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TEXAS psychologist

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FROM THE PRESIDENT

Taking Care of TPA

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Summer often brings a different pace as kids are out of school and most of us schedule time to vacation and visit extended family. Integrating leisure into our fast-paced professional lives is an important part of self-care and prevention of professional burnout. I hope each of you are enjoying this time of the year and remembering to take care of yourselves.

Just as we care for ourselves, we need to take care of our association. The day-to-day work of TPA involves many moving parts, including paid staff and a multitude of volunteer psychologists. In previous issues I have highlighted our legislative advocacy, financial status, interactions with our regulatory board and the work of committees. Necessarily, we deploy both defensive and offensive strategies when it comes to preserving our independent board and agency and maintaining the doctoral standard for independent practice. We will continue to work on the issues pertinent to Sunset and to fighting independent practice for Licensed Psychological Associates. We have other items on our legislative agenda for 2019 as well: prescription privileges for specially trained psychologists, exemption of psychologists from the requirement for certification to provide sexual offender treatment, and protection from civil liability when we take action on the duty to warn. Our members have been involved in hearings and meetings about violence in schools and how to work toward reduction of violence and make our schools safer. This description is an incomplete list of the positive work that TPA members are involved in as we speak.

Taking care of TPA also requires a long-term vision. Where are we going as an organization in the next 3–5 years, what will TPA's priorities be, and how will we implement them? We need a path forward to provide guidance and continuity to our Executive Director (ED) and TPA as a whole, as our psychologist leaders change yearly. With this goal in mind, I have established the Strategic Long-Term Planning Task Force with Co-Chairs Dr. Rick McGraw and Dr. Brian Stagner. Along with our ED, David White, we are in the process of assembling a group of psychologists to gather information from our members, psychologists-at-large, and other stakeholders to assist in preparing this plan which will be proposed to the Board of Trustees by the end of 2018. I am excited about this effort and look forward to the results! Thank you to Drs. McGraw and Stagner for agreeing to lead this initiative, and thank you to those of you who have submitted applications to participate.

Another part of caring for our professional association concerns decision making about social issues. In the past, decisions about TPA speaking publicly, actively supporting or opposing a bill in the state legislature, or signing onto a brief, were made by simple discussion and vote by the board. However, this way of deciding was not systematic and did not account for all of the issues that should be considered before making such an important decision. Deciding whether to respond when TPA is asked to take a stand on a variety of social and public interest issues that affect the well-being and mental health of Texans is not straightforward. TPA members hold diverse opinions and some issues are potentially controversial and divisive. In addition, even if there is general agreement on a social issue, many TPA members do not think it is TPA's role to take a stand, and to do so deviates from our primary goal to protect the profession of psychology and/or could hurt our organization. In an effort to provide a more prudent and professionally responsible approach to these issues, a task force was created to write a Social Issues Policy that was completed in 2016. Although we can agree to disagree and respect each other in the process, I think it's important for you to learn more about the steps taken in making these decisions. The policy is included on the next page.

I hope reading of this policy will illuminate how these decisions are made. Whether we decide to speak out or remain silent, invariably some of us will disagree from time to time. Dissent is not the same as discord or negative relationships among group members, and whether disagreement occurs during BOT discussions or comes from members, as leaders of TPA it is important for us to be aware of your thoughts and opinions on the work of the BOT.

Thank you for being engaged members and please consider volunteering this year in some facet of TPA! There are many opportunities: committees, divisions, special interest groups, the BOT, TPF and the PAC. You can make an impact and help make TPA even better for all of us. Email me if you have questions about these opportunities and/or would like to volunteer at challphd@yahoo.com.

I hope you have the TPA Convention on your schedule this November 15–17 in Frisco and I look forward to seeing you there!

Take CARE of yourself! ■

Texas Psychological Association Social Issues Policy

The Texas Psychological Association (TPA), the primary professional association for psychologists in Texas, advocates for psychology as a science, a profession, and a means of promoting human welfare, guided by high standards of professional ethics. Within its efforts to protect, promote and defend the professional practice of psychology in Texas, TPA may from time to time be asked to respond to a variety of social and public interest issues that affect the well-being and mental health of Texans. Our response may be to 1) Take a public position, 2) Present empirically based information or education relevant to the issue, or 3) Not respond.

The Board of Trustees recognizes that TPA members hold diverse opinions about various social issues, and that some issues are potentially controversial and divisive. The Board of Trustees also recognizes that psychology may have valuable input to further the public discourse on such issues and to potentially enhance the well-being of Texans. The decision whether to take a public position on a potentially controversial public interest or social issue will be made by the TPA Board of Trustees on a case-by-case basis. The resultant public position should be informed by careful analysis of the American Psychological Association Ethics Code and empirical, psychological knowledge.

