with lack of parity by insurance companies, you are encouraged to contact the APA for assistance in dealing with this situation.

Focus on Prevention
Evidence-based community preventive health activities to reduce chronic disease rates and address health disparities were authorized in the ACA. These include coverage for wellness visits; coverage of evidenced-based services; identifying causes of chronic health problems and establishment of maternal, infant, and early childhood home visiting programs.

Evidence-based Services Coverage
Insurers are now required to provide coverage, without coinsurance payments, for certain prevention services that are recommended by the U.S. Preventive Services Task Force (Agency for Healthcare Research and Quality, 2010). These services include screening for depression; screening and counseling for obesity; and counseling for tobacco use in pregnant women. Insurers and health systems also are required to pay for preventative care and screenings for infants, children, adolescents and women as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA, 2010).

Modernizing Our Health Care System
The reforms passed in health care reform provide models and incentives for the development of an integrated health care system. The goals of these changes are to have improved quality and better access to health care, while containing costs (Clancy, 2009). The key components of the model focus on integrated systems of health care and integrated technology in practice and use of health information technology systems (e.g., electronic health record systems). In addition, revitalization of primary care; increased reliance on primary care that includes care management, coordination of services and quality assurance mechanisms; and research to inform practice are emphasized (Clancy, 2009; Patient-Centered Primary Care Collaborative, 2007).

Integrated Health Care
There is a major shift to provide integrated health care through an enhanced primary care system. The ACA authorizes grants to establish community-based interdisciplinary health teams, including behavioral health providers, to support primary care practices. Psychologists may be included, but other professions, such as social workers, counselors, or nurses, also can fill these roles. It is critical that psychologists step into these roles or we will be replaced by other professions who are also authorized to practice in integrated health systems.

Revitalizing Primary Care
The Patient-Centered Medical Home (PCMH) is the new model for primary care within the ACA (Patient Centered Primary Care Collaborative, 2007). The PCMH is designed to provide comprehensive primary care in such a way
to facilitate partnerships between patients and their personal physicians, and when appropriate, the patient’s family.

PCMHs are defined by several principles, which are based on the idea that every person has a personal health care provider who provides first contact, continuous, and comprehensive medical care (Patient Centered Primary Care Collaborative, 2007). The PCMH model is built on the belief that the personal health care provider leads a team of professionals who are collectively responsible for ongoing care of patients. The practice uses a whole person orientation across all stages of life. A goal of the PCMH is to provide coordinated and integrated care across all aspects of the health care system and the patient’s community. The use of health information technology and information exchange is a core part of coordinated care. Both psychologists and nurses prefer the term “patient-centered health care homes.” The APA is advocating for expanded roles of psychologists in participating and leading health care homes (APA, 2010; Bray et al., 2009).

**Psychology Practice Opportunities**

The changes created by the ACA open doors for psychologists to expand their practices. The growth areas for practice are in all parts of health care, particularly in patient-centered medical homes, primary care, organized systems of health care, the public sector, and public health (Bray, 2010; McDaniel & Fogarty, 2009). To fully participate in PCMHs, psychologists need to be full partners in the health care system and identify as health care providers, not just mental health providers (Bray, 2010; Cummings, Cummings, & Johnson, 1997; Frank et al., 2004). Viewing oneself as a health care provider emphasizes the importance of mind-body practice and the use of a biopsychosocial model.

The majority of mental and behavioral health problems are treated in primary care settings, in schools, or through public health programs without the assistance of psychologists or any other mental health professionals (Bray, 2010; Cummings et al., 1997). Psychiatrists and general medical practitioners provide more mental health services than other types of mental and behavioral health providers (Kessler, et al., 2005; Wang, et al., 2006). Most treatments are psychotropic medications, which are mainly provided by general medical providers (Medical Expenditure Panel Survey, 2009). In addition, there has been a decline in the use of psychotherapy and other psychological assessments and interventions (Olson & Marcus, 2010), resulting in the need for psychologists to rethink our approach to practice.

Psychologists can facilitate preventative health by creating healthier school environments; designing programs to increase access to smoking cessation; improving social and emotional wellness; preventing chronic health and mental health problems; and addressing the needs of special populations with mental and physical disabilities. Psychologists are well trained to provide services, design programs, and evaluate the effectiveness of the programs (SAMHSA, 2009). The ACA authorizes psychologists to use evidence-based behavior change strategies for a wide variety of health problems that include compliance to medical regimes, promotion of life-style changes that may prevent chronic disease, and helping individuals adapt to health problems.

In addition, psychologists will need to utilize some medical and public health language and systems. The World Health Organization’s International Classification of Disease (ICD) system is the standard diagnostic system, rather than the American Psychiatric Association (2000) Diagnostic and Statistical Manual. The APA has invested substantial resources in the forthcoming 2014 ICD system and move to using the ICD will facilitate integrated health care. It is recommended that psychologists train in the ICD system rather than the DSM system to be knowledgeable and fit into the broader health care system.

