Trust Sponsored Professional Liability Insurance is now available to ALL psychologists!

Whenever you provide psychological services—clinical, consulting, forensic, academic, even delivered through ethical and approved telepsychology practice. In so many settings and in so many ways, we have you covered throughout your career.

- Broad coverage at affordable rates
- Free risk management consultations
- Discounts on Trust CE workshops and webinars
- Premium discounts include CE, early career, part time, group, and more
- Excellent customer service, including 24/7 Online Service Center
- Free Ethics eBook download
- Financial rating of A++ (Superior) from A.M. Best Company

Move your coverage to The Trust. It's easy!

Simply apply and provide us with proof of current coverage. We’ll do the rest.

- No gap in coverage (seamless transition)
- No costly tail (we pick up past years)
- 10% discount for switching coverage

Questions or concerns?
Call us at 1-877-637-9700

For Psychologists By Psychologists

www.trustinsurance.com • 1-877-637-9700

* Insurance provided by ACE American Insurance Company, Philadelphia, PA and in some jurisdictions, other insurance companies within the ACE Group. The product information above is a summary only. The insurance policy actually issued contains the terms and conditions of the contract. All products may not be available in all states. Surplus lines insurance sold only through licensed surplus lines producers. Administered by Trust Risk Management Services, Inc. ACE USA is the U.S.-based retail operating division of the ACE Group, a global leader in insurance and reinsurance, serving a diverse group of clients. Headed by ACE Limited (NYSE: ACE), a component of the S&P 500 stock index, the ACE Group conducts its business on a worldwide basis with operating subsidiaries in more than 50 countries. Additional information can be found at www.acegroup.com/us.
Table of Contents

From the Editor:
Psychologists Make the World a Better Place ............................................ 1
Brian H. Stagner, Ph.D.

From the President:
Psychology Practice in the Era of Health Care Reform ....................................2
James H. Bray, Ph.D.

From the Executive Director:
Do We Need Psychologists in Texas? ...................... 4
David White, CAE

Latina/o Adolescent Suicidality: Intergenerational Acculturation Gaps and the Potential Impact for Latina/o Youth and Families ................................. 6
Brandy Piña-Watson, Ph.D.
Abigail Cruz

Do You Have Any Friends? ....................................... 9
Angela Cool, Ph.D.
Texas Psychological Foundation President

After a Disaster: A Challenge for Psychologists to Provide Services ................... 11
Ronald S. Palomares, Ph.D.

The Role of Psychologists in Times of Community-Wide Crises ....................... 18
Rebecca Hamlin, Ph.D.
Judith Andrews, Ph.D.

All article references can be found at www.texaspsyc.org.

Don’t forget, you can always view updates and changes about the profession and practice of psychology at www.texaspsyc.org

Find/Follow us on:

@TXPsychAssoc facebook.com/TPAFans www.linkedin.com

Texas Psychological Association
From the Editor

Psychologists Make the World a Better Place

Brian H. Stagner, Ph.D.

This issue of the Texas Psychologist has been a particular pleasure to assemble. Amid all the challenges that face our discipline and our profession, we often lose sight of the good that psychologists can accomplish. At TPA we often get swamped by the relentless need for vigilant protection of the integrity of our profession. As the standard-bearer for the profession, TPA is often responding to predatory reimbursement policies, efforts to exclude us from exercising our unique expertise, threats to our scope of practice, and a general misunderstanding in the public mind about what we have to offer. Thus, it is important to remind ourselves that we are a helping profession. Yes, that means we help our patients. But in a larger sense we are a profession that helps. At the legislature, psychologists advocate for improvements in health, mental health, education, and the legal system. But there is an even larger sense of helping, that of modeling for the community how to share our expertise and indeed to share ourselves to help build a better world.

Gosh, that sounds pretentious and sentimental all at once. But the articles in this issue exemplify how psychologists dedicate themselves to the greater good. This summer several of us were privileged to receive e-mail updates from our colleague Ron Palomares as he traveled to Nepal to assist with disaster recovery following a cataclysmic earthquake there. His eloquence and compassion were inspirational. Throughout his career, Ron has exemplified the very best of psychologists in action. He integrates deeply felt prosocial values with the tools of his professional training in all his endeavors. While in Nepal he used his training to help restore optimism in the individuals he met, and to rebuild a sense of connection and hope in the communities he visited. He’s written a wonderful account of his trip.

But you don’t have to go to Asia to be a worldly psychologist. Dr. Hamlin and Dr. Andrews are the co-coordinators of TPA’s Disaster Response Network (DRN), and their article in this issue reminds us that no community is immune from crisis or tragedy. Catastrophic events disorganize and disrupt individuals, neighborhoods, and civic infrastructure. Psychology’s body of knowledge about stress, resiliency, and systemic stability/instability make us extremely valuable to any response efforts. Disaster management personnel have become increasingly sensitive to the psychological impact of catastrophes, and are ever more appreciative of interventions that can stabilize individuals and help organize groups to begin rebuilding.

Check out the description of DRN activities in this issue and think about how you might be able to lend your expertise to those in need.

Of course, lending expertise doesn’t just involve hands-on engagement like Dr. Palomares or the DRN exemplify. Social good will be achieved through better understanding, and that understanding will be grounded in better science. Dr. Brandy Piña-Watson & Abigail Cruz have contributed a nice piece in this issue that documents disparities in suicide rates among Latina/o youth and the role of acculturation processes in mediating the rate of attempted suicide. Their article models the way rigorous science clarifies problems and then shapes the development of interventions that will help communities resolve disparities in mental health outcomes.

I often remind people that TPA is your most effective advocate to protect and promote your profession, and I make various calls for you to get involved. Today I challenge all of you to find a way to put psychology into action in your community. Follow the example of these different authors and use your tools to make the world a little better.
From the President

Psychology Practice in the Era of Health Care Reform

James H. Bray, Ph.D.

The times are really changing for the practice of psychology. This is due to a combination of legislative changes brought about by the implementation of the federal Affordable Care Act (a.k.a. Obama Care or Health Care Reform), evolution in the science of psychology practice, and the marketplace. There is an increased reliance on the use of psychotropic medications by non-psychiatric physicians and other prescribers. As a result, there is a significant decline in the use of psychotherapy and behavioral interventions (Frank, 2009; Medical Expenditure Panel Survey, 2009). Reimbursement rates have declined by over 20% in the last 15 years, and the mantra of health care reform is “faster, better, cheaper” (Frank, 2009; Kessler, Demler, et al., 2005; Wang, Demler, et al., 2006). In addition, the increase in the numbers of master’s-level clinicians has contributed to the competition and downward spiral of reimbursement rates. These are truly challenging times for psychology practitioners.

At the same time, there has been an increase in the recognition of behavioral and mental health issues at both the federal and state levels. The Veterans Administration has taken the lead at the federal level by increasing behavioral health care to veterans, which has provided a rise in the number of psychology interns and post-doc positions. Psychology is one of the named professions for integrated health care teams in the Affordable Care Act, and the new subspecialty of primary care psychology is on the rise (Bray, 2010). These are exciting opportunities for psychologists. However, they often require that we change the way and where we practice our profession.

Due in part to a legislative report that documented the significant mental health shortages throughout Texas (HB 1023), the Members of the House and Senate crafted many bills to address these shortages. The Texas Legislature increased funding for mental health services (although Texas is still at the bottom compared to other states). The Texas Legislature passed two Bills to help psychologists practice and deal with large debt from graduate school. First, the Legislature rescinded the $200 tax you pay each year over and above your license fee—that’s right—your license is now $200 less because of TPA’s legislative work (HB 7). Second, the Legislature passed a bill that provides loan repayment of up to $80,000 for psychologists who are willing to work in state-approved underserved areas (SB 239).

As I stated in my APA President’s address (Bray, 2010):

“Regardless of changes in health care reform, psychologists and their clients/patients will continue to practice in these traditional ways for at least another generation or two. Why? Because many psychologists and their clients continue to find value in these approaches and people are willing to pay for these services now, even when they are not fully covered by their health insurance. People always seem to be willing to pay for things they value, and we need to remember this in planning our future (p 357).”

