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To refer your patient, call Texas Health Steps 877-THSteps or visit dshs.texas.gov/caseman

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A NOTE FROM THE PRESIDENT

TPA’s Neural Network

ALICE ANN HOLLAND, PH.D., ABPP
Children’s Medical Center Dallas / UT Southwestern Medical Center, Dallas, TX

Well, we have hit the ground running this legislative session, but before looking forward, I want to look back and thank those who laid the groundwork for this important legislative year. While serving as President last year, Dr. Cheryl Hall also served as Chair of the Legislative Committee. In that role, Dr. Hall led TPA in setting our legislative agenda for the current year. You can read more about that agenda in this issue’s “From the Lobbyists” column.

I’d also like to thank the TPA Board of Trustees members whose terms concluded in 2018—Dr. Michael Flynn, Dr. Alfonso Mercado, and Dr. Charles Walker—for their service to TPA the past three years. All of them are continuing to support in TPA in other capacities, for which we are very grateful.

More generally, I want to thank all our past TPA leaders—you all have done amazing work to promote the profession of psychology and advocate for improved mental health policies in Texas. I’m honored to be following in your footsteps.

MEET YOUR PRESIDENT

For those of you who were not able to attend my Presidential Address at our 2018 Convention, I will briefly introduce myself. I am a native Texan who briefly ventured out to California to study psychology and neuroscience at Stanford as an undergraduate. I then returned home to Dallas to get my Ph.D. at the University of Texas Southwestern Medical Center. I completed a two-year postdoctoral fellowship in pediatric neuropsychology at Children’s Medical Center Dallas.

I am now a board-certified clinical neuropsychologist specializing in children, adolescents, and young adults. I have a faculty appointment at UT Southwestern and see clinical patients at Children’s Medical Center Dallas, where I specialize in oncology and rare brain diseases.

I also serve as the Research Director of the Neuropsychology Service at Children’s. My own research focuses on investigating genetic and intrapersonal factors influencing neurocognitive outcomes in medically complex children, adolescents, and young adults.

CONNECTIVITY

As I prepared for my 2019 Presidential year, I wrote out a list of names of people who have encouraged, mentored, and supported me in my academic and professional career. My goal in doing so was to force myself to reflect on how much I’ve learned from and been encouraged by each person on that list. Watching the list grow longer and longer really highlighted the fact that none of us get anywhere or accomplish anything without a lot of help. I’m sure you all could write similarly long lists.

We can think of these people in our lives—and ourselves—like neurons in the brain. To put it simply, on my own, I can do a few things. When connected with a bunch of other people, I can do a lot more. And when all our connections are in sync, we can accomplish amazing things.

As an undergrad, I did research in diffusion tensor imaging, or DTI. It was very new technology at the time, and it was an incredibly exciting time to be doing that research. Conducting research with DTI gave me an incredible appreciation for the way the brain orchestrates even the most basic behaviors through complex algorithms that precisely activate neurons with perfect timing and synchronization across the brain’s vast neural network.

Psychology is facing some enormous challenges in 2019 and beyond. We need to work together in that same way if we’re going to be successful. This coming year has to be about connectivity. I truly believe that if we work together, we will be successful in navigating what lies ahead.

STRATEGIC PLAN

On that note, I want to thank Drs. Rick McGraw and Brian Stagner and the members of their Strategic Planning Task Force for the incredible effort they put into developing a long-term strategic plan for TPA. They produced a 43-page report with many excellent recommendations for improving TPAs efficacy in serving our members and promoting mental health in Texas. I encourage you all to read that report, which is available on the TPA website. It is a five-year Strategic Plan, so certainly not all of the recommendations will be accomplished this year, but I will be working hard to lay the foundations for long-term success in all areas identified in that report.

Many of the primary recommendations of that report relate directly to my goal of improved connectivity for TPA. For example, I was distressed to see the Strategic Planning Task Force’s report that many TPA members feel distant or disengaged from TPA—that you are not aware how decisions are made or how you can become more involved. Distressing as that is to hear, I also very much understand it, because I
have been there myself, even at times as a Board member. So, I will be working hard to improve communications both within TPA leadership and between leadership and membership.

Along those lines, please don’t hesitate to contact me at any point during the year with feedback, suggestions, or questions: TPAPresident2019@gmail.com. Especially if you want to get more involved in TPA, please email me. TPA is your professional organization. Make it yours! It is easier to get involved in TPA than you might think, and I am going to be working hard to improve communication of those opportunities, starting right now. I would be happy to talk with you about what opportunities are available.

The Strategic Plan also identified a need for improved communications from TPA to the public, including media and legislators. I am pleased to announce that two members of the Strategic Planning Task Force have accepted key leadership roles in TPA focused on implementing that report’s recommendations on these issues. Dr. Alfonso Mercado is our new Chair of the Public Education Committee, and Dr. Darryl Johnson is serving as Chair of a newly created Marketing Task Force. The latter group is already at work addressing the strategic plan’s recommendations for hiring a dedicated media/marketing staffer and improving TPAs online presence, given that 93% of Americans seek information online (Stocking, 2018). In fact, even among Americans ages 65 and older, 67% used mobile devices to get news as of two years ago, and that percentage was on pace to increase dramatically (Lu, 2017). TPA’s website currently is not even mobile-friendly. TPA has to modernize and improve how we communicate information online in order to be effective in this increasingly digital world.

Finally, as we all know, neurons in the brain can’t communicate and work together effectively unless they are properly organized. Thus, based on both Strategic Plan recommendations as well as the recommendation of an attorney highly familiar with TPA’s current bylaws and policies and procedures, I have directed the Governance & Staff Committee to thoroughly examine the organizational structure and governing documents of TPA. With legal guidance from TPA attorney Kevin Stewart, that committee will be working to improve clarity in how these documents are written, with the ultimate goal of enhanced accountability, transparency, and continuity in advancing the Strategic Plan as a whole.

IN CLOSING

Thank you for being a TPA member. Every single membership helps, and the more members, the more we’re capable of. For example, last year, TPA hired two Government Relations consultants—Jerry Philips and Kevin Stewart—whose legislative expertise and nuanced understanding of Austin politics truly has been invaluable.

Jerry played a key role in stopping consolidation when we first faced Sunset in 2017, and both he and Kevin are deep in the trenches working for you again this session. In addition to fighting for TPA’s legislative agenda, Kevin also is doing an incredible job of identifying and monitoring other bills being filed that we need to be aware of—please read his column to learn more about some of those!

On my own, I can do a few things. When connected with a bunch of other people, I can do a lot more. And when all our connections are in synch, we can accomplish amazing things.