The federal government is promoting models that rely less on fee-for-service payment systems and more on organized systems of care. These models promote the concept that providers will be employed as staff within the systems. Psychologists will face increased pressures from the federal government to join organized and integrated systems of care. It is up to psychologists to take advantage of these opportunities, as many of the ACA programs include, but do not require, psychologists to participate. If we do not actively engage in these opportunities, other professionals, such as nurses, health educators, counselors, and social workers, will take our places. To take full advantage of these opportunities we will need to practice in different settings and in different ways.

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**The Demise of the Generalist**

Mary Alice Conroy, PhD

This article posits that the future of the practice of psychology lies in specialization. It discusses why this is necessary and reviews recent history indicating we are heading in that direction. The article presents arguments why this is essential for the profession to move forward, and what is needed on the part of organizations and individuals for this vision to come to fruition.

As an educator, I am keenly interested in what the field of psychology will look like in the future. As a Director of Clinical Training for a doctoral program, I hope for the future of the profession I want to initiate or support and where I believe the professional associations to which I belong should be heading. I will apologize in advance for using many examples from the forensic psychology arena; however, it is the area with which I am most familiar.
Too Many Years of "Generalism"

For all too long I have seen our profession pride itself on being a profession of the broad and general. Psychology was a unitary term. My previous employer—a very large federal agency—insisted that any psychologist should be able to provide any necessary psychological service and, therefore, also should be able to supervise any psychological service. If there was a need for a forensic psychologist to do evaluations for the federal courts, an individual who was board-certified in forensic psychology received no more consideration than a psychologist whose background was solely in providing adult psychotherapy. Whoever was promoted to “Chief Psychologist” was expected to supervise forensic evaluation, general assessment, substance abuse treatment, neuropsychological evaluations, and a large array of interventions. In the meantime, our colleagues in medicine embraced the idea of specialization. Consequently, physicians continued to rise in the pay grades, as needed specialists were relatively scarce, while psychologists’ grades remained stagnant. While physicians had assistants, no one was seriously considering replacing medical doctors with “master’s level physicians.”

At the same time, our higher education establishment in many ways supported the generalist model. Until recently, the use of the terms “specialty” or “specialization” in a graduate program would raise eyebrows among accreditation site visitors. If specialization became necessary, individuals could seek advanced training (such as board certification) after receiving their degree and license—something that relatively few psychologists did.

The Need for Specialization

I believe that specific specialization is going to become increasingly essential in the years to come. This is true for three reasons: 1) we are entering a culture of competence; 2) data bases and techniques are increasing at an exponential rate; and 3) the market place will demand it. There was a time when the GPA in graduate school or scores on the EPPP were sufficient testimony to a graduate’s competence. No longer! Graduate programs are now being asked to measure very specific competencies that each student does or does not have (Fouad, et al., 2009). Employers and licensing boards are not simply asking a professor to write a glowing letter, but rather asking for ratings on an array of competencies demanded by the organization. In years past, credentials in the courtroom often meant the degrees and licenses one held (i.e., the letters behind one’s name). Post Daubert v. Merrell Dow Pharmaceuticals (1993), and other court rulings that followed, courts are coming to expect that establishing expert status means proving the specific knowledge, skills, training and experience necessary to assist the trier of fact in the particular case at hand. For example, the fact that I have a doctorate in psychology, or even board certification in forensic psychology, tells the court nothing about whether I am competent to assist in a child custody evaluation.

Thanks in no small part to the academic community, research in almost all areas of psychology has mushroomed in recent years. At this point in time, there is no way I could say that I am current in all areas of forensic psychology, let alone psychology in general. For example, violence risk assessment is an area of particular interest for me. When I began providing workshops in this subspecialty 20 years ago, I struggled to put together a two or three hour presentation and provide a few pages of bibliography. Now, I have difficulty even providing an adequate overview in a seven hour presentation; I am constantly culling my bibliographies given to participants least they exceed a hundred pages. That is only one small piece of a specialty area. In the treatment arena, empirically supported treatments necessary to a sound evidence-based practice are also expanding. I cannot imagine being equally facile in treating eating disorders in adolescents, as in treating substance abuse, as in treating psychotic disorders, as in treating depression in geriatric patients. I recently attended a workshop in which some colleagues in school psychology discussed the latest research in the assessment of learning problems, noting that many clinicians are still using a very outdated model. One has but to go to the American Psychological Association website to get an idea of the myriad of guidelines that have been developed to address the appropriate ethical and professional manner in which various interventions and assessments should be done. And that is just one organization. It would be quite impossible to be familiar with them all.

We have entered an era in which many of our services are paid for by third parties. Whether this is an insurance company, an agency, a court or other entity, contractors are demanding that their scarce dollars finance a quality service. We are also living in a very litigious society. We no longer serve patients/clients, we serve consumers. Over the years, the medical profession has been much more the subject of law suits than psychology. Perhaps this was due to the fact that our practice did not seem potentially harmful. However, as the media increasingly focuses on the mentally ill as problematic to society (and sometimes dangerous), as well as to themselves, this is apt to change.

Current Trajectories

There is already evidence that our field is moving in the direction of specialization. This can be found in higher education, in our professional societies, and in the broader community of courts and legislative bodies. It also can be seen in academia in the organizational structure of research.