Sunset Review of the Texas Psychology License Act. In the 2017 Texas Legislative session, the psychology practice and license act will be up for review and possible elimination or “sunsetting.” What does that mean for you and your ability to practice psychology? First, the licensing act will be reviewed, and the Legislature must decide whether to keep psychology as a licensed profession in Texas. If they do not renew our licensing act, then the profession of psychology will no longer be regulated and licensed in Texas. This happened recently to dentists in Texas, and it happened a few years ago to
psychologists in Florida. What are the practical implications? It would mean that any person may call himself/herself a psychologist and practice under that title. **DO I HAVE YOUR ATTENTION NOW?**

**WHAT YOU CAN DO.** We cannot afford to ignore the importance of this legislative process or we will not have a license to practice psychology. In order to ensure that our license act is renewed and we are able to keep or expand our scope of practice, we will need your help and financial contributions. We will need to make increased contributions to key Legislators who will influence the passage of our licensing act. We will need you to make phone calls to your legislators to let them know how important it is to keep our licensing act. It is simply not sufficient to expect others to do this for you – **IT IS IN YOUR BEST INTERESTS TO ACTIVELY PARTICIPATE.** If you know of colleagues who are not TPA members and who do not give to our Political Action Committee, show them this article and tell them why it is critically important. There is no excuse for not contributing. With the passage of HB 7, which eliminated the $200 professional tax on your license, every psychologist has an extra $200 to contribute to this cause. You can donate online at www.texaspsyc.org/donations/ We will be working with the Texas State Board of Examiners of Psychologists to collaborate on needed changes and expansions to our scope of practice. Some of the areas that we plan to consider include giving psychologists the right to diagnose and treat mental and behavioral disorders. Our current license only gives us the right to evaluate, assess and intervene. We will also be seeking expansions of our scope of practice to give specially trained psychologists the right to prescribe psychotropic medications, provide evaluations and clearances for concussions, provide evaluations and determinations for guardianship, and other areas. Please contact us if you have any other ideas about what we need to address for our licensing act.

**TPA Annual Convention.** We have a stellar group of presenters and programs for the annual convention that will be held November 12-14 in San Antonio. You can get all 20 hours of your TSBEP professional development requirements at the convention, including the three hours for ethics and three hours for cultural diversity. Dr. John Norcross and Dr. Katherine Nordal will be giving keynote addresses. Dr. Norcross will discuss evidence-based relationship therapies. Dr. Nordal, who is the executive director of the APA Practice Directorate, will be discussing the latest developments at APA and implications of healthcare reform for professional practice. Dr. Samuel Knapp, the former director of professional affairs for the Pennsylvania Psychological Association, will give a three-hour ethics workshop. We will also have workshops on the ICD-10 and current CPT codes by Dr. Tony Puente. Dr. Puente is a candidate for APA President. He is donating his time to give these workshops at TPA. I thank Dr. Kay Allensworth, chair of the TPA Convention Program Committee, and the other committee members who volunteered their time to develop this outstanding program.

As this is the last column I will write as TPA President, I want to thank you for the opportunity to serve you and our profession. We have had a remarkably successful year with the Texas Legislature that will serve our profession well for many years to come. Remember, because of TPA’s efforts, you no longer have to pay the $200 per year professional tax for your license, so please consider donating that money to the TPA PAC or Texas Psychological Foundation. I want to thank the TPA Board of Trustees and staff for their hard work and many contributions over the past year. David White, Sherry Reisman, Lauren Witt, Sarah Bann, and Alison Cowden work hard every day for TPA—thank them next time you see them.

TPA needs your help to accomplish our political agenda—you can have great influence by getting involved. Take the time to donate to the TPA PAC: www.texaspsyc.org/donations/ Let me hear from you—engage—get involved—this is YOUR TPA. Contact me anytime: jbray@bcm.edu.
Does Texas need psychologists to take care of the mental health needs of its citizens? That is the basic question the state legislature will decide in 2017. Every 12 years, the State of Texas discusses the merit of that question and decides whether to continue licensing psychologists. It might seem pretty obvious that since psychologists were first licensed in 1969, the odds of eliminating such an important component of our healthcare delivery service would be very slim. However, at this point of the life cycle of the psychological profession, it is not so much if we need licensed psychologists, but rather what role do psychologists serve in the overall mental health care for citizens of Texas. As you know, professionals licensed as LSSPs, LPAs, LPCs, LCSWs, LMFTs, LCDCs, and other individuals specializing in dyslexia, behavioral analysis, or sex-offender treatment providers give the legislature a wide array of professionals that are able to treat the mental health needs of the population. So, what role do psychologists play in overall health care? After 24 years of being your executive director and seeing many changes to the profession, I can honestly say I am concerned about what the next few years could look like.

Psychology is changing. The delivery of health care, and especially mental health care, is changing. Policy makers seeking to define a new way to deliver services are having to look at the cost benefit of what each profession brings to the system.

Psychology is going through sunset review in 2017, and every licensee must understand and get involved with the process.

What takes place during Sunset Review? In 1977 the State legislature passed a law to create a Commission to review state agencies, i.e., all licensed professionals, and determine if they should be continued or abolished. Since its inception, 79 agencies have been abolished, with 37 agencies being abolished completely and 47 that were abolished and certain functions of the licensees transferred to existing or newly created agencies. The Texas State Board of Examiners of Psychology will be reviewed in 2017 to see 1.) if there is still a need to license psychologists, and 2.) if so, can functions currently being provided by TSBEP be streamlined or consolidated with another agency?

The process is fairly simple: the sunset commission staff conducts a thorough review of the agency, in our case the Texas State Board of Examiners of Psychology. This review, conducted by the Commission Staff, reviews the TSBEP’s self-evaluation report, as well as input from their stakeholders (TPA, TASP and TAPA), all of which is confidential by law. The goal is to identify problem areas that need to be addressed in proposed legislation. This review process begins early in 2016, lasting about three to four months, at which time the staff will write their report and submit their recommendations to the Sunset Commission. This commission consists of 12 individuals; five Senators, five Representatives, and two public members. It is worth noting that the legislature has enacted a large majority of The Sunset Commission recommendations. For example, in 2013 the Sunset Commission adopted 96% of the staff recommendations and the legislature adopted 75% of the Commission’s recommendations. So getting our message to the Sunset Staff is crucial in this process.

Once the Commission has reviewed the staff’s recommendation, they will begin holding public hearings around the state. After these hearings, the Commission will issue their final report and, in our case, there will be a bill introduced in the 2017 legislature that authorizes the state to continue issuing licenses for psychologists and defines the new parameters by which you will be able to practice. As with any bill that is introduced in the legislature, they are opportunities to modify, object or outright oppose our legislation. This is a crucial time for TPA and the profession. This legislation will impact everyone who is licensed by TSBEP. It is imperative that all licensees be involved in the process.

So, how do you get involved? The first step is to support TPA — the only organization that will be immensely involved in this entire process and will be at the Capitol every day during the 2017 session to assure there are no unforeseen developments with our
bill. Second, all licensees should contact their legislator and explain the importance of psychology.

Psychologist participation is the cornerstone of this process. Outside of TPA, there is no other professional organization, group, or individual who will take interest in this process and legislation than you, a licensee of TSBEP. Whether you are an LSSP, LPA, LP or even a student who is planning on becoming a psychologist, you are the ONLY one who will make a difference. Don’t assume your colleagues will represent you — it is your responsibility to get involved. The easiest and most efficient approach is to join your local area society and TPA, and to talk to the leaders of these groups to assure your message is being relayed to the staff and legislators. You have the right to participate in all TPA meetings when this is being discussed. This is your organization and you have every right to be involved. As a matter of fact, I strongly believe it is your responsibility to be involved. You fully understood when you began your education to become a licensed psychologist that you were engaging in a profession that is regulated by the state. For the privilege of working as a psychologist in Texas, you need to participate in the process that governs your license.

2016 and 2017 are very important years. TPA will be there every step of the way. We need you to join us and tell your colleagues to join us. Your practice might be different in 2017, so be part of the change!