Your membership is essential to keeping our Government Relations positions funded. And that’s just one example. Just think what we could do if each of you would convince just one colleague to join TPA for the first time!

I am incredibly honored to have the opportunity to serve as your 2019 TPA President. Ultimately, however, I’m just a single neuron in the TPA neural network. Please join me however you can this year—whether that be simply renewing your membership, becoming a Platinum Advocate, responding to action alerts, or even getting involved in Committee or Division leadership. Like neurons in the brain, we’re capable of so much more when we’re connected and working together.

REFERENCES


Our annual convention’s theme was Resiliency. We were honored to hear from Rosie Phillips Davis, Ph.D., ABPP, the incoming APA President (far left), who inspired us to make a positive impact on deep poverty. Beth Rom-Rymer, Ph.D. (second from right) was also a keynote speaker who discussed the battles and triumphs in the prescription privilege movement in Illinois and across the country. Pictured here with them is Cheryl. L. Hall, Ph.D., MS PsyPharm, 2018 TPA President (second from left) and past TPA President Carol Grothues, Ph.D. (far right).
The Texas Psychological Foundation has continued to work diligently in service to its mission. As we reflect on the past year, we can focus on some highlights that exemplify the purpose and goals of TPF. First, let us focus on those who were recognized at the TPA 2018 Convention in Frisco for their contributions to the science of psychology.

**JENNIFER ANN CRECENTE MEMORIAL GRANT**

Alexis Humenik, M.A., a student in the Psy.D. Program in the Department of Psychology and Neuroscience at Baylor University, is the recipient of the Jennifer Ann Crecente Memorial Grant for 2018. Named for a young woman whose plans to enter the study of psychology ended when she became a victim of homicide at age 18, this grant supports research aimed at understanding potential causes and/or prevention of violence against women. Ms. Humenik’s proposed research, entitled *The Role of Executive Dysfunction and Substance Use in Intimate Partner Violent Offenders*, will examine the level of impaired executive cognitive function relative to substance use among offenders whose violent actions are directed toward intimate partners.

**FIRST PLACE AWARD FOR POSTER PRESENTATION OF RESEARCH**

Dalena Le, Laura Captari, M.A., Amanda Flachs, M.A., Ashley Geerts, M.S., and Lina Rodriguez from the Department of Psychology at the University of North Texas are the authors of the study achieving the First Place Award for Poster Presentation of Research. Their work, entitled *Resilience Following Traumatic Loss* examined the roles of social support, self-compassion, and sense of coherence in predicting resilience after traumatic loss.

**SECOND PLACE AWARD FOR POSTER PRESENTATION OF RESEARCH**

Emerging Adults’ Values: Does Parental Financial Involvement Hinder Development? received the Second Place Award. Its authors—Amy Page, Teresa Hulsey, M.S., Amy Murrell, Ph.D., also from the Department of Psychology at the University of North Texas—investigated the impact of the trait feeling in-between on values consistency in the developmental period of emerging adulthood and considered the role parental financial involvement as a potential moderator in that relationship.

**THIRD PLACE AWARD FOR POSTER PRESENTATION OF RESEARCH**

The Third Place Award was given to Narcissistic Personality Disorder and Emotion Regulation: An Inpatient Peer Comparison Study by Ryan Smith, M.A., Christopher Frazier, Katrina Rufino, Ph.D., Bella Schanzer, M.D., and Michelle Patriquin, Ph.D. at Baylor College of Medicine. Their work explored the impact of narcissistic personality disorder traits such as arrogance, lack of empathy, entitlement, and interpersonally exploitive behaviors on emotion regulation and experiential avoidance among psychiatric inpatients.

In addition to the focus on research, TPF was in the spotlight at other times as well. Participants in TPF’s fundraiser during the convention—Painting With a Purpose—enjoyed food and beverage while socializing with colleagues and creating memorable works of art to take home. The diligent effort of the “artists” in the room that evening was counterbalanced by a good deal of camaraderie and laughter. Arguably, an objective assessment of the paintings completed during that evening suggests that none of those persons who were present are likely to leave our field to pursue a career in the arts.

There were moments of recognition and good memories at the TPA Convention Awards Luncheon as we celebrated the contribution of two colleagues with whom there are distinct connections with TPF. Dr. Rick McGraw was honored with TPA’s Lifetime Achievement Award for his numerous accomplishments to psychology on both state and national levels. Among Dr. McGraw’s many contributions during his career is the key role he played in the founding of TPF. The person named TPA Psychologist of the Year for 2018 was Dr. Betty Richeson. Her history with TPF includes a term as its president in the past, as well as long time service on its Board of Trustees. As the generous benefactor of the

If you have interest in becoming involved with the Texas Psychological Foundation, please reach out to one of our board members who can be found on the Foundation page on the TPA website.
From the Editor’s Desk

JENNIFER ROCKETT, PH.D.
Private Practice, Bryan, TX

Colleagues,

Welcome to a new year! First, let me take a moment to thank Dr. Cheryl Hall for her leadership this past year. Many of you may not know how much time and energy Dr. Hall has spent in the last year working for us; her effort is greatly appreciated. As we head into 2019, Dr. Alice Ann Holland will be taking the lead, and I can assure you under her leadership, it will be another very productive year. TPA has plenty to look forward to in this coming year, and I look forward to serving as your Texas Psychologist (TP) Editor again. Thank you to those of you who have provided feedback on the content of the TP, I hope writers continue to provide you with good things to digest.

New to the TP this year is the Lobbyist column which will be written by Mr. Kevin Stewart. In each issue this year, Mr. Stewart will provide readers with a synopsis of legislative issues affecting psychologists. In this issue, Mr. Stewart gives us a glance at what is ahead in this 86th legislative session (January 8–May 3, 2019). Thank you, Mr. Stewart, for agreeing to write this column for us. In addition to Mr. Stewart’s column, we have articles addressing the evaluation of malingering in the Forensic column and a review of screening measures for practicing clinicians in the Practice column. I’ve also asked Dr. Brian Stagner to write an article that discusses our Strategic Plan. Please have a read and provide Dr. Holland and Dr. Stagner with your feedback.

Finally, thank you to those of you who have provided feedback on the content of the TP, Thank you to all the writers in 2018; your work has been greatly appreciated. Keep the articles coming, your colleagues want to read and hear the good things that psychologists are up to in Texas.

—Jennifer

Jennifer Ann Crecente Memorial Grant, which is named for her granddaughter, she joined me on the dais for the presentation of the grant.