One has only to peruse the websites of clinical psychology doctoral programs across the country to find that the vast majority have either a specialty emphasis embraced by the entire program or a number of specialty tracks from which students are expected to choose. APA has recently published a taxonomy designed to outline the degree to which a specialty is offered; carefully described categories of intensity (from the highest to the lowest) include: major area of study, emphasis, experience and exposure. The APA Commission on Accreditation has now opened the door for consideration of “developed practice areas” in professional psychology beyond the traditional divisions of clinical, counseling and school. At the 2012 mid-winter meeting of the Council of University Directors of Clinical Psychology (CUDCP) much concern was expressed over the time and class hours spent at the graduate level providing basic training in broad and general areas of psychology (e.g., cognition, social, biological basis of behavior). A resolution was passed with broad support suggesting that much of the material in these basic areas could be sufficiently covered on the undergraduate level. What, if anything, will come of this resolution is unclear. However, the result could be more room at the graduate level for specialty emphasis. This could be particularly important at a time when graduate programs are striving to make their students more attractive to internships.

There has long been tension in our professional organizations between those supporting the generalist paradigm and those wishing to promote specialization. However, recent history indicates movement toward support for specialization. The American Board of
Professional Psychology (ABPP), founded in 1947, has long been the umbrella organization for bodies whose mission it is to credential psychologists in specialty areas as “board certified.” The various boards and academies composing the ABPP often have been accused of elitism, and board certification has been thought to be reserved for a select few. However, in recent years there has been decided movement within the ABPP to appeal to the broader community, offering materials on the value of the credential, streamlining the application process, offering inexpensive earlier registration options for new career psychologists, and offering qualified mentors to aid applicants through the process. Dr. Nadine Kaslow, past president of ABPP, is currently heading a committee, composed of representatives from the 14 boards, whose mission it is to bring board certification to the forefront of the education and training community. ABPP has even been discussing the need for “subspecialties.” For example, in the American Academy of Forensic Psychology, there are clearly identified sub-disciplines (e.g., child custody, civil commitment, deprivation of parental rights, divorce, employment litigation, guardianship, personal injury, testamentary capacity, workers’ compensation, juvenile court evaluations, criminal competencies, insanity, diminished capacity, and criminal sentencing) (Packer, 2008). Few clinicians have sufficient expertise to practice in all of them, even when they hold the forensic ABPP. Finally, it should be noted that a number of large employers (e.g., the Department of Defense, the Public Health Service, the Veterans Administration) have offered financial incentives to those who hold board certification.

In 1995, the American Psychological Association (APA) established the Commission for the Recognition of Specialties and Proficiencies in Professional Psychology (CRSSPPP) to officially recognize areas of practice that meet established criteria. Then in 1997, the Council of Specialties (CoS) was officially formed. The mission of CoS includes disseminating information to the public regarding the importance of specialty services and developing policies and guidelines for the training of specialists at the doctoral, internship and postdoctoral level.

State legislatures, including the Texas State Legislature, have enacted laws requiring advanced training for those engaged in certain types of psychological work. To take just one example, it is a statutory requirement in this state that professionals who conduct competence and sanity evaluations for the courts are not only licensed but also either have board certification or can document a specific amount of specialty training (Texas Code of Criminal Procedure, 46B & 46C, 2005). Following the Texas appellate ruling in Kelly v. State (1992) and the U.S. Supreme Court ruling in Daubert v. Merrell Dow Pharmaceuticals (1993), rulings that reinforced the need for judges to act as “gatekeepers” in regard to expert evidence and testimony, courts became concerned. Consequently, individual courts are increasingly likely to ask about what particular knowledge, training, skills and experience a purported expert can offer to the trier of fact.

Psychological research also is moving in the direction of specialization. The emerging data on what is being called “Team Science” strongly supports the hypothesis (long embraced by the medical sciences) that greater impact from research can be achieved through an interdisciplinary approach (Hall, Feng, Moser, Stokols, & Taylor, 2008). This has meant that researchers in specialty areas of psychology are much more likely to reach across disciplines for like-minded collaborators than seek out colleagues in other branches of psychology. For example, forensic psychology has a natural alliance with legal and criminal justice professionals; health psychology may be drawn to those in other medical areas; school psychologists often partner with educators. I suspect that in years to come this may mean a complete realignment of disciplines. I also anticipate publications in journals other than those sponsored by psychology.

**We Can Embrace It**

I believe the field of psychology is currently at a cross roads. We can either applaud the notion of specialization as an essential element to practice psychology at the doctoral level, or we can hold to the traditional stance that psychology is a general discipline and specialization is reserved for the elite few. I strongly believe that the former position is what will move the field forward.

The field of psychology is much too broad, with much too much available data, for any practitioner to claim they can do it all—or even a large chunk of it. As I have presented numerous workshops on ethics in recent years, it becomes more obvious to me that one of the most basic ethical standards, that of practicing within the boundaries of one’s competence (APA 2.01, 2002), is also one of the most frequently violated whether or not any complaint is raised. This is not because nefarious practitioners are deliberately providing or supervising services for which they lack sufficient competence, but rather because of a misguided belief that a doctoral degree in psychology and state licensure indicates they have expertise in areas in which they are unaware that specialty training is necessary.

Specialized expertise is generally rewarded with greater financial remuneration. This may come from an organization needing special expertise among its employees or as a matter of higher fees charged by contract practitioners for specialized work.