Texas Psychological Association 2015 Legislative Session in Review

**HB 1924**

As TPA’s primary bill this session, HB 1924 allows licensed psychologists to supervise predoctoral interns. Current law allows psychologists to bill for services that are delegated to provisionally licensed psychologists or early career psychologists. Now interns are included.

**HB 1449**

Pertaining to mental health professionals who conduct child custody evaluations, this bill overhauled the family law code that focused on how the courts deal with child custody matters. The new law requires that a child custody evaluation be provided, rather than the current social study, and defines which mental health professionals are eligible to conduct these evaluations.

**HB 574**

This legislation deals with the insurance companies that practice “de-listing.” HB 574 prohibits insurance companies, as a condition of their contractual agreement, from discussing with or communicating in good faith with a patient any information regarding the facilities, both in-house and out-of-house providers, for the treatment of the patient’s medical condition.

**HB 1998**

This bill would have given occupational therapists a niche in the mental health arena by classifying them as mental health professionals. OTs felt their work has a psychological foundation, and thus they should be classified as a “non-physician mental health provider.” TPA was instrumental in educating the legislature that, even though OTs provide a very important role in our health care environment, they are not qualified or trained as mental health providers and should not be recognized as such.

**SB 239**

This bill addresses the mental health professional shortage by incentivizing mental health professionals to stay in Texas, particularly in the rural areas of the state. It establishes a program that offers student loan repayment assistance for psychologists and other mental health providers. To be eligible for loan repayment assistance, the psychologists must: Provide services in a designated mental health professional shortage area; and provide care to Medicaid and CHIP clients; or provide care to persons committed to certain state-operated correctional facilities. The amount of repayment assistance will be: 1st year – 10%, 2nd year – 15%, 3rd year – 20%, 4th year – 25%, 5th year – 30%

**HB 1878**

HB 1878 passed with the understanding that school-based telemedicine, which utilizes technology to connect children, pediatricians, school nurses, and parents, allows a physician and school nurse to promptly diagnose children and ensure they receive appropriate follow-up treatment without requiring a parent to miss work, thus saving taxpayers money because of reduced costs of emergency room visits and improved health outcomes for children.

**HB 2703**

HB 2703 was introduced to create an independent licensure board for Board Certified Behavioral Analysts. Even though the bill’s legislative sponsor testified that he would be open for them to be under an existing regulatory board, the BCBAAs objected to this and wanted the own regulatory board. We were able to stop the progression of this bill.

**HB 197**

This bill makes it easier for Texas college students to connect with mental health services in their communities and promotes cultural awareness and acceptance of students who have a mental-health need. All public institutions of higher education must post on their website information about mental health resources available to students, as well as the contact information for the local mental health authority.
Latina/o Adolescent Suicidality: Intergenerational Acculturation Gaps and the Potential Impact for Latina/o Youth and Families

Brandy Piña-Watson, Ph.D.
Abigail Cruz
Texas Tech University

Latina/o youth have been struggling with elevated rates of suicidal ideation and behaviors for the past few decades. Across the nation, on average, one out of every four Latina girls, and one out of every nine Latino boys have seriously considered suicide in the last 12 months (CDC, 2013). Additionally, in terms of making a suicide attempt, 15.6% of Latina girls and 6.9% of Latino boys report that they have made at least one suicide attempt in the last 12 months. These rates are alarming—especially in states where there is a large number of Latina/o youth such as Texas. Given this, one may want to understand more about potential contributors to these statistics as well as what mental health practitioners can do to help treat and prevent Latina/o adolescent suicidality. This article will highlight the mental health disparities that exist for Latina/o youth in terms of suicidality, the prevalence and significance of the issue in Texas specifically, and a review of one cultural dynamic, intergenerational acculturation gaps, that could shed light on a potential focus of prevention and intervention strategies aimed at decreasing these rates for these youth, thus bringing a greater sense of well-being to Latina/o youth, families, and communities.

How Do Latina/o Adolescent Rates Compare to Other Groups?
Latinos comprise 17% of the U.S. population and currently one in four children in the public U.S. school system identifies as being Latina/o (CDC, 2015). Much of the focus on Latina/o adolescent suicidality over the past few decades has been on the stark contrast of Latina adolescent suicidality when compared to Latino boys and youth from other ethnic groups. This comparison was made possible by a study conducted by the U.S. Centers for Disease Control entitled the Youth Risk Behaviors Surveillance System (YRBSS; CDC, 2013). Since 1991, the CDC has collected data annually across the U.S. with youth in a variety of risky behavior domains with one area being suicidality. Each year they ask youth across the U.S. if they have seriously considered suicide or made a suicide attempt in the past 12 months. The results can be stratified in many different ways including U.S. region, gender, and ethnicity.

The most recent data that is available through the CDC was collected in 2013. This data reveals that Latina girls continue to have the highest rates of reporting suicidal ideation and attempts in the past 12 months. Additionally, although Latino boys do not have rates as high as their female counterparts, they also still struggle. Figure 1 visually represents the 2013 statistics for youth in the U.S. It highlights the disparity that exists across gender and ethnicity for the largest ethnic groups in the U.S. (Latinos, African Americans, and non-Latino Whites). As demonstrated, Latina girls have the highest reporting of suicidal ideation and attempts when compared to Latino boys and all other ethnic and gendered groups.

![Graph of Suicidal Ideation and Attempts by Ethnicity and Gender in the United States (CDC, 2013)](image-url)
What Are the Rates in Texas?
There is a much larger proportion of Latina/o youth in the Texas school system with approximately one out of every two children being of Latina/o ethnicity (Pew Research Center, 2011). Given that suicidality is a great struggle for Latina/o youth, and the sheer proportion of Latina/o youth in our state, it is not uncommon for mental health practitioners and educators in the state to come into contact with Latina/o youth and families struggling with this issue. Through the CDC data, we can also see that suicidal ideation and attempts continue to be an issue for Latina/o girls; however, Latino boys in the state of Texas seem to be struggling with suicidality at disproportional rates when compared to Latino boys across the nation (see Figure 2). For example, in Texas 13.1% of Latino boys report that they have seriously considered suicide in the past 12 months, compared to 11.5% in the U.S. broadly. Additionally, 9.2% report having made an attempt in the last 12 months, which is higher than the U.S. average of 6.9%. Similar averages were also found in reporting of suicidal ideation and attempts in a sample collected with Latina/o youth in the U.S. Texas-México Rio Grande Valley (Piña-Watson, 2014).

As is demonstrated with the data presented in Figures 1 and 2, for both Latina/o girls and boys, most who think about suicide within the last year go on to make an attempt on their life within the same year period. Therefore, this mental health disparity has been the focus of much research in an effort to understand and treat Latina/o youth in a culturally competent manner (Roberts & Chen, 1995; Roberts & Sobhan, 1992; Roberts, Roberts, & Chen, 1997). There have been many explanations for factors that could explain this relationship with much research focusing on familial relational factors and cultural stressors. For Latinas/os, the experience of acculturation and the stress that accompanies this process can have mental health implications (Buchanan & Smokowski, 2009). One stressful part of the acculturative process concerns intergenerational differences that are present between an acculturating child and their parent or caregiver. Although this is not the only explanation, this is one factor that mental health practitioners should note that could have implications for the mental health and functioning of Latina/o youth.

Figure 2.

Intergenerational Acculturation Gaps: What are they?
Cultural adaptation includes the processes of modifying an individual’s beliefs, values, behaviors and affect about cultures that come into contact with one another. Two parallel processes occur on these cognitive, affective and behavioral levels: acculturation and enculturation. Acculturation, or mainstream cultural acquisition, is the process of acquiring the majority group’s cultural values, beliefs, and behaviors (Berry, 2003). In the case of Latinas/os in the U.S., the dominant group would be non-Latino White Americans. Enculturation, or heritage culture retention, refers to maintaining one’s heritage culture’s beliefs, values and behaviors while living within another culture (Dumka, Gonzales, Bonds, & Milsap, 2008; Gonzales, Knight, Morgan-Lopez, Saenz, & Siroliii, 2002). Often times the term acculturation is used to encompass both of the processes that make up the cultural adaptation process. For clarity and consistency in the present article, the term acculturation will be used to denote the dynamic and parallel processes of acquiring parts of the mainstream culture and maintaining certain aspects of one’s heritage culture. Many studies that look at the impact of acculturation and enculturation on mental health only take into account the acculturation levels of the adolescent and fail to consider the family’s acculturation dynamics that come into play. The degree of similarity and/or differences between the values, beliefs and behaviors of parents and children can often impact their relationship. According to the acculturation gap hypothesis, because parents and children acculturate to the mainstream society at different rates, with parents often having lower levels of acculturation than their children, the relationship between the child and the parent is affected and leads to distress for the youth (Lee, Choe, Kim, & Ngo, 2000). In particular, this gap, or intergenerational acculturation difference, can lead to ruptures in the relationship and can lead to conflict.

