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In this my inaugural issue of *The Texas Psychologist*, I hope to fill the (huge) shoes left behind by Dr. Brian Stagner, and promise to do my best to uphold the guiding principles he set out in his farewell column. I know this first issue of mine was made easier because of his tenure – he has trained us all so well. I was prepared to beg for submissions, but didn’t have to. Writing this column is the most “editing” I have had to do, as the authors are experts in their content areas, good writers, and they turned in their contributions on time.

Dr. Stagner was right; I am enthusiastic about psychology and the many ways that psychologists can improve lives and the communities in which we live. My goal is that the *TP* will continue to reflect the whole of Texas psychology, and I welcome the input and involvement of individuals from all areas of the field. I want to highlight the good work that you do! President Greg Simonsen and I must have been drinking from the same fountain, because no sooner than I accepted this position, he challenged me to solicit contributions in keeping with his presidential themes of Advocacy and Promoting Human Welfare.

As I looked over the articles in this issue, I had an opportunity to reflect upon the themes. It occurred to me (again) that when compared to the general population, psychologists are an over-educated, highly skilled and competent group of professionals. Some of us practice in underserved areas, while others occupy C-suite offices in various businesses and industries, and still others are in independent practice, or are agency employees, educators, practitioners, and researchers. We use our professional skills in profound ways that positively impact our clients, trainees, and communities, all the while successfully juggling competing demands of work and family on a daily basis.

Notwithstanding the reality of psychologists as competent people and professionals, why then are we as a whole generally avoidant when it comes to advocacy? It would be easy to correlate our reticence with the train-wreck of the current political election season (who wants to sully their hands with the likes of some of those clowns?), but as Drs. Holland and Stavinoha remind us in their article on concussion science, correlation is not causation; so as much as I would like to, I won’t go there. Drs. Hall and Simonsen explain that advocacy activities impact a wide range of issues, such as scope of practice, licensure laws (Sunset, anyone?), full parity for mental health treatment, inclusion of psychologists as “physicians” under Medicare, prescriptive authority, the funding of post-graduate training, government funding of research, among many other concerns of import to us (for more information, see the APA Federal Action Network, n.d.). Trust me, when we don’t act, other professionals and lawmakers do, and we unwittingly leave the future of our profession in the hands of non-psychologists who have their own agenda – often accompanied with a threat to our scope of practice and our livelihoods. So why aren’t we, as psychologists, more active in our advocacy work as members of other professions?

Let me share my hypothesis and then suggest a challenge. I don’t think we are lazy or scared (as some have suggested) – we finished graduate school, dissertations, internships and post-docs. Some of us have children and mortgages, for goodness sakes! Not lazy nor scared; but, did you know that...
many medical schools have courses, and yes, entire tracts (i.e., multiple courses and practical experiences over several years) on advocacy and activism in their curricula for their medical students (see for example, Brown University Medical School, n.d.)? Yes. They. Do. How many of us have had a class, let alone an entire course or a whole tract, in advocacy and activism during graduate school, internship, or post-doc? Me neither. It isn't surprising to me at all that we are not more engaged in advocacy and activism, since we don't get mentored in the process during our professional development imprinting stage. We became psychologists with the spirit of addressing problems of human welfare and social justice, and we painstakingly sacrificed our lives for years to earn degrees and licensure toward this endeavor. It makes no sense to leave our future in the hands of others. We must ensure the viability of the profession we worked so hard to join by adding advocacy and activism to our education and training. I further challenge those of us not directly involved in education and training to do good and offer our advocacy and activism skills to graduate, internship, and post-doc programs so we can train the next generation of professionals to protect their careers and their communities.

Speaking about the good that we do, you will be impressed with our colleagues who promote human welfare in their practices and communities. Dr. Arnemann provides us with a truly helpful guide for working with Veterans as the transition from combat to home can be difficult, and many soldiers encounter readjustment problems. Drs. McCoy and Mercado share with us their indefatigable hope for border psychology. Although the Valley is short 110 psychologists for the population it serves, the 30 who practice there are doing wonderful work, and the new medical school and the promise of a new clinical psychology program offer opportunities to welcome a new generation of early career psychologists who are trained to deliver psychological services to the Latino population in the Border Region. Let's make sure they are also trained in advocacy and activism. Órale!

Y'all are gonna love this issue!

References


Submit an article

The Texas Psychologist is soliciting submissions for it’s upcoming 2016 issues. We seek content on broad range of topics of general interest to those in education and training, research and practice, and social justice and human welfare. Collaborations with students are encouraged. 1000-2000 word count; APA Style. Send to CynthiaDLF@gmail.com.

• Summer Issue – Deadline: June 24, 2016
• Fall Issue – Deadline: September 9, 2016
One of my greatest blessings is to be a part of a profession that helps individuals and the communities in which they reside live more successful and productive lives. In our complex world, there are many messages from many sources convincing us they have our best interest at heart. So often, these messages end up stemming from individuals, groups, and organizations that actually have little interest in reducing the pain and struggles that so many of us experience. We, as psychologists, are different. Psychologists play a key role in actually helping individuals who suffer. While most of us are already experts in healing the individual, we can continue to grow by taking on the role of advocate in our associations and communities.

Advocacy and promoting human welfare are wonderful examples of the good we do as psychologists. But what does it mean to be an advocate? Well, as you can imagine, there are as many ways to advocate as there are groups for which to advocate. Let’s take a look at one area where TPA shines: legislative advocacy. TPA currently has an incredible legislative advocacy program. We have been diligent in creating relationships with legislators, following legislative movements that impact our profession, and promoting and enhancing psychology as a profession in our state. We have multiple committees specifically designed to create and enhance relationships with legislators. These committees include our Grassroots Committee, our Legislative Committee, and also our newly formed Legislative Relationships Task Force. We engage in lobbying for the profession at both the state and the national level. We educate our members on issues that impact their practice, and we lobby for changes that will improve psychologists’ ability to practice our profession.

What are the pertinent advocacy issues at the state and national level right now?