The question so often raised in recent years by organizations that employ psychologists is: why should I hire a relatively expensive doctoral-level psychologist when I can hire a master’s-level practitioner to provide the same service? We have all observed the trend in managed care organizations and state agencies of filling many of their psychology positions with master’s-level clinicians or otherwise assigning master’s-level practitioners to perform work previously done by licensed psychologists. It is not sufficient to simply say that “we do it better,” because in many areas there is no firm evidence that we do.

**The Road Forward in a Specialized World**

The way forward will mean changes on the part of our national and regional organizations, our licensing boards, and...
individual psychologists. It is important to recognize that change has become much more jarring and rapid in our technological world—a world in which a plethora of information is instantly available both to colleagues and to the public at large.

Specialties in psychology have evolved almost haphazardly, depending on which group of practitioners has put forth a proposal. There has been no grand plan. A number of the currently recognized specialties clearly overlap. For example, there is overlap between clinical and counseling psychology, between clinical and health psychology, between clinical child and adolescent and family and couples, to name but a few. The future may lead to some reorganization.

Our regional and national organizations will need to actively support the specialty concept. This will mean applauding organizations that recognize and reward specialty credentials among their employees. It will also mean highlighting the work of specialty divisions within organizations. Hopefully, divisions within the Texas Psychological Association (TPA) will offer more recognition and awards for specialty work, especially among early career psychologists. Organizations, such as TPA, will need to continue to expand specialty training offerings both online and at regular CE events.

Specialists themselves will need to carefully review the state licensing law and rules of practice to determine if issues unique to their practice need to be included or amended. The Texas State Board of Examiners of Psychologists (TSBEP) has generally been open to testimony from individuals and from psychologists representing various divisions regarding changes needed. For example, over the past two years, the Forensic Division of TPA and TSBEP have collaborated in making sorely needed rule changes in regard to forensic services. I do not believe many in our profession would like a world in which one must hold multiple licenses—licenses potentially in conflict—to demonstrate proficiency in various specialty areas. To avoid this unfortunate eventuality, psychologists must ensure that we police specialty services within our own discipline. Of course, this places the responsibility on specialists and divisions to stay abreast of proposed changes and developments.

Psychologists often find themselves locked in competition with medicine for authority to perform certain types of assessments or to provide certain interventions. Leveling the playing field will require that psychologists have the training and skills on a par with physicians to provide specific services. A number of years ago, I served on the legislative taskforce to rewrite legislation regarding competence-to-stand-trial evaluations. I was the only psychologist, flanked by five psychiatrists. The finished law granted parity to psychiatrists and psychologists in performing these evaluations (and in a subsequent law regarding sanity evaluations) because it was demonstrated that certain psychologists did have the necessary specialty skills.

Finally, with an emphasis on specialty skills, licensed psychologists can stop arguing with master’s level practitioners about who can best provide a plethora of general services. Surely we can cede the provision of basic, general counseling to those holding a master’s degree, be it an LPC, MMFT, or other credential. In short, psychologists need to set themselves apart in areas that regulators and employers can readily understand.

Conclusions

The practice of psychology has become much too broad to be considered a unitary discipline. Psychologists need to universally recognize specialty skills as necessary for doctoral-level practice. These specialty skills need to be defined so as to be easily recognized by legislative bodies and by other disciplines. This will not be an easy transition and will require considerable change and compromise. It may even involve splitting and uniting with other disciplines. However, in the end it may result in a much more refined and lucrative practice field. Adopting this vision also will assist educators in training new psychologists for the future.

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Whither Now?

Brian Stagner, PhD

Psychology is changing faster than we can keep up. Prognostication is inexact, but a random sample of recent or likely developments forecast unpredictably changing seas for psychology:

• Smartphone apps have proven to increase treatment adherence with behavior monitoring.
• The recent special issue of Professional Psychology: Research and Practice confirms the importance of cultural considerations in service delivery at all levels.
• The feasibility of brain imaging to confirm diagnoses and track treatment progress is imminent.
• Many hospital administrators are rushing to capture markets with Accountable Care Organizations (ACOs) and organized psychology scrambles for inclusion.
• Other hospital leaders fear that ACOs won’t work because providers will bypass third-party payments and market directly to patient populations.
• A researcher announced a computerized tool for helping children manage debilitating anxiety.
• Replicable research establishes that telephone therapy can be as effective as face-to-face contact.
• Soon we will be able to sequence an individual’s genome to try to predict which medication will reduce symptoms (rendering DSM-5 irrelevant).
• The impact of evolutionary psychology on our thinking about normality and pathology will have unforeseen, profound implications.

Let’s start with first principles: what is psychology? Undergraduates learn that it is the science of behavior, which answer muddies more than it clarifies. First, “science” means more than one thing, but it involves using accepted
methods to generate verifiable knowledge. Methods vary with respect to verifiability/falsifiability; some are better than others. Hardcore positivists demand experimental rigor — the gold standard for establishing knowledge. The discipline of psychology aspires to this standard, although more tolerant of theory tweaking and correlational data.