Intergenerational Acculturation Gaps: Empirical Research Findings
According to the acculturation gap hypothesis, parents and children acculturate to the mainstream U.S. society at different rates. Since parents often have lower levels of acculturation than their children, conflict occurs, which leads to distress for the youth (Lee et al., 2000). Specifically, it is hypothesized that the larger this gap is, the more strain and conflict it places on the relationship, which in turn negatively impacts the mental health of the adolescent (Birman, 2006).
Several empirical studies have shown that intergenerational acculturation gaps can have implications on Latina/o youths' mental health.

For example, Céspedes and Huey (2008) examined how gender role discrepancies, a cognitive dimension of acculturation, influenced adolescent mental health and family dynamics. A significant relationship was found between gender role discrepancy and adolescent depression, meaning that the larger the intergenerational discrepancies, the higher the reporting of depressive symptoms. Familismo, or the Latina/o value that family is central to the self and includes aspects such as interconnection, honor, subjugation of self for family, and familial support, has also been investigated as a cognitive dimension of acculturation gaps. In a study with Latina adolescents, Baumann, Kuhlberg, and Zayas (2010) found that the larger the intergenerational gaps between mothers and daughters was related to negative implications for the mother-daughter relationship, which in turn was related to higher reporting of suicide attempts.

### Intergenerational Acculturation Gaps: How Can We Use This Knowledge in Clinical Practice?

Below are some suggestions of ways in which practitioners working with Latina/o youth and families can implement this knowledge in their clinical work to prevent and intervene with those struggling with suicidal ideation or behaviors.

1. **Assess for Gaps.** Given the acculturation gap hypothesis, it is critical that practitioners acknowledge that there can be culturally fueled forms of family disruption in the lives of Latinas/os. Cultural adaptation, acquiring values, beliefs, and behaviors, while at the same time attempting to retain one's heritage culture can be a stressful process. Knowing that this could be something that is impacting the well-being of Latina/o families is key. Practitioners can assess for these gaps by asking both adolescents and parents about potential value and behavior differences that could be relevant to the acculturation process. Additionally, if a youth presented to therapy with issues related to suicidality, it may be prudent to ask about potential intergenerational acculturation differences and how this may be impacting family functioning, and thus the youth's mental health. Another important consideration in assessment is to assess multiple dimensions of gaps. Recall that cultural adaptation can be behavioral, affective, or cognitive. Asking questions to determine if there are differences in behavioral practices, how the youth and parents feel affectively toward the heritage and mainstream cultures, as well as assessing differences in values and beliefs can also shed light into the complexity of intergenerational differences that could be present.

2. **Determine Strengths.** Although intergenerational differences can often be taxing on the relationships between Latina/o youth and parents, there are also many strengths that can be harnessed in order to help mitigate the potential negative impact of gaps. Exploring past healthy family patterns of communication could be beneficial. Also working with the youth and parents to understand the dual process of acculturation and enculturation could help come to a resolution in how to deal with these inevitable generational differences. Another option is to explore how conflicts have been resolved successfully in the past, and encouraging families to engage in similar forms of resolution if conflict occurs in the future.

3. **Acknowledge the Reach.** Intergenerational acculturation gaps have been shown to be present across generation status (Piña-Watson, 2014). That is, not only do immigrant youth and parents experience these gaps, but they can be detected in later generations as well. Although aspects of the Latina/o culture such as the Spanish language may sharply decrease in frequency after the second generation, other aspects such as values and beliefs (i.e., familismo) can remain for several generations after immigration. Given this, practitioners should be aware that this process can be present for Latina/o families regardless of how many generations have been in the U.S.

4. **Avoid Assumptions.** Although research has shown support for the acculturation gap hypothesis, one should approach this topic with caution. It is important to acknowledge that all Latinas/os families are different in their family composition in terms of cultural adaptation. Although some families may be struggling with intergenerational conflicts, this does not mean all families are. Additionally, it would be erroneous to assume that because a youth is presenting with suicidal ideation or a history of attempts that the root is intergenerational gaps. Knowing this is a possibility will help practitioners assess a more holistic realm of possibilities for underlying mechanisms that are contributing to the client's struggles with suicidality.

5. **Family Approach.** The presence of intergenerational gaps with some Latina/o youth provide further support for working within the family context when treating Latina/o adolescent suicidality. Previous interventions, such as the Bicultural Effectiveness Training Program (Szapocznik et al., 1984), can be helpful to address intercultural acculturation differences and conflicts through being aware of the youth within a system. Through this program, it is suggested that the conflicts that occur between the generations are interpersonal in nature and should be treated as such. When working with youth and families who are struggling with distress and suicidality, practitioners should be aware of this interpersonal nature and not treat the youth in isolation.
Making friends in school was easy.

But once you’re all grown up, it gets much harder — especially if you’ve just moved to a new city.

Thankfully, social science has figured out some of the ways that adult friendships form. A few key strategies include getting out of the office more often, getting in touch with people you used to know, and having ridiculous shared experiences together!

And where can you do all of those things? At the Second Annual TPF Jeopardy — Battle of the Universities competition held at the Texas Psychological Association Convention in San Antonio, TX on Thursday, November 12, 2015!

Not only will you connect with old and new friends alike, but will have a blast cheering on your fellow Friends of TPF as a team of psychologists go head-to-head against the student Jeopardy winners.

The Texas Psychological Foundation needs fun friends like you! The success of our donation campaign, and TPF in general, depends upon the contributions from generous individuals like you who believe that students studying psychology deserve support in continuing their education and research interests.

Since 1989, the Texas Psychological Foundation has been working exclusively for charitable, educational, and scientific purposes to promote the future of psychology in Texas.

Will you join us in supporting the best and brightest of Texas psychology students?

Your tax-deductible gift of $100 will make it possible for us to continue our mission to:

- Recognize excellence and achievement in graduate training by granting awards, scholarships, and fellowships;
- Stimulate interest and knowledge of psychology to the public;
- Encourage the design and development of novel techniques and innovative programs for providing effective psychological services in schools, institutions, industries, and in the community-at-large;
- Promote or fund basic and/or applied research programs in psychology;
- Encourage and support scholarship and publication in the field of psychology; and
- Develop materials and programs for the advancement of professional education in psychology.

Our goal is to add 100 new Friends of TPF ($100 donation) and raise $10,000 prior to the 2015 TPA convention. We also know that much can be accomplished from consistent, smaller donations from supportive individuals. So, for just $9 per month, less than the cost of three Starbucks coffees, you could help fund a scholarship. Every donation can make a difference, and each and every donation is greatly appreciated.

To make it easier for you, you may use your credit or debit card to make your monthly or one time gift by visiting our web site at www.texaspsych.org/TPF.

Simply click on the Contribute to TPF button and follow the instructions. When you send in your tax-deductible gift of $100 or a recurring monthly contribution of $9 or more, you will be listed as a Friend of TPF and add another colorful ribbon to your collection at the 2015 TPA Convention.

Would you please join us in supporting the next generation of Texas psychologists by making a financial contribution to a specific scholarship fund or general fund today? Your generosity as a Friend of TPF will be recognized during the Second Annual TPF Jeopardy—Battle of the Universities held at Convention on Thursday, November 12, 2015.