First and foremost in Texas is our work with the Sunset Commission. TPA has developed the Sunset Legislative Task Force chaired by Dr. Carol Grothues. Dr. Grothues and the members of this task force will create a report regarding changes that we would like to make to our licensing act. They will then carry the arguments for why those changes are important to the sunset commission, made up of influential legislators, who will then make recommendations to the legislature as a whole regarding our licensing act. The legislature will then vote on our licensing act in 2017. This advocacy for our profession is paramount if we are to protect our ability to practice at the top of our professional abilities. This is an incredible service that TPA provides not only to members, but to every psychologist in the state!

And what of the national level? How are we advocating for your practice? Several of your TPA leaders recently attended the State Leadership Conference of the American Psychological Association. At this conference, we canvassed the House of Representatives and the Senate to support H.R. 4277. This bill, co-authored by Representatives Noem and Schakowsky, adds “psychologist” to the physician definition in Medicare. If we can get this legislation passed, it will have far-reaching implications for our practices, like getting rid of the need for physician supervision in hospital or inpatient settings, thus allowing psychologists to more quickly serve the needs of hospitalized Medicare patients.
As you can see, legislative advocacy at a state and federal level helps build and protect your profession.

A second area of advocacy that TPA has only just begun to consider is advocacy for underserved and at-risk populations. In TPA, the dialogue continues regarding social justice issues and how we as a professional association should respond when these issues are brought before us. It is my belief that your elected board should have the right to respond to these requests on your behalf with a well thought out social justice policy. It is also my belief that we are directed by our professional guidelines and ethics to advocate on behalf of those who often times have no voice or are marginalized as a result of institutional or cultural bias. As the provision of medical and behavioral health interventions change with the advent of the Affordable Care Act, social justice issues become all the more important. Integrated care, which is a cornerstone of the ACA, incorporates the concept of “population health” as an imperative. This concept directs behavioral and medical health professionals and organizations to be responsible for the mental and physical health of broader populations, not just individuals. This requires mental health professionals to think outside the box. A 45-minute session just doesn’t fit the needs of many people. These changes require us to consider, not just treatment of the individual, but how a population as a whole receives and utilizes services, what barriers there are to treatment, what institutional bias exists for various populations, and how cultural implications impact interventions. There are multiple populations that our association can positively impact by taking our expertise to this level of discussion. A limited list of these populations includes rural populations, populations with serious mental illness, racial/ethnic groups, sexual identity minorities, individuals with disabilities, the homeless, the aging population, individuals living in poverty, and women and children. This is just a limited list of groups that suffer behavioral health problems related to or exacerbated by community and institutional bias. By involving ourselves at an association level with legislators who are advocating for underserved groups, we become potent leaders in our state, directing the discussion about improving the lives of our patients and their communities, regardless of cultural, ethnic, or socio-economic grouping.

One example of this type of advocacy at a federal level is found in Representative Tim Murphy and Representative Eddie Bernice Johnson’s bill entitled Helping Families in Mental Health Crisis Act of 2015. This bill advocates for those who suffer from serious mental illness and the families who support them. It is an extensive bill that, if passed and signed into law, will provide for things like abolishing the 190-day lifetime cap on inpatient hospitalizations under Medicare. It allows for increased hospital beds for people who suffer with serious mental illness. It allows for better communication between mental health professionals and families of patients by adjusting HIPAA requirements. This bill is not without voices of dissent, though. Any time advocacy takes place, there will be differing opinions on best practices to improve the lives of others. Dissenting voices believe this bill puts the privacy of individuals with SMI at risk, and could be used to take confidentiality away from certain at-risk groups, like members of the LGBT community. There are also questions as to whether adding another office in government headed by an Assistant Secretary for Mental Health and Substance Use Disorders is the right idea. In answer to some of these questions, Congressman Gene Green of Texas, among others, have introduced the Comprehensive Behavioral Health Reform and Recovery Act of 2016. This bill answers some of the concerns groups have about the Murphy bill. If you haven’t heard of these bills, please look them up and compare them for yourselves. Call your congressperson and ask for her/him to co-sponsor and support a bipartisan bill that best meets the needs of those struggling with mental health issues in our country.

But why should we engage in any type of advocacy?

True, advocacy protects our profession and helps those we treat and serve, but are there other reasons? I believe these alone are reason enough, but to the question, I say a resounding Yes! While it isn’t always seen as a primary role of a psychologist, advocacy is deeply imbedded in the DNA of both our national and state associations. The Texas Psychological Association’s mission reads as follows: “The Texas Psychological Association is to represent and enhance the profession of psychology in Texas, promoting human health and welfare through education, science and practice.” The promotion of human welfare plays a significant role in our own mission. In our statement of purpose, members of TPA are asked to:

Advance psychology as a science, profession and as a means of promoting human welfare by the encouragement of psychology in all its branches in the broadest and most liberal manner; by the promotion of research in psychology and the improvement of research methods and conditions; by the improvement of the qualifications and usefulness of psychologists through high standards of professional ethics, conduct, education, training and achievement; by the increase and diffusion of psychological knowledge through meetings, professional contacts, reports, papers, discussions and publications; thereby to advance scientific interest and inquiry, and to foster the application of psychology in the promotion of the public welfare.

I argue that one such “liberal” manner is through advocacy. In our national association, the Preamble of the Ethical Principles of Psychologists says that psychologists “strive to help the public in developing informed judgments and choices.
concerning human behavior. In doing so, they perform many roles, such as researcher, educator, diagnostician, therapist, supervisor, consultant, administrator, social interventionist and expert witness." Social interventionist sounds a lot like advocate to me. Advocacy is in our professional DNA.

There are even more reasons why advocacy is a good thing for psychologists to do. It brings great personal reward. Perhaps not anchored in a monetary reward, but rewards related to personal responsibility and growth. It allows us to build relationships with others that enrich our lives. It creates community and a sense of connectedness that breaks the sense of isolation and aloneness that so many in our communities (even ourselves sometimes) feel. Advocacy can enhance our personal skills of leadership as we educate and speak on behalf of those who have no voice. It allows us to explore and uncover not only our own personal biases, but also brings to light our passions. Finally, advocacy enhances our own empathy and compassion as we understand our own personal privilege and recognize how others may not share these privileges, due to no fault of their own.