With the closing of 2018, we bid a heartfelt farewell to Dr. Jo Vendl as she completes her term with the TPF Board of Trustees. We are most sincerely grateful for her faithful and dedicated commitment to TPF as a Board member, and especially for her time and service as its president for two years. We offer our best wishes as she moves forward into other endeavors.

If you have interest in becoming involved with the Texas Psychological Foundation, please reach out to one of our board members who can be found on the Foundation page on the TPA website. We invite not only your financial support, but also your patronage through volunteering and by sharing of ideas about the better fulfillment of our mission.

We express our thanks to all who helped to make 2018 a successful year for TPF. We look forward to having your support in 2019.

Call for submissions

The Texas Psychologist is seeking submissions for upcoming issues. We are seeking content in the following areas: Independent Practice; Ethics; Multicultural Diversity; Forensic Issues; and Student and Early Career. Collaborations with students are encouraged. 1000–2000 word count; APA Style.

Send to drjenniferrockett@gmail.com by 3/15 for the spring issue.
Things at the Texas Legislature are already heating up, so we wanted to provide our members with a quick update. In the House, Speaker Joe Straus has retired, so House members have been hard at work finding a new Speaker. While it won't be official until the members vote during session, Representative Dennis Bonnen (R-Angleton) has the endorsements needed to become the next Speaker. He was first elected to the House in 1996, and last session he served as the Chair of the House Ways & Means Committee.

At the time of this writing, the healthcare committees in each chamber are also in flux. In House Public Health, many expert Chair Four Price to move to a more coveted position. It is also likely, given the new Speaker, that the membership of that committee will be reshuffled. On the Senate side, the University of Texas concluded its investigation into the alleged sexting of a UT student by Charles Schwertner, Chair of the Health and Human Services Committee. It will now be up to the Lieutenant Governor to decide whether Schwertner will keep his chair, and we expect Dan Patrick to announce committee membership early on in the session.

TPA’S 2018 LEGISLATIVE AGENDA

As you know, the Texas State Board of Examiners of Psychologists (TSBEP) is going through the Sunset process again. Last session, the Sunset Commission recommended consolidating TSBEP with other mental health boards, including the Texas State Board of Social Worker Examiners, the Texas State Board of Examiners of Professional Counselors, and the Texas State Board of Examiners of Marriage and Family Therapists. TPA maintains its position that consolidation is both unnecessary and potentially harmful to the progress the state has made in mental health. We will continue our fight this session to keep TSBEP independent.

We are again working on a bill that would protect mental health providers from liability if they report a patient believed to be a risk to themselves or others. Rep. Senfronia Thompson filed our bill, HB 461, on December 4. Last session, this bill made it through the House with unanimous votes, but it died in its Senate Committee due to deadlines. We are going to get this bill moving as quickly as possible this session to ensure passage.

We are also working on a bill that would exempt psychiatrists and psychologists from the licensure laws of Licensed Sex Offender Treatment Providers (LSOTPs). Many psychologists are trained to treat this population, yet state laws have had the effect of prohibiting these qualified providers from treating them. We have been working hard to remedy this issue, and we expect a bill to be filed shortly.

In addition to our current legal action against TSBEP, challenging their rules that granted independent practice authority to Licensed Psychological Associates (LPAs), TPA will also be pursuing legislative action on this issue. TSBEP has stated repeatedly that they changed their rules out of fear of a lawsuit by LPAs. We feel that individual TSBEP board members’ fear of being sued should not overcome good public policy decisions. We hope that the legislature will pass a law to reinstate supervision and take such important decisions out of the hands of TSBEP.

Finally, TPA is again asking the legislature to allow psychologists with specialized training to prescribe mental health medications. The shortage of prescribing mental health providers is palpable, especially in rural and underserved areas.

OTHER RELEVANT LEGISLATION

In addition to TPA’s agenda items, there have been about 900 bills filed so far. We are still very early on, so we expect that number to increase dramatically as time goes by. TPA is currently tracking about ten percent of the bills currently filed—those relevant to mental health and/or the practice of psychology—and we expect that number to increase as well. The state legislature’s interest in mental health has never been higher, and TPA’s Government Relations consultants (myself and Jerry Philips) are ensuring that psychologists are well represented as stakeholder meetings commence. With that being said, there are a few bills that we would like to bring to your attention immediately.

Senator Jane Nelson, Chair of the powerful Senate Finance Committee, has filed SB 63. The bill would create what is called the Texas Mental Health Care Consortium. The Consortium would be charged with
Jennifer Rockett has asked me to write about TPA’s Strategic Plan; I want to paint a picture of how that plan might be implemented to position TPA to be stronger in the face of coming challenges.

First, some history (bear with me). The TPA Board of Trustees (BoT) met in November during our annual convention and agreed to receive the final report of the Strategic Planning Task Force (SPTF). The report (which can be found on the members page of the TPA website) describes the background for the SPTF, its composition, its process and the results of extensive data gathering conducted last summer and fall from members, nonmember psychologists, and community stakeholders. The report includes a summary of findings from this process, a list of specific recommendations, and a timeline for achieving numerous goals that are operationalized in the report. The BoT agreed to use these recommendations and timeline as guidelines for its actions in the coming year and to re-evaluate the strategic plan at its meeting next August. I encourage you to access the report and keep it in mind as we move through the coming legislative year and beyond. Read it and hold your association accountable for pursuing the goals it establishes.

I’m writing now to elaborate on some of the specific findings from the task force and to articulate some ideas that are implicit in the report and, in my opinion, foundational to where TPA needs to grow. I’ll conclude with a call for a particular policy position that may help unify the process.

Finally, suicide prevention has been a focus for many legislators, and some of the bills filed on the subject would impact psychologists. For example, HB 471, by Representative Shawn Thierry, would require suicide prevention training for all healthcare providers, including psychologists. Psychologists would need to complete six hours of suicide prevention training every six years.

The legislature is also looking into a statewide fix for the problem created by the Supreme Court’s North Carolina Board of Dental Examiners decision. In that case, the Supreme Court declared that state boards with a majority of active market participants are only immune from antitrust suits if their rules are reviewed by the state. HB 112, by Representative Valoree Swanson, would create a legislative review process for rules. Essentially, all rules would pass through the legislative committee that has jurisdiction over the proposing agency. The rule would need a unanimous vote from committee members; if the vote were not unanimous, the rule would go to the entire house for a vote.