Your support means so much, Friend.
Texas Psychological Foundation
2015 Silent Auction

Texas Psychological Foundation is centered on promoting the future of psychology. On Thursday, November 12 at the TPA Annual Convention in San Antonio, TPF is hosting a silent auction. Join The Foundation in promoting and supporting the future of psychology in Texas by participating in the auction. Come check out the prizes and get a head start on your holiday shopping! Below is a partial list of auction items that will be available.

Original Acrylic Artwork
Dr. Elizabeth Abbott

Texans vs. Patriots Tickets plus Parking
Dr. Angela Cool

Italian Specialty Food Basket
Dr. Michael Ditsky

Texas Specialty Food Basket
Dr. Michael Ditsky

Two Texas Spirits Baskets
Dr. Heyward Green

Sur La Table Gift Bag
Dr. Jayna Halverson

Soft Cooler
Dr. Sydney Kroll

Wine Basket
Dr. Sydney Kroll

The Heart and the Fist (Book)
and Love our Vets (Book)
Dr. Sydney Kroll

Houston Livestock Show and Rodeo Tickets plus Hotel
Dr. Robert McPherson and Mr. David White

Custom Made Jewelry
Dr. Roberta L. Nutt

2016 Convention Registration
Ms. Sherry Reisman

¼ ct. Diamond Heart Pendant
Dr. Elizabeth Richeson

Fitbit Flex
Dr. Elizabeth Richeson

The Ultimate Adventure Sourcebook
Dr. Elizabeth Richeson

Hand-painted Art Pin by Joe Sam
Dr. Elizabeth Richeson

Two Custom-made Bracelets
Dr. Ollie Seay

Houston Livestock Show and Rodeo Tickets plus Hotel
Dr. Robert McPherson and Mr. David White

Circuit of the Americas Package
Dr. Jo Vendl

Business Marketing Package
Dr. Jo Vendl

Leonard Handcrafted Crystal Decanter
Dr. Linda Jackson (and her LAS)

Garmin Nuvi 1450 GPS
Dr. Linda Jackson (and her LAS)

Tea Forte Tea Brewing Pot
Dr. Linda Jackson (and her LAS)

Marshall’s Photo Pencil Set
Dr. Linda Jackson (and her LAS)

Auroville Papers made in India
Dr. Linda Jackson (and her LAS)

Paula Deen & Friends Southern Style Cookbook
Dr. Linda Jackson (and her LAS)

Friends of TPF

Cindy Carlson, PhD
Celeste Conlon, PhD
Angela Cool, PhD
Michael Ditsky, PhD
Patricia Driskill, PhD
Patrick Ellis, PhD
Heyward L. Green, PsyD
Andrew Griffin, PhD
Cheryl Hall, PhD
Amanda Johnson, PsyD
Sydney Kroll, PsyD
Linda Kuisk, PhD

Linda Ladd, PsyD, PhD
Marcia Laviage, PhD
Megan Mooney, PhD
Anne Morton, PhD
Elizabeth Richeson, PhD, MS, PsyPharm
Pete Stavinoha, PhD, ABPP

Honey Sheff, PhD
Glenn Sternes, PhD
Jeff Temple, PhD
Jo Vendl, PsyD
Michelle Viro, PhD
Early in July of this year I found myself sitting cross-legged on the dirt floor of a village's hut. I was eating a rice and vegetable dinner, and began wondering how I ended up in Nepal, while the summer monsoon rains whipped across the mountain outside. But as I thought more about it, I realized that the answer to how I ended up on that rain-drenched mountain was in the larger context of why I was there and how my life's experiences took me halfway around the world at this specific point in time.

The “why” I was in Nepal was easy: I was there providing psychological services to victims of the recently devastating earthquakes. The “how” I reached this point in my life is actually due to the coalescing of many key points in my professional career. However, it is best to start at the beginning by reminding you of the tragedy that befell Nepal this past spring.

Around noon on Saturday, April 25, 2015, an earthquake with a magnitude of 7.8 rumbled through Nepal. Reports of 9,000 lives lost, 22,000 injured, and buildings collapsing quickly became the headline across the world. Then a second quake, measuring 7.2, tore through the country two weeks later on May 12th, collapsing already weakened structures that had not fallen during the first quake, and killing several hundred more and causing injuries to thousands of Nepalese. Relief efforts began, and support and money was sent to the country to help. With the earthquake being centered in the remote mountainous regions of Eastern Nepal, the resulting destruction of roads and bridges initially allowed only emergency support to reach the villages through air, preventing the access of help to some of the people hurt the most by the earthquakes. To further compound the damages, the predominant mode of building construction in these mountain villages is the stacking of flat rocks and sealing cracks with a mud mixture. In other words, the buildings were not designed to come close to holding up to the violent forces of an earthquake of any strength.
But the damages were not confined to just the remote mountain villages. Numerous towns and cities, including the capital of Kathmandu several hundred miles away, had buildings collapse or left severely damaged. For example, the National Children's Organization maintained an orphanage in central Kathmandu, with just over 200 orphans and another 50 full-time staff, including the house mothers who lived in the building with the children. When I spoke with one of the house mothers, she explained that they were so grateful for the timing of the earthquake, a Saturday around noon, because everyone was outside playing in the open field. Several outside walls of the orphanage collapsed and the building was immediately condemned. No one was allowed back inside to retrieve anything, including any personal belongings. The children and staff were relocated to two temporary locations with literally the clothes they had on their backs that sunny afternoon. They are still housed there four months later.

So how did I end up enjoying a simple dinner during a monsoon in Nepal? My path to that moment in time might seem circuitous, but upon further reflection, I believe it began while I was very young. My parents, whose parents emigrated from Mexico, raised us with two core beliefs – do unto others as you would have them do unto you and to share what you have with others in need. Perhaps those are the reasons why I chose to become a psychologist. What greater good can one do than helping others overcome emotional distress and pain?

This drive I have to help others became very clear in the first few days I was in Nepal. While connecting with a local nonprofit organization, the Community Development Relief Agency - Nepal (CMDR), I had a meeting with the Director and their Psychosocial Counselor. During our discussion about the reason I was there, responding to the need for psychological services because of the earthquake, they asked if I would meet with one of the women they had recently been helping obtain a temporary shelter because her home had been destroyed. I agreed and arranged to meet with her later that day. It turns out that her life had been tragically impacted by the effects of the two major earthquakes. She lost her home during the first one and then her husband died suddenly during the second earthquake due to a fatal heart attack. She was left with two small children, no job and without a home. When I met her, she was living with a family member, but had been told recently that she had to leave to find her own place because they could no longer support everyone. Although her neighbors had been sharing food and help when possible, they too were pulling back that support.

So we arranged to have a meeting later that day with the psychosocial counselor acting as a translator for us. When the woman arrived, it was clear by her demeanor and body language that she was emotionally downtrodden and struggling. Using a brief therapeutic model for the session, we focused on her seeing the future and alternatives she could take to reestablish an independent life for her and her children, while also acknowledging the inner strengths she has demonstrated during this tragic period of time. At the end of our time together, it was clear by the smile on her face and upbeat attitude that I had been able to help her see how she could begin to move her life forward and feel better about her future. Afterward, my translator commented on the dramatic change in attitude and appearance she saw in the woman simply between her arrival and departure. The translator, also a psychosocial counselor, also complemented me while discussing how she planned to incorporate my approach and aspects of the session into her own future work.

Following up two weeks later with the psychosocial counselor, I found out the woman was now employed, able to care for her children and herself independently, and had made a huge turnaround in both her attitude and life circumstances since we met. However, I do not feel that I can take much of the credit for her successes. At the same time when I met with her, earlier that morning CMDR had laid the foundation (packed dirt) for her new temporary home, and completed the wooden frame and sheet metal siding/roof a few days later. Additionally, they were able to find her employment: sewing bags and baby blankets that CMDR was collecting for distribution in the coming winter months. Yet I could take comfort in the fact that while psychology does not address the physical needs of individuals, something I saw and struggled with a lot while in Nepal, psychologists work on the emotional and behavioral needs that often are as important, or maybe even more important, to the individual.
This was the first of many times I found myself engaged in an internal struggle of how I could help meet the psychological needs of the people in Nepal while at the same time seeing the far greater physical and safety needs everywhere I turned. It was during these times of struggle when Maslow and his Hierarchy of Needs (Maslow, 1943) came to mind, and made my attempts to justify the role of psychology after a disaster that created even more of a challenge for me. If the Nepalese people’s basic physiological and security needs were not currently being met, what could I, a psychologist, bring to them during these early stages of recovery from the devastating earthquakes? In response to my unspoken questions and internal struggle with my actual role, I began to notice that on numerous occasions, the importance of psychological services and my work there was very apparent from the tremendous gratitude, and also by the impact of my direct work with the individuals and groups I encountered.