As TPA and you, both as psychologist and citizen, embark on this journey of advocacy, I offer these gentle reminders. Change is difficult. We often have to start with ourselves first, and as we manifest changes in our own personal lives, these changes have a way of turning outward and touching important others around us. In order to advocate for others, we must do our best to understand and embrace their experiences, without judgment. We must educate ourselves and be mindfully aware of our own biases and cultural insensitivities. Humility, on everyone’s part, will help us smooth the difficulties of differing opinions and defensiveness. And finally, change is inevitable. We as psychologists have special abilities to embrace and promote healthy change that can forever impact the communities we serve. Even when change, at first blush, doesn’t appear to benefit us, don’t give up. When we involve ourselves in these discussions and take positions on making our world better, we will benefit from happier and healthier communities, families, and friends. Keep doing the good that psychologists do….it will save our communities and our lives.

You, as a Texas psychologist, work under both a title act and a practice act. This means the state of Texas (in essence, the State Legislature and Governor) defines both the required credentials to be called a psychologist, and the parameters you must work within to practice psychology in the state. The TPA leadership is extremely vigilant in assuring that no one violates these statutes, but if someone does, we take action. This was the case six years ago, when we took action to protect your profession. Join me in looking back to 2011:

In preparation for the upcoming legislative session, we reviewed and analyzed all the candidates running for the state legislature. To my surprise and enthusiasm, I noticed there was a psychologist running for the Senate. Being an avid proponent of a psychologist holding political office,
I was excited that someone with psychology knowledge and experience was going to be part of the ‘inner circle’ at the state house. However, further investigation revealed this individual was not licensed by TSBEP. Therefore, according to our title act, she could not call herself a psychologist. Our statute clearly states this in Section 501.003 (b):

(b) A person is engaged in the practice of psychology within the meaning of this chapter if the person:
1. represents the person to the public by a title or description of services that includes the word “psychological,” “psychologist,” or “psychology”;
2. provides or offers to provide psychological services to individuals, groups, organizations, or the public;
3. is a psychologist or psychological associate employed as described by Section 501.004(a)(1) who offers or provides psychological services, other than lecture services, to the public for consideration separate from the salary that person receives for performing the person’s regular duties; or
4. is employed as a psychologist or psychological associate by an organization that sells psychological services.

Our argument focused on (b) (2), which addresses the representation to the public as a psychologist. This candidate, Dr. Serafine, declared on her campaign website that she was an attorney and a psychologist. After contacting and informing Dr. Serafine that she might be in violation of state law, she refused to change her position. So TPA, with the approval of our Board of Trustees, filed a complaint with TSBEP. This complaint lead to Dr. Serafine filing a lawsuit against the state (i.e., TSBEP). Dr. Serafine contended that since she was running for public office (political speech), then not allowing her to call herself a psychologist violated her First Amendment rights. In October 2013 she had her day in U.S. District Court in Austin, Texas. I was subpoenaed and testified in court on the definition and understanding of our title and practice Acts. Several months later, Judge Lee Yeakel ruled in favor of TSBEP and rejected the political speech claim. He held that the Licensing Act is a legitimate use of the state’s police power to protect the profession. In essence, they found no evidence that the state violated Dr. Serafine’s First Amendment rights.

An appeal was filed with the U.S. Fifth Circuit Courts of Appeals in New Orleans. The appeals hearing took a different turn, and in January 2016 the justices claimed there is a difference between “political speech” and “professional speech.” They claimed TSBEP has the authority to regulate professional speech but limits that right to regulate political speech, which is protected by the First Amendment. The difference is that Dr. Serafine was not providing advice to a particular client, but communicating to the voters at large through her website, and therefore her campaign statements are protected.

We all know the essence of the First Amendment of the U.S. Constitution: freedom of speech. But let’s take a look at the actual wording:

First Amendment - Religion and Expression. Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the Government for a redress of grievances.

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I thought it was interesting that the justices stated in “a political campaign, a candidate’s factual blunder is unlikely to escape the notice of, and correction by, the erring candidate’s political opponent.”

So, do we have a title act?

Can anyone call him or herself a psychologist?

We thought there were no longer any exceptions to the term “psychologist” when we passed in HB 807 in 2013. But now there could be a unique situation where, by constitutional rights, some could portray themselves as psychologists and not violate Texas law.

In my next article, I will discuss this case and how it challenges the practice act of your law.

Here is something to consider: What do you think the justices meant when they referenced “a factual blunder is unlikely to escape the notice of the political opponent”?

This situation is the quintessence of what we are called to do when psychology became a regulated profession. The entire judicial system (which begins at the legislative level) is based on “checks and balances.” There are laws, and then there is society to enforce those laws. If nobody questions the actions of an individual, then the laws are meaningless. TPA questioned the actions of this individual and we learned about our profession. As a psychologist, you have the RESPONSIBILITY TO PROTECT YOUR PROFESSION.

Do me a favor. Give this printed article and a member application to a non-TPA member and tell them TPA is protecting their vocation. It’s time for them to spend $28/month to help protect the profession.
Here is a synopsis of the high points of last month’s meeting of the APA Council of Representatives (CoR) held in Washington Feb. 19–21, 2016. The meetings pivoted around three broad issues: the ongoing responses to the Independent Review (the Hoffman report), the declining membership in APA and calamitous budget problems of the Practice Directorate (APAPO), and the issue of diversity training and diversity voices.

Interim CEO Dr. Cynthia Belar opened the meeting with an inspired speech that acknowledged many current fractures and schisms within APA. She provided a cogent history of some of the problems that now plague the organization and a very pointed critique of the level of discourse and dysfunction that has led the organization away from its stated mission: **to advance the creation, communication and application of psychological knowledge to benefit society and improve people’s lives** (APA, n.d.).