Psychology fights to be taken seriously as a STEM discipline, to have parity with the basic life sciences. Some of psychology’s subdisciplines make a strong argument here — behavioral neuroscience for example. Other areas of psychology are in the social science camp, where standards differ; the targets are more fluid and the methods admit descriptive and correlational data. It’s harder to develop experimental designs when the variables are ephemeral and subject to myriad influences that are themselves difficult to operationalize. Nevertheless, we do consider pollsters, epidemiologists and archival data miners to be engaged in science.

There’s another thread in social science dominated by theory-based analyses. Empirical facts are marshaled to support arguments, not to test them. Critical social theory, social constructionism, deconstructionism, and other intellectual trends have influenced many social sciences. While these perspectives offer a corrective to the excesses of the status quo, they make extra-scientific arguments. Grounded in untestable assumptions, they rely on narrative truths bolstered by sifting data; data which contradict the narrative are dismissed as tainted by the “mainstream” (read: old white men, oligarchs, hidebound traditionalists, etc). The iconoclasm of these perspectives excites the adolescent in us (this writer included). Sometimes these extra-scientific truths spur pivotal shifts in our larger project of understanding the world. See, for example, the impact of feminism on women’s health.

Psychology’s quest for scientific credibility founders when the two kinds of social science — what I’ll call statistical versus narrative — are conflated. The narrative folks critique the measurement people and vice versa, while the wet brain folks try to slip out of the room. The public face of “psychology” becomes a lumpen jello salad with fruit and nuts and marshmallows floating in shapeless gelatin that falls apart. Psychology will always be a mash of many ingredients, but it must cohere. More like meatloaf, maybe, or fruitcake, if you prefer. We’ll come back to this problem of science.

“Behavior” is another concept distorted by the ways it is invoked. Skinner knew behavior could be counted, and that was enough to build his science. For Freud the behavior Skinner tabulated was like a shadow on Plato’s cave: the interesting behavior was a drama in the unconscious that had to be inferred from anomalies of overt behavior. Multicultural theorists note that “behavior” is not the same across cultures and subcultures. Consumer psychologists study spending behavior across economic conditions. For the neuroscientists the notion of behavior is discovering different neural networks lighting up fMIRIs when we read or experience anxiety. Phenomenologists recognize sense-making and experiencing as fundamental behavioral building blocks. Geneticists see the behavior of alleles across generations, and the evolutionary psychologist sees Skinner’s data as evidence of mechanisms selected far back in evolutionary time.

There has always been a Venn diagram with “Psychology” at the center. Surrounding, and overlapping Psychology we find: Philosophy, Economics, Sociology, Neuroscience, Politics, Social Justice, Jurisprudence, Medicine, Education, Management, Genetics, Marketing, Human Factors Engineering, etc. We can’t really narrow the discipline without discarding psychology’s valuable contributions. Our best argument for the discipline is the broad reach of its scientific rigor. Ultimately, the discipline won’t survive by claiming to be all things to everybody. The days are over when simply invoking the title “psychologist” commanded respect. The discipline must be held together by its scientific strengths. We should not expect that the discipline will survive without it.

The Profession?
I’ve been discussing the discipline because the profession will thrive only by standing on the academic discipline. We should recall that the discipline is a science, drawing on life sciences, aspects of the physical sciences, and the part of social science which is scientifically grounded. It excludes voices in psychology which sidestep rigorous hypothesis testing in favor of the impassioned critique. Again, those critiques are useful and important, but they can’t supplant falsifiable inquiry.

Not everybody agrees with this perspective. I stumbled into a listserv aimed at “therapists” of all pedigrees and the posts are discouraging. I read master’s and doctoral clinicians spouting astonishingly anti-intellectual views: “I know we have to seem to be scientific;” “Statistics is the way you convince people you are right;” “I have developed a therapy based on evolutionary theory and the teaching of the Dalai Lama. How do I market it?” “Sometimes the scientists go too far;” “How do I patent my new mindfulness-based group therapy?” “Researchers don’t really ever discover anything important;” “I don’t know what the journals say, but I know what my gut tells me.” These individuals, having finished training, act like they’ve been admitted to the inner sanctum and thus are licensed to impose personal opinions and self-interested urges on the world. Psychologists get doctoral training that involves critical evaluation of evidence. We accept all knowledge as subject to improvement. Unfortunately, some folks (including a few psychologists) take cover in narrative social science yet claim that they are part of the larger enterprise of psychology. This naïveté drags us all down.

The profession of psychology is under pressure and will have to change its ways. Master’s level disciplines encroach on traditional activities of psychologists, public sector mental health services are sacrificed in pound-foolish penny pinching, and third-party payers continue to push mental health services to less qualified providers (right before pushing these services completely out the door). Many folks from the leadership of TPA and APA have spent years fighting these forces. We advocated for our patients, for social justice and for the survival of our profession. As I talk to the many people who have carried the flag for TPA I find them demoralized and fatigued by the Sisyphan ordeal of fighting yet one more defensive action on behalf of psychology. We need to be proactive, but it will be hard.

The fact is that our profession is valued and essential. Nobody is complaining that our services aren’t needed; indeed many folks in both the private and public sectors are turning away needful consumers. The problem is to figure out how to find the niche where we survive and contribute and then to connect with those who most stand to benefit.