But stepping further back, I asked myself what circumstance came together in my life to have the training and skills to provide psychological services to survivors of the Nepal earthquakes? What were those professional and personal experiences that led me to spending five weeks in this foreign country during the monsoon season, before the U.S. Department of Homeland Security removed their travel warning to Nepal?

To begin with, my present circumstances have me currently on the graduate faculty of the Texas Woman’s University Department of Psychology and Philosophy. While I began my education as a psychology major at Texas A&M, I also served in the Army National Guard. Upon graduation, I was commissioned and then served in the U.S. Air Force, earning a master’s degree in counseling psychology from Lesley College. I returned to Texas A&M when my Air Force commitment was fulfilled and earned my doctoral degree in school psychology. Initially employed as a licensed psychologist with Parkland Hospital in Dallas, I have maintained my Texas license since 1995. Between 2000 and 2013, I served on the staff of the American Psychological Association’s Practice Directorate, and my work there focused on policy and advocacy around children and family issues, as well as staffing several APA task forces, working with governance groups, and serving as APA's liaison to several other organizations.

It was through those varied work experiences and the many opportunities I had to talk with psychologists from across the nation, seeing and hearing about the work they engage in, that truly brought to light the important role psychologists play in helping those from a wide range of backgrounds and needs. Serving indigent and low SES populations at Dallas’ Parkland Hospital began to open my eyes to these underserved populations. Then, when I was at APA, using my vacation time to engage in contract work as a Military and Family Life Consultant (MFLC), to provide direct psychological services to U.S. service members and their families at Fort Hood, Texas (in response to the shooting in 2009) and in Germany (serving family members with a deployed soldier, 2010 and 2012). Through these experiences, I quickly realized the tremendous psychological needs of a wide range of people, many who do not, due to a wide range of reasons, show up at our hospitals, clinics, schools, or offices seeking psychological services.

Furthermore, isn’t it our professional duty and responsibility to seek out ways and opportunities to serve others who could not otherwise seek or receive our psychological services? Keep in mind that the American Psychological Association’s (APA, 2010) ethical principles guide our professional work as psychologists. Although many of the ethical principle can be found to be applicable, I believe Principle D (Justice) is the most relevant in regard to this type of service. In Principle D, we find that all persons should be able to access psychological services. If the people of Nepal, with a dire need of psychological services, are not able to access our services locally, what is there to prevent us from bringing our services to them? I believe the broader question is how can a psychologist reach out to share their services to others who do not have, not only the means to obtain those services, but also the ability to access the psychologist?

So I found one of many of my opportunities to meet my professional and ethical responsibilities by serving as a MFLC when my work responsibilities and time allowed. Through my MFLC work, especially during my assignments in Germany, I began to see the tremendous need for psychological services many underserved populations crave and yet are not able to find the resources or security to seek help. I remember when I was on Active Duty in the Air Force, working underground in an ICBM nuclear missile launch center on the Fourth of July, there were several protests occurring with U.S. citizens burning the American flag. Some protesters were burning the flag and others were protesting their actions. It was then that I truly understood my service to our country. We fought and formed the United States to protect the rights of our citizens for their freedom of speech. Whether or not I agree with what they are proclaiming, they have that right, and my service to the country was to protect those hard-fought freedoms. And there was something good in the sacrifices I made to help others rather than being at home on Thanksgiving or during other important family holidays. My family understood and supported my choice to be away helping others during those opportunities. For their support and understanding, I am truly grateful and proud that they continue to stand by me when I am gone for these service trips.

For example, my wife and family hosted in our house my father-in-law’s 80th birthday. Originally I was to be home to help with the various preparations and participate in this joyous occasion when numerous friends and relatives, many I have not seen in years, descended upon our home. However, my trip to Nepal overlapped with that day. Instead of being home, I was visiting a church and then a small orphanage located just outside Kathmandu, discussing the importance of self-care and sharing fears with those we trust as a means to overcome the constant anxiety they feel.
because of the earthquakes and continued small aftershocks. I can still remember how pleased I was to see how well the children at the orphanage helped each other, playing with the balloons and small rubber balls I passed out to them in a sharing manner. I think I spent that entire afternoon with a smile on my face thinking about when they brought me a cup of tea and then jostled each other in an attempt to stand next to me, even though my six-foot frame always seemed to tower over almost everyone I came across. Yet, I also had my family in mind that day as they celebrated a joyous occasion over 8,000 miles away from me.

Still, the question is how did I get to Nepal and have this opportunity to work with the Nepalese for over five weeks this past summer? It was during my second Germany MFLC assignment when I met a colleague, Elisabeth Scheffer. She subsequently left the MFLC program in order to open her own non-profit mental health consultation service, Elisabeth Scheffer & Associates (ESA). While Elisabeth was organizing her new venture, she contacted me initially to engage in. But then came an email from Elisabeth in late May – “Are you ready to come to Nepal?” She explained that through various contacts, she had just arrived and began providing psycho-social services. She sent me pictures of her and several villagers on a mountainside explaining the work she was doing. I was awestruck and amazed at the work she had begun, as well as the point of not dwelling on the recent past. resilience, not dwelling on the recent past.

That’s when my past research on resilience came to the forefront for me. I had worked with school children in the Washington, D.C. region after 9/11, talking about resilience and building resilience skills. That is what was needed here, moving forward and building resilience, not dwelling on the past.

The point of not dwelling on the past was reinforced to me while talking with an intern from Norway, who was completing her internship in physical therapy and rehabilitation at a local spinal clinic. This twenty-nine year old woman was in Nepal during the two earthquakes and had first experienced the terror of the earth’s undulations while standing in an open field, and then during the second earthquake, streaming with others out of the hospital, fearing that the walls or roof might collapse on her at any moment before she made it to the open courtyard. While talking about this,

Still, the question is how did I get to Nepal and have this opportunity to work with the Nepalese for over five weeks this past summer? It was during my second Germany MFLC assignment when I met a colleague, Elisabeth Scheffer. She subsequently left the MFLC program in order to open her own non-profit mental health consultation service, Elisabeth Scheffer & Associates (ESA). While Elisabeth was organizing her new venture, she contacted me initially to engage in. But then came an email from Elisabeth in late May – “Are you ready to come to Nepal?” She explained that through various contacts, she had just arrived and began providing psycho-social services. She sent me pictures of her and several villagers on a mountainside explaining the work she was doing. I was awestruck and amazed at the work she had begun, as well as the point of not dwelling on the recent past. resilience, not dwelling on the recent past.

That’s when my past research on resilience came to the forefront for me. I had worked with school children in the Washington, D.C. region after 9/11, talking about resilience and building resilience skills. That is what was needed here, moving forward and building resilience, not dwelling on the past.

The point of not dwelling on the past was reinforced to me while talking with an intern from Norway, who was completing her internship in physical therapy and rehabilitation at a local spinal clinic. This twenty-nine year old woman was in Nepal during the two earthquakes and had first experienced the terror of the earth’s undulations while standing in an open field, and then during the second earthquake, streaming with others out of the hospital, fearing that the walls or roof might collapse on her at any moment before she made it to the open courtyard. While talking about this,
That I was to deliver? That was easier. The staff and others who worked with children but what was the message for the school had not raised during the presentation! Feelings bottled up inside in a way that I see the potential consequences of keeping feelings inside of us, we then turn to my message, saying that if we keep these feelings. Another girl reframed going to try talk with his mother about those feelings.  Another girl reframed feelings inside of us, which results in us getting into trouble or hurting others by our actions. At the end of these presentations, I passed out balloons to the students to help reinforce the message. Then my translator and I would ask the students to summarize what they heard, or say whom they could trust to talk about their feelings.