There has also been a great deal of discussion about Extreme Risk Protective Orders (ERPOs). ERPOs allow courts, after providing due process, to temporarily prohibit a person from having a gun under certain circumstances. Representative Joe Moody, currently the Chair of the House Criminal Jurisprudence Committee, has filed HB 131. If it were to pass, mental health providers would not be one of the parties that could seek an ERPO, but courts could order a person to submit to an examination by a mental health provider to determine whether that person suffers from a serious mental illness.
TPA cannot thrive on its own. We have adversaries at all corners, from physician groups, allied mental health professionals, regulatory forces, and market pressures. We are a small organization. We must leverage our voice.

members, but we need to be much clearer about communicating with our members about these activities. For example, some member and nonmember psychologists are under the impression that TPA has put a lot of its resources into pursuing RxP, but this is inaccurate (money for this was raised independently). The take-home message is that we need much better engagement between governance and membership; I’ll return to this issue in a minute.

We likewise need to repair our relationships with erstwhile allies. TPA cannot thrive on its own. We have adversaries at all corners, from physician groups, allied mental health professionals, regulatory forces, and market pressures. We are a small organization. We must leverage our voice. We need to increase the public’s awareness of all the good psychologists do, and we have not done enough here. Media representatives would welcome more input when critical issues arise and yet they are not turning to TPA for expertise. Legislators have a generally favorable view of psychology, but again we need a stronger presence—not the presence that lobbies for our interests but the presence that lends expertise and highly skilled manpower to help the State of Texas provide for its citizens. Many state agencies have high praise for what we could do to help them but lament that it is difficult to locate experts when they are needed. In these areas, people feel good about psychology but we are too difficult to access and they don’t see TPA as the go-to resource for mental health science.

Our relations with allied health professions are in worse shape. Nationally some groups are attacking psychology directly—CACREP has made substantial inroads into accredit- ing all counseling training programs and has stated that they will be the go-to resource for mental health. In Texas we have the long-festering fight over the credentialing of master’s level providers. That story is a prolonged one that has preoccupied TPA a great deal but thus far we have struggled to make headway. This is not a local Lone Star fight—other jurisdictions are or will soon face some of the same battles. TSBEPS’s board chair has written about the backdrop to this fight in the National Psychologist (Branaman, 2018). Whether you agree with his analysis, it is clear that his arguments are neither frivolous nor easily dismissed.

As we have engaged these battles in the legislature (e.g., over Sunset, which is a whole ’nother long story) and the master’s issue, we have made enemies. Some groups that are our natural allies view us as self-interested and not reliable collaborators. Some legislators see us as having a limited interest – protecting private practice (The future of solo practice in the face of integrated care is an additional whole ’nother saga that we need to discuss another time).

Thus, our association has lots of work to do if we are to meet the challenges of the next decade. The strategic plan outlines a foundation for that work and details specific operations that will be needed from various committees and divisions in TPA. But the overarching goal is to increase TPAs credibility and visibility on all fronts: members, non-members, the public, and policymakers.

There are two areas that seemed very important to psychologists who were surveyed. The first was a clear wish for TPA to be an advocate for the science in psychology. That’s how we differentiate ourselves from other groups—WE produce the science. It is not too fanciful to imagine that every statement coming out of TPA or in our newsletter or at our convention should begin with a discussion of the psychological science that is settled and a reasoned discussion of the quality of evidence when it is not settled. By advocating for our science, we increase our credibility and become the go-to source for future policy and public understanding.

The second area that was very important to our respondents was social justice. This is an unqualified social good around which opportunity, to safety. And equality of access. The severely mentally ill. Virtually all social justice issues that I can imagine will have access. And equality of access. The socially justice concern and then blow that trumpet anywhere. We need to ensure access to the best psychological services everywhere. Kids in detention tents in El Paso. Prisoners in solitary. The poor cancer patients. Kids with LD/ED issues. The poor. Cancer patients. Kids with LD/ED issues. The severely mentally ill. Virtually all social justice issues that I can imagine will have an aspect of access to care, to services, to opportunity, to safety. And equality of access is an unqualified social good around which members should easily rally.

What issue would have appeal to the majority of psychologists and would avoid the politicization of our efforts? ACCESS.

TPA should define ACCESS as its core social justice concern and then blow that trumpet whenever and wherever possible. We need to ensure access to the best psychological services everywhere. Kids in detention tents in El Paso. Prisoners in solitary. The poor. Cancer patients. Kids with LD/ED issues. The severely mentally ill. Virtually all social justice issues that I can imagine will have an aspect of access to care, to services, to opportunity, to safety. And equality of access is an unqualified social good around which members should easily rally.

And how do we make this case? With SCIENCE. We have the tools to define the problems, to outline the need and to suggest solutions that will and will not be worth spending money on. We wouldn’t have to ask for anything for psychologists only.
though some of us would probably benefit. What allied group would reject an offer to collaborate on “increased access to services for XXX population”? What agency manager, legislator, or media influencer could resist listening when we back up our initiatives with “Psychological Science for the Good of the People.”

Ok, I think this is a great idea. I’ll be pressing for it in the coming months. But maybe it’s flawed. If you have a different vision, we need you! The plan (on the member page at texaspsyc.org) has lots of tasks and roles. We need troops to get involved, so go read the plan and then contact Sherry Reisman to be put in touch with the appropriate committee or division or workgroup that gets your interest up.

TPA is all of us!

REFERENCES

Bonny Gardner, Ph.D., M.P.H.
Named APA Citizen Psychologist in 2018

TPA member Margaret Ann (Bonny) Gardner Ph.D. of Austin, Texas, has been recognized with an American Psychological Association Citizen Psychologist Presidential Citation for her leadership and sustained commitment to social justice through the dissemination of knowledge, advocacy, and leadership in the Austin, Texas, community. Dr. Gardner currently chairs the TPA Business of Practice Committee and has served on the TPA Board of Trustees in previous years.

“Dr. Gardner exemplifies the definition of a Citizen Psychologist by using psychology to make her community a better place,” said APA President Jessica Henderson Daniel, Ph.D. “Helping to improve lives in one community at a time is how we can change the world.” Launched by Dr. Henderson Daniel, the Citizen Psychologist Initiative recognizes APA members who engage their communities through public service, volunteerism, and board membership. Representing every branch of psychology, Citizen Psychologists serve as long-term volunteers for service organizations, participate in church ministries, and volunteer as expert speakers for non-profit organizations, among other roles.

From 2006 to 2013, Dr. Gardner served on the Austin Mayor’s Mental Health Task Force and Mayor’s Mental Health Task Force Monitoring Committee. The mission of these groups was to identify problems and needs within the mental health service delivery system and then to make recommendations for improving access and resources within the system. One of Dr. Gardner’s major concerns was ensuring effective public access to psychological and emergency psychiatric services in the community. Another objective was developing better coordination within existing networks of care to create a safety network and continuum of care.