Appealing to our nobler aspirations Dr. Belar warned against becoming overly mired in guild-based self-interest and she challenged members to work toward inclusion and unity. A link to her speech can be found here www.texaspsych.org/resource/resmgr/Texas_Psychologist/Belar_Council_Presentation_F.pdf

**Actions regarding the IR**
Several initiatives were approved or put on the agenda for the August meeting. Council approved the establishment of the following three work groups:

- A work group to review best practices in order to develop APA organizational policies and procedures to address, but not be limited to: Organizational checks and balances, appropriate oversight of governance members in the execution of their roles and responsibilities, application of established policies and procedures, transparency of decision-making, sensitivity to, and willingness to address, differences arising from power differentials and consideration of effective governance and staff working relationships.
- A work group to develop aspirational civility principles as well as procedures for all forms of direct in-person communication and online messages and postings within and on behalf of APA.
- A work group to develop guidelines that will reduce bias, increase transparency, and promote diversity in the selection of individuals serving on APA task forces. This system for task force selection should emphasize self-nomination, as well as nominations by, and consultation with, relevant stakeholders (e.g. Divisions, SPTAs, other affiliated groups).

Council voted to approve amending the Guidelines for Council Resolutions to include the extent to which the resolution is consistent with APA’s core values, and the extent to which it addresses human rights, health and welfare, and ethics. Council also voted to prioritize ethics, human rights and social justice in all aspects of the next Strategic Plan.

**Finances**
APAs chief financial officer, Archie Turner, reported that membership has continued to decline somewhat. Since membership is a small fraction of the budget, this does not alarm our CFO; revenues from real estate, publishing, and investments are presently doing well.

However the Practice Directorate is in a more precarious position. APAPo was established in order to protect APA’s tax status as a non-profit (501(c)(3)) entity that, by law, may not lobby. Thus the Practice Directorate (APAPO) was spun off as a 501(c)(6) entity which is permitted to lobby for the profession. APAPO is dependent exclusively on membership dues at this time and it cannot receive any proceeds from APA
activities such as the convention, publications, and etc. We were told that APAPO membership has declined significantly in the past year. With a weakened APAPO, the profession is at risk for losing its voice on Capitol Hill. Bottom line: any psychologist who does any business with the feds (Medicare, Medicaid regulations, DoD contracts, NIH/NIMH/SAMSHA, the VA, etc.) should be alarmed.

Diversity Issues
On the last day of the meeting a group of women and ethnic minority psychologists assembled at a floor microphone in a show of protest and solidarity. The immediate aggravation was a presentation by a consultant who was hired to observe and comment on the cultural milieu at APA. The representative from the Society of Indian Psychologists objected to several aspects of his presentation, but the discussion quickly expanded to a more general discussion regarding the degree to which many representatives feel excluded or dismissed in CoR meetings. Council has historically required diversity training to be part of every Council meeting and a task force is working on improving these offerings. For many attendees this very heartfelt discussion did more to raise awareness about diversity issues than did the scheduled diversity presentations (which addressed the stigmatization of Muslims and the role of violent extremists in all religions).

Part of the backdrop to the discussion is the ongoing resentment that the ethnic minority psychological associations were denied representation on the CoR (they have observer status). In addition there is a perception that APA is run by a collection of insiders whose interests do not reflect the values or concerns of a significant portion of the membership. This dovetailed into another source of dissent: the perception among some that APA staff has over-reached their authority. In both cases there is substantial dissatisfaction with the status quo. The meeting then came full circle to the call for civility, transparency, and open-minded listening with which the meeting began.

Struggle Ahead
I am often asked, “What can APA do for me?” A visit to the CoR is not the place to find a good answer. What happens there is a lot of procedural and ritual activity and a lot of spirited but arcane debate – inside baseball that is essential to keep the organization functioning. In this regard, the CoR exhibits all the strengths and weaknesses of representative democracy. There are 160+ voting members representing the states and provinces and the substantive divisions of APA. Like the U.S. Congress the CoR flirts with paralysis in the face of competing agendas from these many constituencies. Recently enacted changes to the governance process should help APA be more nimble and proactive in the face of rapidly evolving working environments for psychologists. This will enable APA/APAPO to continue to advocate for our profession and to provide for timely, high-quality education and guidance for new and seasoned practitioners as they adapt to these changing environments.

References
Keeping with Dr. Greg Simonsen’s presidential theme of “The Good that Psychologists Do,” I was asked to write an article on how our advocacy benefits the well-being of others. First, it occurred to me that this benefit is not only limited to the individuals many psychologists serve directly as health service providers. It includes the general public within Texas and across the country because everyone can benefit from improving mental health and prevention of mental illness. Additionally, even those individuals who do not personally grapple with mental health challenges, have friends or family that do. So, isn’t that a powerful statement? The good that psychologists do with our state and federal initiatives benefit everyone.

Although roughly 44 million Americans are diagnosed with a mental illness each year, fewer than half get mental health treatment. Of those getting outpatient care, most are treated only with drugs, yet only 23% of prescriptions for psychotropic drugs are written by a psychiatrist. Mental health disorders are the single leading cause of disability in the US. Major depressive disorder alone costs us more than $52 billion a year in lost productivity and suicide-related costs. And did you know that psychotherapy is the preferred form of treatment by individuals with mental disorders, preferred over medication alone by a ratio of 3 to 1? Even patients who benefit from a combination of medication and psychotherapy, which is supported by the outcome research as often the most effective treatment, still prefer to try psychotherapy alone as a first attempt to treat the mental disorder, free of unfortunate side effects.

So what are the federal advocacy initiatives that will help benefit the public? One 2016 initiative is centered on Medicare beneficiaries and access to effective mental health care. Shockingly, although we are licensed to practice independently in all US states, Medicare still requires unnecessary physician sign-off and oversight of services in some settings (but inconsistently, not others). This reality is hampering and even preventing delivery of needed care. The data reveals that only one in three older adults with a mental health disorder receives any mental health treatment and that making patients wait for mental health care increases the costs of treating other chronic conditions like diabetes and congestive heart failure by as much as 67%. Psychiatrists are in short supply and they are 30% less likely to accept Medicare than other physicians. In many areas, physician oversight is provided by general practitioners who do not have training in psychology; and, the “supervision” is completely unnecessary anyway. Primary care physicians have been shown to adequately detect, refer and/or treat only 40-50% of patients who have mental health disorders. Psychologists from across the country have recounted stories of patients referred by nurses, social workers and families for mental health consultation and treatment, but it's delayed for weeks waiting for physician approval, and meanwhile the patient's overall health deteriorates, culminating in some cases with the patient being sent to an ER for evaluation and treatment. The Institute of Medicine stated in a 2012 report, “The burden of mental illness and substance disorders in older adults in the United States borders on a crisis.” Medicare spends less on mental health than any other payer.