It was in these responses of the students after my presentation that really began to reinforce for me the power of the message I was sharing and the impact it could have on their lives. So many of the students truly understood the need to share feelings; for example one boy said he normally would go to his room and shout into his pillow or break things when he felt overwhelmed. After that day, he was going to try talk with his mother about those feelings. Another girl reframed my message, saying that if we keep these feelings inside of us, we then turn to drinking or drugs. Exactly! She was able to see the potential consequences of keeping feelings bottled up inside in a way that I had not raised during the presentation!

But what was the message for the school staff and others who worked with children that I was to deliver? That was easier. The focus of those presentations and conversations were on identifying children who are not moving forward, establishing their new “normal” life. Being aware that the majority of students should by that point in time have begun to establish new routines and returning to actions and behaviors similar to how they interacted with others before the earthquakes. Their role, as teachers and caregivers, was to look for those children who seem to still be struggling with emotions, the loss of the previous routines and other behavioral manifestations that would suggest they still were not able to cope with the results of the how the earthquakes have impacted their lives. Then we would talk about the limited available resources they had for referrals and what they could do to themselves to provide emotional support and stability for these children.

But back to how I ended up on that mountainside in Nepal during the monsoon season… As I mentioned previously, a key reason was due to the values my mother and father instilled in me while growing up, both by treating others in the same way you’d want to treat you, and the value of sharing what you have with others less fortunate. During my childhood, growing up on a military installation, I found that it was normal to have enlisted soldiers who were far away from their home and families come over to share Thanksgiving and Christmas dinners with our family. Seeing the dining room table swell from the six of us to twelve and even sixteen was common. That sense of giving back through sharing what you have with those less fortunate was modeled at home and became integral in my own personal life.

My desire to help others was then emotionally tested at times while I was in Nepal. What could I actually do, beyond my mission to bring psychological services to them? While working with groups in Kathmandu, I initially wondered how much the earthquakes had impacted the city's inhabitants. Within Kathmandu, signs of the earthquake's effects are noticeable, but only if one were actually looking for them. Many structures had the outward appearance of being fine, and the numerous construction projects seemed to only be part of a growing city. However, when my guide pointed out a popular mall structure that was now empty, he explained that the building had also been condemned because of the damage caused by the earthquake and no one knows what will happen to this place where many Nepalese would congregate. Finding new places to go and mourning the loss of previous traditions and day-to-day life had impacted these city dwellers. In fact, I conducted some presentations at an orphanage in Kathmandu in mid-August, and my contact arrived that morning dressed professionally and wearing high-heeled shoes. During the presentation to the staff, while talking about the subtle impact the earthquake had on the lives of each individual, she disclosed that today was the first time she wore high-heels since the first earthquake. She explained that she
had been afraid that if she had to run out of the building and was wearing high-heels, they would either slow her down or she would end up being outside barefoot. This was over three months since the first earthquake and even though she was wearing her high-heels, she was still somewhat apprehensive.

Unfortunately, but as it is with many of the tragedies that occur around the globe, the “breaking news” stories about the Nepal earthquakes that aired on all the news channels soon moved on to other “breaking news” and many people have forgotten about the ongoing suffering in Nepal. The country is rebuilding and is considered to be safe to visit; the travel warning from the U.S. Government was lifted in early July. As the rebuilding of the damaged infrastructure and homes continues, I began to see the Nepalese people move upward on Maslow’s hierarchy of needs, thus reinforcing to me that now is the time for their psychological and emotional needs to be addressed and supported.

Remembering our own professional responsibilities and principles (APA, 2010), I believe the broader question is how can a psychologist reach out to share their services to others who do not have the means to obtain those services, but also lack access to the psychologist? Traveling to Nepal is one option, but other options can be found locally. There has been the recently coined term “food deserts” – those locations in large urban cities where there are swaths of neighborhoods where the individuals who live there do not have access to grocery stores where they can purchase fresh fruits and vegetables. Instead, they must rely on the limited food options available at a corner market or gas station. Similarly, where in your community and surrounding area are there “mental health deserts?” Are there locations where individuals are unable to access psychological services, even if they wanted to do so? Then the more important follow-up question is how can you help expand services to those areas?

So I end this unique and wonderful chapter of my recent experiences with a challenge to my colleagues. How can you find ways to help others beyond your specific day-to-day job duties and experiences? You do not have to spend five weeks isolated from family and friends while surviving without hot water and air conditioning or eating your meals while sitting on dirt floors. But consider what sacrifices you might be willing to make to bring your own knowledge and skills to others in great need of them, but who are not able to connect with you due to the barriers they face? I can attest to the simple fact that the more effort you put into doing this, the greater the impact there is in the lives of others, as well as yourself.

---

HERE’S WHERE THE TALENT IS FOUND.

THE TPA CAREER CENTER IS YOUR ONLINE RESOURCE FOR QUALIFIED PSYCHOLOGIST CANDIDATES.

EXPERIENCED | QUALIFIED | TALENTED

The Texas Psychological Association Career Center is the exclusive resource for candidates in the mental health industry. The system offers you an extensive resume database and powerful, user-friendly searching capabilities that allow you to find the candidates that you need to meet your organization’s recruitment goals. To find out why practices, businesses, and organizations across Texas and beyond rely on the TPA Career Center to fill their positions, visit us today!
Join a Community of Psychologists - Connect with colleagues by joining one of TPA’s divisions or special interest groups

### Divisions
- Aging
- Forensic Practice
- Military
- Neuropsychology
- Psychologists in Schools
- Psychology of Women
- Psychopharmacology
- Social Justice
- Student

### Special Interest Groups
- Bi-national Issues
- Child-Adolescent Issues
- Disaster Response
- Early Career Psychologists
- Gay-Lesbian-Bisexual-Transgender Issues
- Intellectual and Developmental Disabilities

---

**Get Covered** With Professional Liability From CPH & Associates.

Your practice is too important to leave unprotected.

---

**A++ Professional Liability Insurance For Psychologists**
- Occurrence Form “Lifetime” Coverage
- Up to 50% Discount for Newly Licensed Professionals
- 10% Risk Management Discount
- 5% Online Discount
- Online applications processed in minutes: receive your proof of coverage immediately!
- 2 Free Hours of Attorney Consultations per year HIPAA Coverage
- Unlimited Defense Coverage
- State Licensing Board Coverage: $35,000 automatically and option to increase up to $100,000

---

**Instant Quote in Less than a Minute at CPHINS.COM**

---

CPH & Associates | 711 S. Dearborn Street, Suite 205 | Chicago, IL 60605
Web www.cphins.com | Email info@cphins.com | Phone 312.987.9823
The Role of Psychologists in Times of Community-Wide Crises

Rebecca Hamlin, Ph.D.
Judith Andrews, Ph.D.
Disaster Response Network Co-Coordinators

Dr. Palomares’ article about disaster relief in Nepal provides a dramatic illustration of the role that psychologists can play in helping disaster victims build (or rebuild) their lives and their communities. For psychologists, both our personal values and our Code of Ethics impel us to be compassionate and to contribute to a community’s efforts to better itself. However, one needn’t travel to the Himalayas in order to express this wish to “do good for the hive.” Psychologists are active in times of crises much closer to home.

The American Psychological Association (APA) Disaster Response Network (DRN) of state and provincial programs has been busy preparing for and responding to disasters. California and Washington state programs are currently providing support to the evacuees from large-scale wildfires. In August, the Florida program prepared alongside local Red Cross chapters for the arrival of Tropical Storm Erika, which fortunately spared the state from large-scale flooding. The Michigan Disaster Response Network Coordinator was deployed by the Red Cross to offer disaster mental-health assistance to residents of Saipan following Typhoon Soudelor. The Georgia program conducted a “Done in a Day” training for 30 psychologists that enable them to take all necessary Red Cross training to become disaster mental health volunteers and sign up with their local chapter. In July, psychologists in Louisiana used a compilation of mass-shooting resources to help survivors of the Lafayette theater shooting. The program has been tracking community violence and civil unrest that has occurred in a number of areas this year (e.g. Charleston’s shootings, Baltimore’s Freddie Gray protests, and Chapel Hill’s shootings). The APA/DRN will bring together coordinators from across the U.S. and Canada for its every-other-year DRN Coordinators Working Meeting on October 1-3, 2015, in APA’s Washington, D.C. Capitol View Conference Center. Six workshops will cover an array of topics, including community violence, ethics in international disaster work, and an overview of field-leading research. A key-note speaker for this program’s Coordinators Working Meeting will discuss how psychologists can offer support in these tension-filled community situations. Dr. Hamlin will help facilitate a session on disaster partnerships and response activities.