Dr. Gardner also served on the Executive Committee of the Texas Suicide Prevention Coalition.

Since her formal service on these committees, Dr. Gardner has continued to be involved in promoting increased access to and improved resources for public mental health. For example, in addition to other local officials, Dr. Gardner has consulted with the Sheriff of Austin on issues relating to the intersection of criminal justice and the mental health system, including diversion of people suffering from substance use disorders and people with non-violent offenses and mental health problems to rehabilitation programs rather than jail or prison. This has presented a unique opportunity for psychology to cross traditional disciplinary lines and encourage greater interagency cooperation for the solution of common problems, according to the APA citation.

For over 25 years Dr. Gardner has also been an active member of the Public Affairs Forum of the First Unitarian Universalist Church of Austin. The Public Affairs Forum has featured expert speakers on social, economic, and political issues, as well as presentations on matters of health policy, human rights, and social justice. Dr. Gardner chaired the Forum from 2009 to 2016. The weekly programs were featured on Austin Public Access TV and also on...
an Austin public radio thereby creating a larger platform through media to reach a wider audience. The programs, which were free and open to the public, gave an opportunity to ordinary citizens to interact directly with experts and public officials. As a psychologist, Dr. Gardner provided insight and leadership within the team framework of the committee and demonstrated the importance of psychology in framing public policy.

Dr. Gardner’s work as a citizen psychologist specifically on behalf of older adults has also been exemplary. For nearly 23 years she served on the Steering Committee of the Austin Gray Panthers, an affiliate of the national network. Her role within that committee included promotion of improved health care policy at the national and local level and advocacy on other social justice issues, including preserving the Social Security system and increasing community and police awareness of the need for improved services for persons with mental illness.

Dr. Gardner said she became interested in social justice issues as a child. Her father was a federal executive with the Department of Health, Education, and Welfare (HEW). One of his jobs was to implement Brown v. Board of Education in five Mid-Atlantic states, the Virgin Islands, and Puerto Rico. In effect, he oversaw the desegregation of public schools, health facilities, and transportation systems when this was a groundbreaking development. There was some resistance, including shutdowns of some public schools in Virginia and Maryland for a while and Dr. Gardner remembers going to school in a makeshift classroom in a neighbor’s basement. She said, “These were turbulent times, but most schools desegregated gradually without incident. I grew up watching TV coverage of the local resistance and protests to desegregation, with some of the incidents not too far removed from what went on in Arkansas and Alabama later. My father also oversaw the emergence of the federal Medicare and Medicaid programs as well as other federal programs designed to improve public health and reduce social and economic inequality.

“All of this made a deep impression on me, and I saw it as important work,” she continued. “My high school, the National Cathedral School for Girls, was affiliated with the Episcopal Church and promoted social justice concerns within a larger religious context. Right after graduating from University of Texas undergraduate school, I had an opportunity to go to the Lower Rio Grande Valley of Texas to observe and be involved in the work of the United Farm Workers as they began establishing legal and social services, health clinics, and community centers for the farmworker population. Despite providing food for our nation, arguably the most important job of all, the farmworkers were socially and economically marginalized, denied basic rights, and struggled to maintain a basic standard of living. These experiences led to a long-term interest in social change and community service which has made my life much richer and more exciting. I encourage other psychologists to get involved in community work. On days when I’m struggling with the more mundane aspects of the practice of psychology, I can still remember why I went into this field and the potential good that psychologists can do.”

Dr. Gardner expresses deep appreciation to Dr. Cynthia de la Fuentes for nominating her for this award and to Andrew Griffin, Ph.D., for his work on the application process.

On January 18, 2019, Drs. Alfonso Mercado, Amanda Venta, Jeff Temple, Megan Mooney, and Shannon-Guillot-Wright participated in a Symposium at the University of Texas Rio Grande Valley in Edinburg, Texas, on Migration and Mental Health: Trauma, Health, and Evidence from the Texas/Mexico Border. They also visited a border wall and the Texas Humanitarian Respite Center in McAllen, Texas, run by Sister Norma Pimental.
Through civil litigation, individuals can claim monetary damages on the basis of a civil wrong, or tort. For example, tort law allows for financial recovery following a motor vehicle accident, in which a defendant’s negligent or reckless driving had an adverse psychological impact on the other driver. Damages in such cases can cover pain and suffering, mental anguish, and associated healthcare expenses, including psychological services deemed necessary to remediate symptoms of psychological injury. Psychological injuries sustained as the result of a tort can range from mild, transient experiences, such as embarrassment, to severe, chronic conditions such as depression and psychological trauma (Vallano, 2013).

A majority of U.S. jurisdictions permit damages for emotional distress or mental injury, whether or not physical injuries were sustained, and it is estimated that 50% of civil injury awards involve the experience of psychological pain and suffering. However, claims of psychological injury or emotional harm are often disputed. As such, the law requires “objective indicia of mental injury,” typically in the form of an official diagnosis or professional opinion (Melton, Petrila, Poythress, & Sloboedin, 2007). This necessity places mental health practitioners at the forefront of many psychological injury cases, as they are tasked with evaluating the presence and degree of impact of those injuries.

The opportunity for financial gain provides substantial incentive for individuals to exaggerate or falsify psychological symptoms or conditions (Peace & Masliuk, 2011). As such, when conducting evaluations in cases involving alleged emotional injuries, mental health practitioners must be attuned to forms of negative response bias in which symptom reports are exaggerated or completely fabricated. Feigning describes the fabrication or exaggeration of psychological or physical symptoms where the specific reasons for the exaggeration are unknown or unintentional. Conversely, malingering is the deliberate fabrication or exaggeration of symptoms in order to achieve an external goal, such as financial compensation. Critically, it must be noted that malingering is not a diagnosis (American Psychiatric Association, 2013; Rogers & Bender, 2013). Rather, it is a condition of interest (V65.2), which should be considered when evaluating alleged psychological injuries.

In practice, a revelation of a specific motive or intent rarely occurs and there is no direct test of either. Thus, mental health professionals can rarely definitively conclude an individual is malingering and should exercise caution in using this term. Instead, practitioners may speak to the relative likelihood or probability that an individual is exaggerating or faking symptoms, noting the degree to which evidence is consistent with some form of negative response bias. Thus, it is important for clinicians working in this field to understand malingering on a conceptual level. The legal, financial, and psycho-social consequences inherent in a litigation context necessitate the need for a clear understanding of the underlying construct of malingering and how best to approach testing when dishonest responding is suspected.