Our solution is the Medicare Mental Health Access Act which removes the unnecessary physician oversight requirement and adds psychologists to
the list of doctoral providers that are already independent and included under Medicare’s definition of “physician,” that already includes other non-physicians such as podiatrists, chiropractors, optometrists and dentists. This act would not change state licensure laws and would not add coverage for any new services and based on the collateral costs associated with untreated mental health disorders on other health conditions, from a budget standpoint, it would save money, which is always a consideration for the taxpayer and therefore, also with legislators representing all of us on Capitol Hill. Benefiting human welfare AND saving money on healthcare for Medicare recipients….it seems like a Win-Win!! Many consumer and provider organizations have gone on record endorsing the Medicare Mental Health Access Act. Our sponsors in the House are Reps. Kristi Noem (R-ND) and Jan Schakowsky (D-IL) (HB 4277) and the Senate companion bill is S. 2597 sponsored by Sherrod Brown (D-OH) and Susan Collins (R-ME). The fact that this is a bipartisan bill means it has a real chance of passage! Psychologists from all 50 states, including TPA leaders, attended the State Leadership Conference in late February and went to Capitol Hill to educate and ask for support on this bill from our U.S. Legislators.

Another initiative for 2016 is an overarching push for Congress to pass consensus, bipartisan mental health reform legislation. Only 1 in 3 Americans with a mental disorder receive minimally adequate treatment and 60% don’t receive any from a mental health specialist. The proportion of health care spending devoted to mental health and substance abuse is 28% smaller today than it was in 1986. After the first onset of a mental disorder, the median delay before first treatment is nearly a decade. I was appalled myself when I read that statistic! Individuals with serious mental illness are much more likely to be in jail or prison than a mental health facility. The APAPO office has detailed a list of reforms that would address these needs and benefit the welfare of the public in a myriad of ways. First, we need to pass the Medicare Mental Health Access Act, but also support other bills including the Mental Health Awareness and Improvement Act, which already passed the Senate, introduced by Senators Lamar Alexander (R-TN) and Patty Murray (D-WA). Another is HR 4435, the Comprehensive Behavioral Health Reform and Recovery Act introduced by our own Rep. Gene Green (D-TX).

In addition, there is a list of specific recommendations made by APAPO on our behalf and on behalf of the public that would optimally be included in sweeping mental health reform.

- First, make psychologists part of the “health” system like all other providers, eligible for use of health information technology that integrates all health providers. Provide the same grants as those given to physicians to help psychologists implement this goal.
- Allow limited Medicaid coverage for services provided in institutions for mental disease.
- Institute consistent reporting on the effectiveness and enforcement of requirements under the Mental Health Parity and Addiction Equity Act to prevent discriminatory coverage limitations for individuals using mental health and substance use disorder insurance benefits. Parity means parity!
- Remove the 190-day lifetime limit on Medicare coverage for services provided in inpatient psychiatric hospitals.
- Help healthcare providers work with patients and their families by providing resources and training on requirement under the Health Insurance Portability and Accountability Act (HIPPA) for communication between providers, patients and families.
- Increase the number of mental health service providers by reauthorizing the Minority Fellowship Program and the Graduate Psychology Education Program. Require Health and Human Services to develop a nationwide strategy to recruit, train, and increase the mental health service provider workforce
- Require Medicaid coverage of primary care and mental health services provided on the same day within community mental health centers
- Prioritize grant funding for the development and dissemination of evidence-based interventions and integrated service programs, including early childhood intervention and treatment, jail diversion programs, assistance in transition from homelessness (PATH), suicide prevention (Garrett Lee Smith Act), and comprehensive community mental health services for children with serious emotional disturbances.
- Establish an Assistant Secretary for Mental Health and Substance Use Disorders, charged with leading a National Mental Health Policy Laboratory within the Department of Health and Human Services and an Interagency Serious Mental Illness Coordinating Committee.

Finally, another initiative discussed at the national level, but must be fought and won on the state level is prescription privileges for appropriately trained psychologists, e.g., Prescribing Psychologists. The shortage of psychiatrists is a well-established broken record. As I mentioned earlier, only 23% of patients receive psychotropic medication from a psychiatrist and the rest receive their prescriptions from general physicians, nurse practitioners and physician assistants with little to no training in mental health and psychotropic medication. The safety, effectiveness and efficiency of prescribing by Prescribing Psychologists is well established in the
military, Indian Health Service and in states like New Mexico and Louisiana. Data from Illinois is forthcoming and many other states are on the verge of making this law as a way to fill the mental health shortage. As Prescribing Psychologists we have multiple tools; we can use medication if that's the best choice, we can use other cognitive, behavioral and psychosocial interventions instead, or we can use both modalities. We see our patients more often and spend more time with them which allows us to monitor responses, side effects, dosage changes and other fine-tuning that must occur. We will collaborate with the primary care physician and provide integrated, coordinated care. We can work in shortage areas (which includes almost all the counties in Texas!) and provide the access and expertise to benefit the citizens of Texas. There is much more I could say about RxP (those of you who know me well know that's an understatement!) but that is outside the scope of this article.

In closing, stay abreast of important developments and respond to those action alerts when they show up in your inbox. It only takes a few minutes to contact your legislators by email when we alert you that the time is NOW. If you are not already involved, volunteer to become a key contact for your legislator, especially if you already have a relationship with him or her, either personally or professionally. If not, volunteer to take on the role or say “yes” when someone calls and asks for your help as a constituent psychologist to call or meet with a particular legislator. Ask those of us on the grassroots committee or in federal advocacy to help you get started. When you are talking to the legislator, you will want to cover the issue at hand, but don't overlook the power of asking what they are working on that TPA might help support. Offer to be a resource and grow the relationship as you educate and advocate about important mental health legislative efforts that will help their constituents. I'd be remiss if I didn't earnestly thank all of you who have long been involved in advocacy; you fully understand it's critical importance for the public welfare. After all, we ARE in the business of improving the health and well-being of our clients and the public in general. Make sure you communicate that message any chance you get because there are many misconceptions about advocacy. Advocacy is one powerful step toward that goal of “The Good that Psychologists Do.” Let me know if you want to be a part of it!