Is There Flouride in Your Future?
Been to the dentist lately? Does the thought of the dentist, uh, set your teeth on edge? We have it easy. Gather round youngsters and I’ll describe dentistry in the dark age of the 20th century. For a couple of hundred years dentists were artisans. They made the crowns, dentures and bridges right in their offices, with no outsourcing. I broke some teeth in 1968,
and I still recall the dentist putting an enormous metal device into my mouth so I could clamp down, pushing my broken teeth (with exposed nerves!) into a mold filled with a medium that the dentist had made on a tray in front of me. It was excruciating. He admonished me not to twitch even a little or we’d have to start all over—meaning he would have to re-clean my broken teeth. I held my breath for two hours, and then he took the mold out, slapped on some temp caps and sent me home. Two weeks later he presented me with two caps that he had fashioned by hand from gold, then covered with acrylic that matched the real teeth. They’re still there after 44 years. My current dentist is disappointed I won’t upgrade to teeth fashioned by a computer from wondrous new polymers.

My point is that dentistry changed. If you were born before 1950, odds are you have several metal fillings. Gold or silver amalgam fillings were the blue chip solution for caries. They worked well right until they failed, often resulting in teeth breaking. The dentist-cum-artisan would then fashion bridges or dentures, which were commonplace. You probably don’t know many folks with full dentures these days. People keep their teeth now because of fluoridation—that evil plot to encourage fluoridation of water supplies and fluoride treatments at the dentist office. With the introduction of fluoride treatments, caries dropped dramatically. The need for fillings and dentures fell. Dentistry was in decline because there was less work.

What happened next is instructive. Dentists retooled. With a decline in prosthodontistry (fewer cavities to plug) they specialized in other ways. Some became endodontists, working on root canal problems; or periodontists, working on gum disease; or orthodontists, or pediatric dentists or cosmetic dentists. And while many health insurance plans offer some coverage for dental procedures, out-of-pocket expenses are a high portion of the costs. Orthodontists (and probably others) have pretty effective payment contracts.

We face parallel challenges. Pharmaceutical interventions will continue to improve. Assessments will become more automated. Therapeutic interventions will become more technologically driven (e.g., Apps, or websites such as CogMed or Lumosity). Well-specified evidence-based treatments can be effectively delivered by subdoctoral clinicians when the presenting problems are well circumscribed. The doctorate means that we bring not only a knowledge base of factoids but also a capacity for critical analysis of problems which are unique, or complex, or in some other way don’t fit the cookie-cutter treatment plans.

In the ’50s through the ’80s, people who consulted psychologists thought of themselves as seeking help from a specialist. A psychologist was a specialist in the problems people have when confronting transitions in their lives. We did psychoanalysis, b-mod, MMPIs, gestalt therapy, the Rorschach, psychodrama, PET, RET and all sorts of stuff. It all got lumped into “therapy,” and the public had a hard time distinguishing psychiatry, psychology, psychotherapy and “counseling”. I think that will change. “Psychologist” no longer tells us much about the specialist; what KIND of psychologist are you? Forensic? Developmental? I/O? School? Neuro? Family? Group? etc etc.

Leaving dentistry, let’s consider another gruesome profession: the law. When I need legal counsel I don’t go online, and I’m unmoved by the late night ads for litigators. When something is important I’m willing to pay for quality, and fortunately I can afford it. My attorneys are not threatened by the lesser competitors. For somebody with no assets and little to lose the online DIY Will or the $100 Divorce Kit will suffice; top flight attorneys don’t compete for that market. Same goes for my accountant vs. HR Block, my physician vs. WebMD, and so on. I pay more when I am convinced that my particular situation will not be dealt with optimally by the unimaginative methods of the one-size-fits-all storefront providers. I have ongoing relationships with my providers; they are better trained, and I am convinced that they will apply their expertise in a way that is tailored to my particular problem. For this, I am willing to pay more than the cut-rate and hi-volume practitioners’ rates. We could make similar arguments on our own behalf.

There will be a need. We can prove that we are doing something valuable. We need to remember to value ourselves, and we need to start building the next models.

Finding Optimism for Psychology
First, the science advances every day. For instance, research has demonstrated that a package of psychological interventions targeting stress reduction and treatment compliance for cancer patients is clearly beneficial. There is evidence for mood improvement, behavioral change, fewer physical side effects and reduction in anxiety. These are not small effects, which is itself very promising. More notably, there is a substantial reduction in risk of mortality at an average of 11 year follow up. (Death is a compelling dependent variable.) Our academic colleagues face substantial challenges with dwindling funding for basic research, but they push for breakthroughs in assessment, in validating causal models for psychopathology, and in treatment efficacy. They are not our enemies, they are supplying our armory, for we will understand better than any other group how to apply scientific breakthroughs intelligently.

Economic globalization and rapid population shifts heighten our awareness of cultural differences in child development, interpersonal relations, intergroup relations, and the attitudes and beliefs that affect problems such as group conflict, public health and education. We will re-examine many of our “basic truths” and foundational assumptions as we learn that what we thought were universal certainties are, in fact, subject to important cultural variation. Thus, replication of the factor approach to personality in Hong Kong uncovered a handful of factors that are similar to the Big Five factors which have been identified in North America — similar but not the same, and it may be more useful to think of the Big Six when working in China. Likewise we are learning how different groups in the U.S. show different rates of acceptance, compliance and responsiveness to empirically validated treatment protocols. So in addition to big breakthroughs in knowledge, we anticipate significant advances in the science of delivering this knowledge to diverse populations.