Identifying exaggerated claims of psychological injuries is one of the most challenging tasks for clinicians, independent of legal context. Psychological disorders, by nature, are heterogeneous, comorbid, and largely diagnosed based on subjective report, due to an absence of biological markers of mental disorder. Each of these features contributes to the challenge associated with parsing genuine illness or injury from a falsified or exaggerated presentation. As such, estimating the prevalence of malingering in clinical and forensic populations is difficult. Some estimates suggest that malingering occurs in up to 40% of civil litigation cases involving neuropsychological assessment (Larrabee, 2003), while other studies have found that 20-30% of results from psychological testing on personal injury plaintiffs suggest that malingering had taken place (Taylor, Frueh, & Asmundson, 2007).

In general, there are two main types of malingering measures, symptom validity tests (SVTs) and performance validity tests (PVTs). Symptom validity tests (SVTs) are used to detect the exaggeration or fabrication of psychiatric symptoms based on self-report, by utilizing detection methods that capitalize on the relative infrequency, odd combination, or unusual severity of psychological symptoms. SVTs exist in two
Mental health professionals can rarely definitively conclude an individual is malingering and should exercise caution in using this term.

Performance validity tests (PVTs) are designed to corroborate symptoms by looking at an individual’s performance, typically on neurocognitive tasks. Similar to SVTs, PVTs utilize a variety of detection methods, including identifying uncommon or unlikely performance presentations, when compared to a genuinely impaired normative sample. Other methods make use of the floor effect, operating under the principle that malingerers will exaggerate substantial impairment on tasks which even genuine patients are able to pass. PVTs may also be used to gauge effort, capturing whether an examinee was sufficiently engaged or putting in sub-optimal effort in the task. Examples of PVTs include the Test of Memory Malingering (TOMM; Tombaugh, 1996) and the Morel Emotional Numbing Test (MENT; Morel, 1998). The TOMM was the most frequently used measure to detect poor effort or malingering among a sample of 188 neuropsychologists (Sharland & Gfeller, 2007).

Despite extensive research, no standardized protocol for detecting malingering has been developed, and there is substantial variability in the ways that mental health practitioners approach this problem. In a survey of 80 emotional injury evaluators, who had conducted a career sum of 10,500 evaluations, no two evaluators used the exact same set of psychological tests (Boccaccini & Brodsky, 1999). A more recent survey of test usage found that in an international sample of 868 assessment cases conducted by 434 clinicians, the top ten most used measures in civil tort cases focused on the domains of trauma, intelligence (e.g., WAIS), and general psychopathology (e.g. MMPI–2, PAI, and symptom inventories), with no specific measures of malingering represented (Neal & Grissos, 2014). Rather, measures of malingering were only represented in insanity and competency to stand trial cases. The psychologists who conducted these evaluations reported using, on average, 4.6 measures, with some cases requiring up to eighteen different measures.

There are several reasons for this variability. First, all psychological measures, including tests that target malingering, have individual strengths and weaknesses. Mental health professionals must weigh these test qualities when selecting and combining tests to use. For example, one must consider minimum reading level, difficulty and length of administration, cost, and comprehensiveness. Secondly, mental health professionals are able to assess response bias by evaluating inconsistencies and inaccuracies across subjective reports, testing data, medical records and other case documents. Thirdly, as noted by Boone (2011), it is not atypical for honestly-responding individuals to fail a single malingering measure. It is, however, unusual for individuals to fail more than one measure, and rarer for someone to fail more than two. Thus, administering more than one measure of response bias reduces the likelihood of a false positive error.

Difficulty in detecting malingering is impacted by the shifting nature, or instability, of malingering behavior itself. Often erroneously deemed a “monolithic,” or stable and enduring, construct, individuals who malinger may be inconsistent in their false responding across tests, time, or symptomology, be that psychiatric, physical/somatic, or cognitive/neuropsychological (Berry & Nelson, 2010). It cannot be assumed that known feigners will always falsify responses in assessment, or that individuals who feign one type of symptom will also feign others. Similarly, responding is influenced by factors such as fatigue, cognitive capabilities, and distractions, which may result in suboptimal or invalidated performances that are not necessarily reflective of a willful fabrication of symptoms. Lastly, it is valuable to note that these estimates of presumed malinger- ing may not take into account that faking or exaggerating symptoms does not rule out the possibility that the individual is experiencing some form of genuine psychopathology.

Research in the field of malingering detection has focused on developing a greater understanding of the degree to which various measures of malingering and peripheral factors (e.g., cognitive functioning, memory, genuine psychiatric symptoms) operate interdependently. One method of examining this interdependence is via correlational studies. Much of the extant literature focuses on collecting validity evidence across SVT measures, such as examining convergence between an abbreviated version of the SIRS with MMPI validity scales (Story, 2000). Alternatively, another body of literature has highlighted the importance of using both PVTs and SVTs in the evaluation of malingered neurocognitive impairment, specifically traumatic brain injury (TBI; Larrabee, 2012).

Some authors have extended this recommendation to include feigned posttraumatic stress disorder, which can co-occur with TBI. Two studies have examined the relationship between PVT and SVT malingering indices across affective and neurocognitive domains.
Demakis, Gervais, and Rohling (2008) found that elevated psychological symptoms were not associated with PVT failure, nor were poorer performances on measures of neuropsychological functioning associated with SVT failure. Similarly, Grieffenstein, Gola, and Baker (1995) found that, in a sample of TBI patients involved in personal injury cases, scores on PVTs and SVTs were not significantly related. Factor analyses did not support a unitary construct of malingering, leading to the conclusion that malingering should be approached as a multifaceted construct consisting of both performance and symptom-endorsement factors, and that each contributed unique information. These findings support recommendations to use a variety of measures, which tap different constructs via different methods, when conducting a comprehensive evaluation of psychological injury.

Using a between-subjects design, Fox and Vincent (in preparation) evaluated bivariate correlations amongst the TOMM, TSI-2, Atypical Responding Scale, SIMS, and M-FAST, in a simulated personal injury paradigm, in which psychological, but not neurocognitive or physical symptoms were alleged. Consistent with assumptions of a multi-trait, multi-method (MTMM) approach, participant scores were expected to correlate according to measurement of underlying traits and methods. Convergent validity between symptom validity measures was demonstrated through moderate, statistically significant correlations across measures related to psychological symptom endorsement (SVTs; i.e., TSI-2 ATR, SIMS, M-FAST). Divergent validity was demonstrated through weaker correlations between scores on the SVTs and scores on a PVT measure of performance or effort (i.e., TOMM). In this study, we found evidence consistent with the conceptualization of malingering as a non-unitary construct comprised of both performance and symptom-endorsement factors. Likewise, these findings support clinical recommendations to administer a variety of malingering measures when conducting evaluations of psychological injury in civil tort cases.