A Practical Guide for Effective Therapy with Veterans

Adapted by Kelly G. Arnemann, PhD
Veterans Administration Psychologist
San Antonio, Texas

As entering into the U.S. Armed Forces involves becoming a member of a unique subculture, it is important to understand clinical implications in psychotherapy. The projected data indicates that approximately 7% of Americans will serve in the military (National Center for Veterans Analysis & Statistics, 2014), which means that 93%, or nine out of every 10 adults, do not understand Veteran culture. This article draws heavily upon the work of Castro, Hoge, Milliken, McGurk, Adler, Cox & Bliese (2006) from the Walter Reed Institute of Research in developing the concept of “BATTLEMIND TRAINING I & II” (www.nacanet.org). The acronym “BATTLEMIND” represents the psychological adaptations military personnel experience during their training. While originally designed to assist Army personnel in their transition home after combat, I found it applicable to all Veterans as most do not serve in combat theaters during active duty. I find “BATTLEMIND” to be a great resource in my clinical work because it helps to explain the lifelong impact of military training, rules and regulations, codes of conduct, and chain of command in a Veteran's life. “Buddies & Unit Cohesion versus Withdrawal”
is explained in therapy in order to help them understand how this training affects their daily functioning after active duty and that civilians invalidate the importance of these concepts. Veterans have shared experiences, whether or not they served in a combat zone. At home, this may manifest as them preferring the company of peers over family and friends. I also often hear from Veterans that coming home from a deployment is like “starting over” in a new marriage/intimate relationship. This renewal of relationships, both emotional and intimate, takes time.

“Accountability versus Controlling Behavior” refers to survival through maintaining control of their weapon and gear. In the civilian world, anger is often expressed toward those who “mess with” their belongings – including that misplaced screwdriver. Veterans also tend to believe that they are the only ones who do things “right.” The resulting anger can be addressed in therapy by explaining that without appropriate instruction about the “right way” to civilians, it is unreasonable to be angry. This “all or none” thinking is a direct result of their training when “do it right or people die” is instilled into them. At home, they must be reminded that “small” details that could have previously resulted in death are no longer applicable.

“Targeted Aggression versus Inappropriate Aggression” is a result of needing to make “split-second decisions…in ambiguous environments” that kept the veteran alive. Instilled hatred toward enemy combatants kept veterans hypervigilant, resulting in inappropriate aggression at home. Clinically, the veteran must be reminded that there are no enemies in their current environment – an idea that I have often found to be met with resistance.

“Tactical Awareness versus Hypervigilance” is an assessment of their surroundings to which the veteran may need to “react immediately” if sudden changes are viewed as perceived threats.

In daily life, deviating from a set plan/schedule during their structured day – even while vacationing – can result in great distress and angry outbursts due to their inability to assess threat of unanticipated environments. I retrain them to relax by utilizing breathing techniques.

“Individual Responsibility versus Guilt” stems from survival training and the Veteran doing their best to keep their “battle buddies” alive. If deaths of any kind have occurred during military experiences, the Veteran can be haunted by feelings of failure. The life-and-death decisions in their combat/military experiences may manifest in therapy and at home as a continual second-guessing about daily decisions that civilians take for granted, such as where to go to dinner, or even what color to paint the living room. This usually results in resentment from loved ones due to the Veteran’s refusal to be involved in decision-making in the family – this burden on partners increases and relationship discord often ensues.

“Non-defensive (combat) Driving versus Aggressive Driving” is experienced by many civilians living in communities with large Veteran populations. With the latest generation of Veterans, the fear of IEDs and VBIEDs has colored their view of safety on roadways. In therapy, I remind them that I am driving on the highway with family members and have no ill intent toward them despite their aggressive driving. I often tell them to “knock it off,” to which they usually chuckle. Asking a Veteran when they last had “a good belly laugh” may result in a blank stare, which is clinically significant.

“Discipline versus Ordering & Demanding Behavior” impacts all relationships. Control of the therapy session may become a struggle – simply reminding them that if they are this aggressive in therapy, how much more so they must be with family and friends, creating conflict and stress where ever they go.

I end my discussion with an explanation of “Emotional Control versus Anger/Detachment” because of my clinical experiences. Military training regards anger as the only acceptable emotion to express. Anger appears to be a direct result of Veterans having higher than reasonable expectations of civilians. When civilians fail to “make rank;” Veterans often become frustrated and depressed as they realize their powerlessness over others, usually manifesting in feelings of depression due to a self-imposed isolation.

In therapy, I utilize the public SAMHSA resources (www.SAMHSA.gov), DBT, and a CBT approach to address anger, depression, and anxiety. The VA has “Gold Standard” treatments for trauma, including CPT and PE (www.ptsd.va.gov). If you are unaware of this resource to address multiple sources of trauma, I strongly encourage your exploration of this website for your clinical work.

I also encourage the use of well-regarded psychological measures of progress in therapy. I utilize the PCL-C, the BAI, the BDI-II, and the PHQ-9 to measure multiple areas of psychological distress, both past and present.

This practical guide to effectively work with Veterans offers a brief introduction to successfully providing therapeutic interventions by utilizing the abovementioned resources in conjunction with your theoretical orientation. It is my hope that my clinical and anecdotal experiences are found to be helpful.