Expanding knowledge will be outpaced by the expanding consumer base. Forgive an old fart, but life sure got more complicated, faster and scarier than it was. We’re healthier and wealthier than my parents’ generation, but no wiser. Unbridled free market approaches inevitably rewarded ruthlessness and while these excesses may enrich a few, brutal pressures were exerted on those left behind or pushed off the bus after they paid for their ticket. By many measures we are failing as a nation. We incarcerate more individuals per capita than any nation in the world. Our childhood poverty rate is among the highest in the West, approaching 20 percent (in Sweden it is 3 percent). As a nation we are sleep deprived, obese and pessimistic. All these conditions involve psychological handicaps; well supported behavioral interventions will be fundamental to any
coherent response to these challenges. In short, there is no shortage on the demand side of the equation for individuals, families and communities.

When properly prepared, psychologists have advantages in this environment. When psychologists stepped out of the VA system in the 1950s to start private practice they flew blind. There was no licensure, no parity legislation, no Medicare, and virtually no business model whatsoever. These early pioneers had to invent a professional identity. Resistance was huge. Psychiatry wanted to run us off. Most of the (academic) psychological community felt that private practice was somehow tawdry and unethical. (When an attractive doctoral student won bunches of money on a TV show in the ’50s, the emcee asked her for psychological advice. As a result, the American Psychological Association expelled Dr. Joyce Brothers.) The general public had little understanding of the private psychological consultant. Those mavericks survived — without insurance money, with limited opportunity for institutional jobs, and without the benefit of state psychological associations to advocate for their profession. Those trailblazers founded the state associations by pushing through the licensure laws and freedom of choice legislation. They invented their professional identity and then sold it to the public.

They succeeded because they traded on their expertise — forming relationships and demonstrating their effectiveness. Their situation was (like the dentists) fundamentally no different than the one we face today. On the downside, our hard-won identity and business models are threatened, besieged by other providers and wasting away from the privations of managed care. We need to build new models. Exemplars are out there. Kyle Babick has admirable success using evidence-based treatments to open Workman’s Compensation to mental health interventions. Several groups have developed walk-in clinics for psychological care (see Gary Schoener in Minneapolis or Arnold Slive and Monte Bobele in San Antonio). Bonny Gardner has had remarkable success at getting patients seen by psychologists — without insurance money, in settings away from special education families; shifting role of LSSPs in school districts; guidelines into crisis intervention; guidelines for teletherapy and use of social media; increase in complaints against LSSPs; staff salaries much lower than those in other agencies and trouble with staff retention.

Another troubling part of the meeting concerned the recently proposed revisions to Board Rules and Regulations. Some of these rules, which govern our daily practice, were not well considered and seemed to have been prepared and approved for publication without much attention to significant implications for practice or looking at consistency with other rules. Two published rule changes had to be withdrawn due to obvious problems that were too involved for even a subcommittee of the Board to figure out in a reasonable time. Others had less involved changes that could have been incorporated in the original proposals had

Texas State Board of Examiners of Psychologists

Paul Andrews, PhD

Recently, I attended a TSBEP meeting (May 3) and have some personal observations to share. Much of the meeting consisted of the Board functioning as a Committee of the Whole (entire board functioning as a working committee with inherently limited time for brainstorming, securing pertinent information, discussion of alternatives, resolution of questions) with inadequate use of delegation for committees to address complex issues and bring well-thought recommendations. As a consequence, the Board spent a great deal of time bumbling around opinions with seemingly little direction of discussion. Consider that at least half an hour’s discussion was devoted to whether the General Counsel’s position in the organizational chart should be raised half an inch above others who report to the Executive Director. Bear in mind, none of this discussion was about any change in administrative lines of reporting, duties, or authority—ONLY about where the organizational chart box should be located. What makes this seemingly pointless discussion even more wasteful is that it occurred as the only point of discussion about the strategic plan report in which it was listed. Half an hour about a box on a flow chart, no discussion about the future of the agency.

Contained in that Strategic Plan document was information that indicated TSBEP again faces budget restrictions due to state budget cuts. TSBEP continues to take in fees that amount to nearly three times what it is returned in state appropriated funding. As a result we pay but do not get services. I don’t know what can be done about the loss of services, budget cuts despite intake surplus, or why we have to pay a surcharge for which we get no services; but I would have liked to have heard some discussion or planning on the part of the Board. Same with other topics contained in this document: projected population increases in Texas with resulting increased demand for psychological services but problems getting candidates into internships and postdoctoral supervision; high cost of untreated “or incarceration treatment” of mental illness in Texas; preparation for meeting extensive needs of veterans and families; shifting role of LSSPs in school settings away from special education and into crisis intervention; guidelines about teletherapy and use of social media; increase in complaints against LSSPs; staff salaries much lower than those in other agencies and trouble with staff retention.