In summary, current research supports the conceptualization of malingering as a non-unitary or multifaceted construct. Detecting falsified or exaggerated symptom presentations is a difficult task, which is made more challenging by the natural variability inherent in psychological conditions. As there are substantial consequences associated with the misidentification of malingered symptoms, it is recommended to utilize more than one measure of malingering in order to improve assessment validity. Based on extant research, variation in sub-construct, method, and approach will allow for a more comprehensive assessment of malingering, and thus yield more valid and reliable results.

REFERENCES


Moving Beyond the PHQ-9: Free Screening Tools for Integrated Care


**MOOD**

In primary care settings, it has been found that 30% of patients have mood disturbance, such as anxiety, dysthymia, and bipolar disorder (DHHS, 2006). Given these statistics, quickly measuring mood symptoms in primary care settings can prove effective. The Mood Disorder Questionnaire (MDQ) is a 15-item, self-report screening instrument used to assess adult patients for possible bipolar disorder. The MDQ includes questions assessing specific behaviors related to bipolar disorder, as well as symptom co-occurrence and functional impairment. The MDQ has been developed only as a screener for bipolar I disorder, and not a diagnostic instrument; it takes approximately 5 minutes to complete. A clinical evaluation by a trained professional should follow a positive screen (Hirschfeld, 2002; Williams, 2017). It has also been found reliable and valid (Hirschfeld et al, 2000).

The Depression Anxiety Stress Scales (DASS) is a 42-item, self-report measure used to identify experiences of depression (i.e., dysphoria, hopelessness, anhedonia), anxiety, (i.e., arousal, anxious affect, skeletal muscle effects) and stress (i.e., difficulty relaxing, nervous arousal, irritability). The questions on the DASS are answered on a 4-point severity scale, identifying the severity or frequency patients have experienced each emotional state over the past week. There is also a shorter version of the DASS, containing 21 items. The use of the DASS has been widely researched and has been found to be reliable and valid for use among many settings.

**SUICIDE**

Death by suicide is the 10th leading cause of death. Within the healthcare system, there is a need to provide effective suicide assessment tools. Given the imminent risk to individuals who experience suicidal ideation, accessing measures to properly assess and target suicidal risk is paramount. The Columbia Suicide Severity Rating Scale (C-SSRS) can be completed in an interview format or as a self-report measure. The C-SSRS has 10 categories, which include yes/no responses that indicate either the presence or absence of the behavior. The categories include a comprehensive assessment of the domains of suicidal ideation and suicidal behavior. The C-SSRS demonstrates moderate to strong internal consistency and reliability. There are versions of the C-SSRS available for children, adolescents, and adults (Posner, Brown, Stanley, Brent, et. al., 2011).

The Reasons for Living Scale (RFLS) is a commonly used tool that is a 52-item, self-report questionnaire, which evaluates motives for individuals to continue their lives. The purpose of the RFLS is to assess suicidal risk as it relates to the range and strength of reasons for living. Protective factors became a focus when developing the RFLS. There is a short form of the RFLS that...
consists of 48 items, in addition to a military (RFL-M) and adolescent version (BRFL-A; Deutsch & Lande, 2017; Linehan, Goodstein, Nielsen, & Chiles, 1985).

The Suicide Behaviors Questionnaire-Revised (SBQ-R) is a brief, 4-item questionnaire that assesses previous suicidal ideation and suicidal behaviors. Specifically, the SBQ-R examines patterns of previous ideation and attempts, recent occurrence of ideation, suicide risk, and self-reported endorsement of future suicidal behaviors. The SBQ-R is commonly used in clinical and nonclinical populations (Osman, Bagge, Gutierrez, Konick, Kopper, & Barrios, 2001).

ANXIETY AND PHYSIOLOGICAL AROUSAL

Using brief and validated screening tools can be an effective way to identify anxiety and other related disorders in primary care settings and facilitate a referral for further assessment and treatment. The Generalized Anxiety Disorder Scale (GAD-7) is a commonly used measure that screens for symptoms associated with generalized anxiety disorder, one of the most common presenting anxiety disorders in the primary care setting, with an estimated prevalence of 2.8–8.5% (Spitzer, et al., 2006). The GAD-7 is a brief self-report measure comprised of 7 items inquiring about symptoms experienced within the past two weeks. Scores range from 0–21, with cutoffs of 5, 10, and 15 indicating mild, moderate, and severe anxiety. This screener is appropriate for use with adults and has a strong specificity, internal consistency, and test-retest reliability (Spitzer et al., 2006).

The Nijmegen Questionnaire is a self-report measure that has been used to screen for hyperventilation syndrome as well as symptoms of dysfunctional breathing associated with various medical and anxiety-based disorders (van Dixhoorn & Folgering, 2015). It is comprised of 16 symptoms rated on a five-point scale. A total score of 23 or higher suggests the presence of hyperventilation disorder or dysfunctional breathing (Thomas et al., 2001).

The Hospital Anxiety and Depression Scale (HADS) has been widely used for over 30 years to identify anxiety and depression among patients presenting to non-psychiatric medical and hospital clinics. The screener yields two subscales, the HADS-A anxiety subscale and HADS-D depression subscale, which both contain 7 items. The HADS is used with adult patients and has strong psychometric properties; it is considered a valid tool to identify symptoms of anxiety and depression in medical populations (Bjelland et al., 2002).

SLEEP

Sleep concerns among patients are common, with the prevalence of sleep disorders estimated to be approximately 40% (Colten & Altevogt, 2006). The gold standard of assessment of sleep disorders is expensive, time-intensive, and in integrated care settings often impractical, thus creating the need for brief, self-report screening tools to guide further assessment and intervention.

The Insomnia Severity Index (ISI) is a brief self-report measure that assesses the patient’s perception of their insomnia, and can also measure treatment outcomes. The ISI measures the severity of sleep-onset difficulties and sleep maintenance difficulties, satisfaction with current sleep, impact on daily functioning, impairment observable to others, and degree of distress caused by the sleep problems. Higher scores suggest more severe insomnia and established cutoff scores are provided to identify different degrees of insomnia. The ISI appears to be a reliable measure of perceived insomnia severity and is sensitive to changes in patient’s perceptions of treatment outcomes (Bastien, Vallières, Morin, 2001; Wong et al., 2017).