References
A New Day is Dawning in the Rio Grande Valley

Joseph McCoy, PhD  
Independent Practice, President, Valley Psychological Services, P.C.  
Supervisor, Lone Star Psychology Internship Consortium  
Edinburg, Texas

Alfonso Mercado, PhD  
Assistant Professor, University of Texas Rio Grande Valley  
Edinburg, Texas

In the Rio Grande Valley 20 years ago there were only 30 psychologists available to the public of slightly over one million people. Many of the psychologists were graying and did not reflect the diversity of this community, though they served it well. The bad news is that there are still only about 30 psychologists available to the public, which is now an official population of about 1.4 million people. As has always been the case, there is a much larger population here than that. Many people from the reflexive side of the border, which is about 2.8 million people, and Monterrey, an area of 7 to 8 million people, also utilize the services of healthcare professionals in the Valley. To meet healthy-community standards, there would ideally be 140 psychologists serving the Valley. The current climate suggests we may soon move toward that number.

To begin with, the 30 psychologists we now have available to the community are early career psychologists who reflect the diversity of this area. Several have recently opened practices after a five-year period in which more practices closed than opened. In addition, the recently formed South Texas Psychological Association’s membership is predominantly filled with these early career psychologists. This STPA is led by TPA stalwart, Dr. Selia Servin-Eischen, who is its current president. The past president is Dr. Mary Deferriere. The rest of the board are all early career psychologists including Dr. Teresa Chapa-Cantu (president-elect), Dr. Ebony Butler (treasurer), Dr. Alfonso Mercado (secretary), and Dr. Paul Gonzales (communications/technology director). Dr. Butler is also a VA psychologist who is recognized by the VA as an expert in diversity and gay and lesbian issues for the military culture that she serves. Dr. Josephina Irygoen is the only clinician running a group for those dealing with transgender issues. As this article evolved, it became clear that we are just highlighting a portion of what psychologists are doing for the Valley.

These highlights include the 17 psychologists serving the Valley as part of the Costal Bend VA. The Valley has a proud tradition of military service, and even with this high number of psychologists they are working hard to meet the need. Twenty years ago there was only one psychologist serving the VA system here. The VA also has a captive internship program. Unfortunately, with a couple of rare exceptions, the interns do not stay in the Valley. That in part can be due to the fact that there are few and sometimes no post-doctoral positions available here. Drs. Cynthia Gonzalez and Joseph McCoy frequently offer internship and post-doc positions in their practices for this reason. These opportunities are about to expand with the advent of the new medical school.

In June, the University of Texas Rio Grande Valley (UTRGV) is about to have its first medical school class of 50 students. At the same time there are already four residency programs that are about to complete their first combined class of 42 residents. These programs include internal medicine, OB/GYN, family practice, and surgery. Within the next two years, residencies in psychiatry, pediatrics, and gastroenterology will begin. Many of the residency directors are interested in having psychology faculty and associated internship and post-doctoral programs. One exciting facet of this is that the Lone Star Psychology Internship Consortium is cooperating with the Hogg Foundation.
to reach out to these and other Valley entities to offer their expertise and assistance in helping to develop future internship programs.

In addition, the UTRGV psychology department has a proposal before the UT regents to start a doctoral program in clinical psychology with a Latino mental health focus. They have already begun the search for hiring more clinical faculty in preparation for this program that will include a psychology training clinic. One of TPA’s current board members, Dr. Alfonso Mercado, is a member of this department. In addition to donating time to many community agencies, he has a research project in translational research for DBT groups for Spanish-speaking individuals. It’s an extension of the work he did on internship in Massachusetts. He solicited community partners to assist with this project, which he hopes to finish within the year. One of those partners is Tropical Texas Behavioral Health in Edinburg, which means underserved community members are receiving this cutting-edge therapy while helping to shape it so it is applied more appropriately to this understudied population. Recently a local paper, The Monitor, featured Dr. Mercado regarding his role as TPA’s Diversity Division Chair, as well as his research and clinical work in the community. Dr. Mercado’s research lab has also begun examining psychological factors with new immigrant populations, such as mothers and their children who are crossing the Rio Grande River. Another of his colleagues, Dr. Zina Eluri, is providing applied behavioral analysis services to children with developmental or behavioral disorders. This is a free service for those families who consent to participate in Dr. Eluri’s research.

Finally, another promising development is that psychologist Dr. Erica Bonura, who was born and raised in the Valley, is working at a local Federally Qualified Health Care Center, called Nuestra Clinica. More importantly, her organization along with Methodist Health Ministries Foundation, Social Innovation Fund (affiliated with Americore), and matching funds from Legacy Foundation at Valley Baptist Health Center have come together to form an internship program that will be placed in one of the high-need areas in the Nuestra Clinica system. Two interns will start in the fall of 2016. In addition, Dr. Bonura takes every opportunity she can to present on integrated care with underserved Hispanic populations at national meetings for systems like Nuestra Clinica. She comments that even at these meetings the Latino population is underrepresented. She often asks herself “where are the brown people?” We are very proud of her and the new generation of Valley psychologists who are a testament to the good work that psychologists do for the underserved in the Valley.
The Science of “Doing Good:” Remember, Research on Concussions is Still in its Infancy

Alice Ann Holland, PhD, ABPP
Research Director, Neuropsychology Service, Children’s Medical Center Dallas
Assistant Professor, Department of Psychiatry, UT Southwestern Medical Center
Dallas, Texas

Pete Stavinoha, PhD, ABPP
Professor, Behavioral Pediatrics, Clinical Neuropsychology, Children’s Cancer Hospital
Houston, Texas

As psychologists, our clinical work is often the clearest example of ways in which we “do good.” Psychological interventions have countless times saved the life of a suicidal person, helped someone overcome a crippling eating disorder, and facilitated mental/emotional recovery after a traumatic event. Indeed, through our clinical work we promote individual welfare, and collectively we contribute to the promotion of the welfare of the population. In the busy routine of day-to-day practice, it is easy to forget that the life-changing, life-saving power of our clinical work is derived from the decades of scientific research that developed these evidence-based interventions. We ought not to forget that we are truly practicing psychological science, and as such our ability to “do good” extends to our scientific reasoning: how we think, how we learn, and how we implement what we have learned.

Psychologists are scientists trained to critically evaluate new science. As we learned in graduate school, critical evaluation of new science requires the ability to critique experimental design and execution, and the ability to identify flaws in scientific thinking and writing. For example, we know that the findings of studies consisting of samples that are small and/or limited in diversity do not necessarily generalize to the entire population. Drilled into our minds is the mantra that “correlation is not causation.” Such knowledge may seem simplistic and obvious to us, but it is important to remember that the average member of the general public does not have this training or knowledge.