In Texas, the Texas Psychological Association (TPA) DRN partnered with the Texas Health and Human Services Disaster Behavioral Health Consortium. We join many other organizations in this endeavor, including the Department of State Health Services (DSHS), Mental Health Substance Abuse (MHSA), Disaster Behavioral Health Services, the DSHS Response and Recovery Unit, Health and Human services Commission, Texas Division of Emergency Management, Texas Department of Public Safety Victim and Employee Support Services, Office of the Governor Criminal Justice Division, Office of the Attorney General Victim Services/Consumer Rights, Texas School Safety Center, Texas Voluntary Organizations Active in Disaster (VOAD), the American Red Cross, and the National Association of Social Workers (NASW)–Texas Chapter. As the TPA representatives in this effort, we have been able to assist in a number of planning initiatives for our state, including rapid response teams that have been very effective in incidents such as the floods earlier this year. Texas TPA/DRN Co-coordinator Dr. Rebecca Hamlin has been the primary representative for the consortium and has also been very active the Ebola/pandemic planning for Texas. Trainings specific to this type of response will begin in December and will be offered around the state throughout the first half of the year.

As always, we encourage members to consider becoming part of our network. Please visit the TPA website for further information on the TPA/DRN. Your coordinators can also be contacted through the TPA website as well. (Go to www.texaspsych.org, and under Public/Media Resources menu, click on Disaster Response Network).
2015 Platinum Advocates

Thank you for showing your commitment to being defenders of the profession of psychology.

Laurence Abrams, Ph.D.
Barbara Abrams, Ed.D.
Kay Allensworth, Ph.D.
Corinne Alvarez-Sanders, Ph.D.
Judith Andrews, Ph.D.
Paul Andrews, Ph.D.
Kelly Arnemann, Ph.D.
Kim Arredondo, Ph.D.
Kyle Babick, Ph.D.
Jeff Baker, Ph.D.
Laurie Baldwin, Ph.D.
Matthew Baysden, Ph.D.
Connie Benfield, Ph.D., ABPP
Tim Branaman, Ph.D.
James Bray, Ph.D.
Josh Briley, Ph.D.
Barry Bullard, Psy.D.
Mary Burnside, Ph.D.
Sam Buser, Ph.D.
Holly Carlson Zhao, Ph.D.
Jorge Carrillo, Ph.D.
Cynthia Cavazos-Gonzalez, Ph.D.
Steven Coats, PhD
Celeste Conlon, Ph.D.
Mary Alice Conroy, Ph.D.
Jim Cox, Ph.D.
Leslie Crossman, Ph.D.
Rafael Cuellar, Ph.D.
Edward Davidov, Ph.D.
Cynthia de las Fuentes, Ph.D.
Hildy Dinkins, Psy.D.
Michael Ditsky, Ph.D.
Melinda Down, Ph.D.
Jay Duhon, Ph.D.
Amy Eichler, Ph.D.
John Elwood, Psy.D.
William Erwin, Ph.D.
Frank Fee, Ph.D.
Linda Felini-Smith, Ph.D.
Ruthmarie Ferguson, Ph.D.
Christopher Fisher, Ph.D.
Alan Fisher, Ph.D.
Jessica Forshee, Ph.D.
Richard Fulbright, Ph.D.
Sheree Gallagher, Psy.D.
Cynthia Galt, Ph.D.
Ronald Garber, Ph.D.
Bonny Gardner, Ph.D.
Orna Goldwater, Ph.D.
Grace Graham, Psy.D.
Jerry Grammer, Ph.D.
Heyward Green, Psy.D.
Carol Grothues, Ph.D.
Kristy Hagar, Ph.D.
Cheryl Hall, Ph.D.
Rebecca Hamlin, Ph.D.
Michelle Hanby, Ph.D.
Michael Hand, Ph.D.
Henry Hanna, Ph.D.
David Hensley, Ph.D.
Lynn Herr, Ph.D.
Roderick Hetzel, Ph.D.
George Hill, Ph.D.
William Holden, Ph.D.
Keisha Holley Johnson, Ph.D.
Robert Hughes, Ph.D.
Rebecca Johnson, Ph.D.
Melody Jones, Ph.D.
Morton Katz, Ph.D.
Richard Kownacki, Ph.D.
Sarah Kramer, Ph.D.
Sydney Kroll, Psy.D.
Stacey Lanier, Ph.D.
Kelsey Latimer, Ph.D.
Marcia Laviage, Ph.D.
Garland Lawlis, Ph.D.
Stephen Loughhead, Ph.D.
Katherine Loveland, Ph.D.
Alaire Lowry, Ph.D.
Ronald Massey, Ph.D.
Denise McCallon, Ph.D.
Stephen McCary, Ph.D., JD
Joseph McCoy, Ph.D.
Marsha McDonough, Ph.D.
Michael McFarland, Ph.D.
Richard McGraw, Ph.D.
Robert McLaughlin, Ph.D.
Jamie McNichol, Psy.D.
Robert McPherson, Ph.D.
Robert Meier, Ph.D.
Brad Michael, Ph.D.
Jo Mitchell, Ph.D.
Megan Mooney, Ph.D.
Marlin Moore, Ph.D.
Lee Morrison, Ph.D.
Anne Morton, Ph.D.
Orion Mosko, Ph.D.
Renata Nero, Ph.D.
Lane Ogden, Ph.D.
Nadine Palau, Psy.D.
Dean Paret, Ph.D.
Michael Pelfrey, Ph.D.
Walter Penk, Ph.D.
Stephanie Petersen Leachman, Ph.D.
Dorothy Pettigrew, Psy.D.
Angela Pfeiffer, Ph.D.
JoAnn Radeke, Ph.D.
Martha Ramos Duffer, Psy.D.
Patrick D. Randolph, Ph.D.
Michael J. Ratheal, Ed.D.
Elizabeth Richeson, Ph.D., M.S. PsyPharm
Diane Roche, Ph.D.
Jennifer Rockett, Ph.D.
Allison Sallee, Ph.D.
Gordon Sauer, Ph.D.
Roger Saunders, Ph.D.
Selia Servin-Eischen, Psy.D.
Robbie Sharp, Ph.D.
Edward Silverman, Ph.D.
Gregory Simonsen, Ph.D.
W. Truett Smith, Ph.D., Ph.D.
Brian Stagner, Ph.D.
Pete Stavinooha, Ph.D., ABPP
Alan Stephenson, Ph.D.
Glenn Sternes, Ph.D.
Larry Thomas, Ph.D.
Russel Thompson, Ph.D.
Adrienne Tinder, Ph.D.
Thomas Van Hoose, Ph.D.
Melba Vasquez, Ph.D.
David Wachtel, Ph.D.
Charles Walker, Ph.D.
Beverly Walsh, Ph.D.
Lisa Weaver, Ph.D.
Patricia Weger, Ph.D.
Mary Yancy, Ph.D.
Miguel Ybarra, Ph.D.
Does she need more than just medicine?

When she needs help getting medical equipment, refer her for case management services, a Medicaid benefit for children birth through age 20 and high-risk pregnant women. Case Managers help patients navigate the health system by providing access to medical, dental, behavioral health, educational, and social services related to their health conditions.

Anyone can make a referral. Call 1-877-THSTEPS or request a new Referral Pad by visiting https://secure.thstepsproducts.com.
2015 Annual Convention

The Future of Psychology Practice in the Era of Health Care Reform

See you in San Antonio!

November 12-14 | The Westin Riverwalk

www.texaspsyc.org