The STOP-BANG Questionnaire was designed to be a concise, reliable, easy-to-administer screening tool for obstructive sleep apnea (OSA). The STOP-BANG screening tool consists of 8 yes/no questions related to the clinical features of sleep apnea: snoring, tiredness, observed apnea, high BP, BMI, age, neck circumference, and male gender (Chung, Abdullah, & Liao, 2016). The total score ranges from 0 to 8, and is used to determine the patient’s OSA risk classification. The STOP-BANG Questionnaire can be administered and scored quickly, and the cutoff score of 3 has demonstrated high sensitivity in detecting sleep apnea (Chung et al., 2008).

The Epworth Sleepiness Scale (ESS) is an 8-item, self-report questionnaire that assesses the patient’s general level of daytime sleepiness, as daytime sleepiness is a key diagnostic feature of several sleep disorders (Johns, 1991). The ESS asks patients to rate their usual chances of dozing off or falling asleep while engaged in 8 different activities (e.g., sitting and reading, watching TV). The item scores are summed for a total ESS score, which gives an estimate of the patient’s “average sleep propensity” (Johns, 2002), with ESS scores of 11–14 indicate increasing levels of excessive daytime sleepiness.

SUBSTANCE USE AND PAIN

The evaluation of alcohol and drug use is an integral part of assessing risky health behaviors in integrated care settings. The 10-item Alcohol Use Disorder Identification Test (AUDIT) is a self-report measure developed by the World Health Organization to assess alcohol use (Saunders, Aasland, Babor, de la Fuente, & Grant, 1995; Selin, 2003). Validated within medical settings, total scores of eight or higher suggest problematic drinking (Bohn, Babor, & Kranzler, 1995; Conigrave, Hall, & Saunders, 1995). For concerns about other substances, the Drug Abuse Screening Test (DAST-10) is a brief, 10-item measure, with each question answered with a yes or no response (Skinner, 1982); a score greater than 2 is suggestive of drug abuse (Maisto et al., 2000).

Although a frequently utilized treatment for chronic pain, prescribed opioid medications present serious risks for many patients. The Screener and Opioid Assessment for Patients with Pain – Revised (SOAPP-R) is a 24-item scale that can be completed in approximately ten minutes (Butler et al., 2008). A score greater than 18 is considered at risk for opioid misuse. Although other factors should also be considered when assessing risk of opioid misuse, the SOAPP-R is a helpful and quick addition to an opioid risk assessment.

TRAUMA AND PTSD

Approximately 7.7 million individuals in any given year will experience posttraumatic stress (PTS) symptoms, which impact individuals of all ages across the lifespan and individuals of all backgrounds and nation-
While the PHQ-9 is a useful measure, there are many other screening tools available in the public domain to assess a variety of symptomatologies, including mood, suicide ideation and behavior, sleep, substance use, and memory and cognition.

ties (Department of Health and Human Services, 2018). Given the impact that trauma can have, assessment of PTS symptoms in integrated care settings is imperative. The Posttraumatic Stress Disorder Checklist (PCL-5) is a 20-item, self-report measure that assesses 20 symptoms corresponding with criteria of PTSD symptoms in the DSM-5 among adults aged 18 years and older. The purpose of the PCL-5 is to screen for PTSD symptoms, support a provisional diagnosis of PTSD, and monitor PTSD symptom changes during and after treatment. Completion of the PCL-5 takes approximately 5 to 10 minutes. The PCL-5 has strong internal consistency reliability (.94) and test-retest reliability (.82) (Blevins et al., 2015).

**MEMORY AND COGNITION**

Cognitive screening is a first step in evaluating dementia and other neuropsychological disorders. The importance of brief cognitive screening in integrated care cannot be understated, especially among an aging patient population. The Mini Mental Status Exam (MMSE) has been widely used among health care providers and researchers. The MMSE has both validity and reliability for the diagnosis and longitudinal assessment of Alzheimer’s Dementia (AD), with scores greater than or equal to 24 points (out of 30) suggesting normal cognition. Scores below 24 suggest severe (≤9 points), moderate (10–18 points) or mild (19–23 points) cognitive impairment.

The St. Louis University Mental Status (SLUMS) exam was developed as a screening tool for detecting mild cognitive impairment in a veteran population. It has since been extended to other populations and can be useful in the detection of early dementia. The SLUMS has 11 items and takes approximately seven minutes to administer, with scores ranging from 0 to 30. Scores of 27 to 30 are considered normal, and scores of 26 or below are suggestive of possible cognitive impairment or dementia. Compared to the MMSE, the SLUMS is superior in identifying people with milder cognitive problems (Stewart et al., 2012).

**PEDIATRICS**

Specially designed measures for children and adolescents are invaluable to proper screening for issues relevant to a pediatric population and help bridge the gap between what caregivers report and what kids experience. The Child and Adolescent Trauma Screen (CATS) is used to screen for potentially traumatic events (PTEs) and PTSD symptoms in children and adolescents. These symptoms are based on the DSM-5, therefore the CATS can act as a useful diagnostic aid. The CATS is also available in Spanish, with both caregiver (ages 3–6 or 7–17) and self-report (ages 7–17) versions (Sachser et al., 2017).

The Screen for Child Anxiety Related Emotional Disorder (SCARED) is a 41-item self-report measure of symptoms of anxiety for children aged 8–18, which yields an overall anxiety score, as well as subscales for panic disorder or significant somatic symptoms, generalized anxiety disorder, separation anxiety, social anxiety disorder, and significant school avoidance. A 5-item version of the SCARED also exists, which can be useful as a brief screener in fast-paced settings, when no anxiety disorder is suspected, or for children with less verbal capacity (Birmaher et al., 1999; Birmaher et al., 1997).

The Revised Child Anxiety and Depression Scale (RCADS) is a 47-item self report or caregiver report (RCADS-P) of potential anxiety and affective symptoms for children ages 8–18. The RCADS yields total anxiety scores and subscale scores for separation anxiety disorder, social phobia, generalized anxiety disorder, panic disorder, obsessive-compulsive disorder, and major depressive disorder. It has been translated into many languages, including Spanish and Chinese (Chorpita et al., 2000).

The CRAFFT Screening Tool for Adolescent Substance Use (CRAFFT) is administered by the clinician for youth ages 14–21. The first three questions ask about alcohol, marijuana, or other substance use during the past 12 months. What follows are questions related to the youth’s specific experiences with substances in relation to Cars, Relaxation, being Alone, Forgetting, Family/Friends, and Trouble (CRAFFT).

**REFERENCES**


CRAFFT Screening Tool for Adolescent Substance Use (CRAFFT)
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