Although not every psychologist engages in original research, critically evaluating the current state of science is a responsibility for all psychologists. Being able to separate correlation from causation, speculation from proven truth, and essentially fact from fiction benefits not only our clinical work with our individual patients, but also the well-being of the public at large.

Consider how many times a family member, friend, or airplane seatmate has asked you a question about psychology—misconceptions about everything from “electroshock” to Freudian theory abound. Often this is due to Hollywood portrayals of psychology being focused more on entertainment than science. In some cases, this is due to media hype about research findings that have not yet withstood scientific critique and independent replication. The media frenzy about a (now thoroughly debunked) connection between vaccines and autism is perhaps one of the more sobering examples of this danger, having caused the needless reemergence of several debilitating and potentially fatal diseases that were once a thing of the past.

Our own eagerness to advance our efficacy with patients can make it tempting even for us psychologists to embrace novel research findings without putting those findings through the crucible of scientific examination, even with the best intentions. However, taking the time to allow ideas to evolve
from scientific question to hypothesis to preliminary findings to independently repeatable conclusion to settled practice—however frustratingly slow a process this may be—is necessary to produce reliable, robust, and clinically actionable results. Knowing where along this timeline the state of science falls is important as we consider if, how, and when to translate science into practice. In other words, being scientifically critical, cautious, and even skeptical consumers of psychological research is necessary to for us “do good” as psychologists; to ensure that we truly are promoting human welfare.

The recent explosion of research on concussions—spanning post-concussive symptoms, clinical management of concussions, and even neuropathology—represents the most recent opportunity for psychologists as scientists to promote human welfare through education, advocacy, and clinical work. Even before the Will Smith movie hit screens, the word “concussion” was on every American’s radar, in large part due to extensive media coverage of the suicides of a few retired NFL players and associated autopsy findings of what has been termed “chronic traumatic encephalopathy,” or “CTE.”

However, fear is a powerful emotion, especially when fueled by the media and Hollywood presenting such preliminary, unproven findings as established fact. The Concussion movie’s narrative of that “fact” being suppressed by a multimillion-dollar corporation is undeniably compelling and easily believable. There may be some truth to that narrative, but just as with concussion science itself, much remains unknown and uncertain. As with any emerging body of research, there are two sides to every coin. For example, many of the former NFL players who have committed suicide had significant risk factors for suicide, such as family histories of mental illness, severe psychosocial stressors, or a personal history of substance abuse. This is not to say that concussions or CTE are irrelevant to those players’ stories, but such risk factors represent potentially confounding variables that prevent any responsible scientist from making the leap from correlation to causation just yet.

Unfortunately, public attention is focused almost exclusively on just one side of the coin—the emotionally gripping possibility that concussions may cause CTE and in turn a host of other negative outcomes, from dementia to suicide. It is worth noting that there is a longer history of evidence suggesting that concussions are serious injuries, yet typically are not accompanied by long-term behavioral or emotional/psychiatric sequelae. We are witnessing the emergence of research that is challenging this notion, but this research on concussions and CTE is still very much in its infancy.

Thus, this article is not intended to provide conclusive data or declare how psychologists “should” think about concussions, other than to say that we should think about this emerging body of research scientifically. Challenging current scientific thinking helps to make scientific conclusions, and therefore the basis of our clinical work, more robust and reliable. Both challenging existing science and approaching “revolutions” in science with caution and skepticism make for better science. Of course, the good that psychologists
do is not solely defined by our clinical work, though for many of us that is the final common pathway of our education, experience, empathy, and wisdom. Given the heavy publicity being given to concussion research at the moment, there is great opportunity here to “do good” even beyond our clinical work, as we are experts in the community from whom our patients, family members, friends, and even casual acquaintances are seeking clarity and guidance on this topic.

We will do the most good—for both our patients and the greater public—by practicing responsible, thoughtful psychological science, just as we have been trained to do. We practice this way on a daily basis in our clinical work, but we must remember that our education and scientific training can be put to great use promoting human welfare even outside of the therapy hour. Psychologists are uniquely trained and positioned to critically analyze, digest, and clearly communicate the state of our science to the public. In doing so in a responsible and scientific manner, we can truly maximize our potential to “do good,” touching lives far beyond those of our patients.

References

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We all know that purpose-aligned goals drive successful plans, and TPF’s 2016 plans are no different. As the first quarter of the year comes to a close, TPF has set its 2016 funding goals to align with the Foundation’s purpose of supporting students in graduate and undergraduate psychology programs across Texas.

**What is the goal for 2016?** Keep up the momentum. Last year TPF celebrated a great accomplishment by giving away almost $2,000 in awards and grants. This only added to the Foundation’s successful impact in 2014 when we awarded $6,950. We aim to keep up the momentum of previous years and increase the impact of TPF’s support by offering the following awards and grants to deserving undergraduate and graduate psychology students:

- Jennifer Ann Crecente Memorial Research Grant ($1000)
- Manuel Ramirez Dissertation Award ($1000)
- Graduate Student Research Proposal Grant ($1000)
- Undergraduate Student Research Proposal Grant ($500)

Total award/grant money to be given in 2016: $3,500

**What is the plan? How can you help?** You are part of the plan. Help us accomplish our 2016 goals by talking to students in psychology programs now. Begin conversations to prepare them for applying for these awards when TPF begins accepting applications in August. You also can support the future of psychology by donating to TPF and helping us to fund these awards in full. Our hope is that each of these grants are given this year, and we need your help to accomplish this goal.

Additionally, TPF will continue sponsoring the Student Poster Competition at TPA’s annual convention (Nov. 10-12 in Austin). TPF Board of Directors judge and award prize money to outstanding research poster presentations. First, Second, and Third place winners receive award money ($350 total) for their deserving poster presentations of research accomplishments. TPF has sponsored the competition the past two years and will continue to do so in 2016 at convention in Austin.

Help TPF Fund the 2016 Awards, Grants, and Poster Competition by donating online today at www.texaspsyc.org/donations/.

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