We have the best science if we value it. The need for psychological services is growing, and we have the know-how that should give us the advantage in inventing and marketing our value in new business models. We are experts at forming trusting alliances. We can promote our profession to be ready for the challenges ahead. We did it before. We can do it again. What’s your model going to be?
there been input from licensees or review by practitioners.

What is frightening about problem resolution in a Committee of the Whole process is that discussion is limited to a single point in time and dependent on the information readily to members. It is limited by the expertise present around the table at the time of the discussion. Expertise was evident in two matters of discussion where three board members effectively applied their practice knowledge to issues at hand; but on other matters, there was more limited experience evident so that discussion was not nearly so rich or well informed. Surely TSBEP can function more efficiently and effectively with greater use of delegation, committee deliberation, and consultation with a broader representation of licensees than only the six who sit around the table. I am concerned about rules and proposed rules seeming to retreat to moralistic thinking about what are ethical issues. For example, a rule was passed establishing a ban on having a sexual relationship with a family member of a client for two years after treatment. By this rule, what is forbidden at day 730 is okay at day 731. Instead of stating that it is generally inappropriate for such a relationship and stating that the licensee has the burden of proof for such a relationship ever being allowable, the Board opted to forego wording that would have involved highlighting professional ethics and responsibility and instead adopted a calendar-counting approach to the potential problem. Licensees (and informal settlement committees hearing complaints) as a result are released from having to wrestle with what is ethical for clients and licensees and now only have to determine if the right number of days have lapsed. With such rules, the focus shifts from professionals asking, “What do I need to do for the protection and wellbeing of the client?” to “What is the least that I need to do to protect myself?” The moralistic rule makes it easy to see if a rule transgression has occurred in a specific case, but it misses the heart and spirit of our collective professional wisdom. Such an approach seems best suited for use at the low end of Kohlberg’s stages of moral development, and I think licensees and informal settlement committee members have more to contribute on these issues.

Money was also an issue in the meeting. TSBEP operates on a budget that is approved or modified by the legislature every two years. Last session, the two proposed annual budgets for TSBEP were each slashed about $86,000 from previous years and resulted in cuts in services (no more hard copies of Rules and Regulations, no more online list of licensees, no written or email newsletters) and loss of money for additional staff and computer resources. Although TSBEP collected approximately $2.3 million this year, all this money went directly to the state general fund. The appropriated budget amount TSBEP expects annually from the state is about $800,000—a net surplus of about $1.5 million a year for state revenue. Half of this surplus comes from the $200 surcharge we pay atop our license fee each year. If it were being spent for schools, I might feel better about paying it. In recent years, if the legislature approves an increase over the prior biennial budget, TSBEP is required to raise that much more in new revenue according to Ms. Lee, Executive Director. Preliminary thinking about the next budget request proposes a budget that makes up for the cut from last time—and will necessitate a license increase of about $15 per year. Traditionally, TSBEP has requested and obtained TPA support for any license increase in exchange for discussions about programs that TPA wanted to be instituted. This quid pro quo last time turned into a “quid” with no “pro quo” as TSBEP failed to follow through on a continuing education monitoring agreement after TPA supported the fee increase. In a time when our reimbursement rates are being eroded and when mental health services are being restricted for our clients, how willing should we be to support a fee increase when the last agreement was not honored? And when we still pay a $200 surcharge on our license fee?

As a psychologist licensed by TSBEP, I ask that the Board make better use of committee delegation in order to more carefully consider proposed rule changes. Doing so before potential rules are proposed can allow for better worded rules that have fewer unintended implications and consequences. The recent revision of the forensic rules serves as an example of how a task force of licensees worked with TSBEP staff and board to develop proposed changes that had been comprehensively reviewed even before they were presented for initial board approval. The Board makes good use of delegation in considering complaint cases—the committees take time to adequately consider matters and then make recommendations to the full board for action. This model seems preferable to expecting the Board to function as a Committee of the Whole on matters needing exploration. And there are a whole lot of matters that need exploration (supervision rules, electronic media and practice, termination of practice guidelines, credentialing in specialty areas).

I also want the Board to take a different perspective on its focus in looking at rules and what is important to protect the public, as well as the integrity of the practice of psychology in Texas. I think our rules need to be specific about matters such as requirements for licensure and instructive about matters of practice. But I think neither is the public protected nor the integrity of psychology upheld with legalistic rules about how long before a licensee can wait to have sex with a family member of a former client. I think we can do better, and I hope Board members and staff do not resort to attempts to be “black and white” to the point that we lose sight of the profession’s ethical resources and responsibilities.

I want the Board to recognize that the duty to protect the public means also a duty to uphold the integrity of the licenses that its members sign. This is a social contract that licensees have with the Board. Part of that contract depends on licensees upholding the rules and laws governing practice as well as the ethical obligations that are inherent in the collective wisdom of the profession. There is also another part—the Board has a responsibility to take action to assure that the licensed practice of psychology is protected. 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.

Regarding the issues around budgets and license fees, I do not have a specific suggestion. I recognize that the legislature is focused on cutting services and not raising (direct) taxes. TSBEP has to find money to operate. However, I think 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.

Dr. Andrews is in private practice in Tyler. He has generously given his time and energy to many TPA projects, including traveling to Austin to monitor the TSBEP board meetings on behalf of TPA.
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