The following process will guide the TPA Board of Trustees in determining a prudent and professionally responsible means of addressing potentially controversial public interest or social issues.

When an issue is presented to the TPA Board, the Board will decide which of the following categories applies. The time limit for this decision will be determined on a case-by-case basis.

CATEGORY I

If the issue clearly involves human rights, is substantially supported by empirical psychological research, and is relatively non-controversial, the TPA Board will respond to the issue by either taking a public position and/or presenting empirically based information/education relevant to the issue. The manner of response will be decided by TPA Board vote after a period for discussion/deliberation, with a simple majority deciding.

CATEGORY II

If the issue may involve human rights and may evoke more controversy (e.g., reproductive rights) and is still important to the practice of psychology in Texas, the TPA Board will vote whether or not to respond, with a simple majority deciding. The time frame for this vote will be determined on a case-by-case basis. If the decision is to respond, the Board will deliberate and vote by the same method as to whether to make a public statement or to simply provide empirically based information/education relevant to the issue. If the decision is to not respond, then the Board will make no response at all. If the issue is considered a Category II issue, then the board will decide, in a timely manner, which of the three responses under Category II to make.

CATEGORY III

If the Board decides an issue is clearly unrelated to psychology, there will be no public response from the Board and no education or information will be provided.

EXEMPTION

In response to an event that is potentially highly distressing to the public (e.g., natural disaster, war, terrorism, violence, national crisis, etc.), the Board may provide a position-neutral statement of concern and consolation with relevant information and resources to help the public.

Written responses will be prepared as quickly as possible, recognizing that the time required for a thorough and thoughtful response will vary depending on the complexity of each case and resources available. The TPA Board of Trustees is encouraged to consider the following questions when determining whether or not to respond to an issue:

1. Does the need for a public position address definitional issues of established ethics or professional standards or guidelines? If so, the question is most appropriately addressed by APA, with possible endorsement by TPA.
2. Is there a substantial empirical knowledge base to support a position on the issue?
3. Does our current empirical knowledge base support a clear and meaningful contribution to the public discourse?
4. Does a public position promote the profession of psychology balanced with benefit to the public?
5. Does a public position conflict with positions of APA or with the APA ethical principles or code of conduct?
6. Does formulating a response require a disproportionate use of our time and resources?
7. Does providing psychological knowledge inform the public discourse without TPA taking a particular position on the issue, i.e., serve an educational function rather than an authoritative attempt to resolve the issue?
8. Could taking a public position in this matter have a detrimental effect on our work with the legislature?
9. Could taking a public position in this matter have a detrimental effect on psychologists', or a subset of psychologists', ability to practice psychology in Texas?
10. Would a response demonstrably support the science and practice of psychology and/or those served by the profession?

11. Would a response primarily support a political agenda that is tangential to the profession of psychology and psychological scientific research?
12. Would not responding have an inordinately detrimental effect on the public?
13. Does this issue affect Texas psychologists?

The TPA Board of Trustees will exercise final authority regarding recommendations and subsequent action or non-action regarding an issue. If the Board decides to respond to an issue in any way, the board will communicate this decision to the membership and to the Local Area Societies.

EXEMPTION

The Legislative Committee is exempted from this policy but will consider these same questions when making decisions about legislative bills.

This policy was utilized by the Legislative Committee in 2017 to discern whether TPA should publicly take a stand on various bills. In several cases, the committee voted that it was not appropriate and/or not in TPA's best interest to take a public stand. Psychologists who felt strongly about a particular issue were encouraged to take action individually and/or through their participation in other community groups. This month, for the first time since the development of this policy, the Board of Trustees applied it to an issue outside the purview of the Legislative Committee. This decision concerned whether to speak publicly about the negative effect of separation of children from their parents at the U.S. borders. After consideration of the questions outlined in the policy, the board voted that this issue was a Category II issue and that TPA should make a public statement and provide relevant research. The decision was made to speak solely to the traumatic effects of separating children from their parents. ■

From the Editor's Desk

JENNIFER ROCKETT, PH.D.
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Dearest Colleagues,

I trust each of you are sweating buckets at the pool and are in need of a good summer read. Because you responded with abundance to my call for papers, I am looking at a record number of submissions. I have enjoyed reading your work and have difficult decisions to make – which I love! Thank you, thank you, thank you! Keep them coming, please! I trust you will find all of the articles in this issue worthy of your summer attention.

In this issue, our TPA President, Dr. Hall, provides information concerning our legislative agenda as we head towards 2019. One agenda item, prescribing authority, is further explored by Drs. Pujol and Moore, who describe their path and experiences as prescribing psychologists in the Texas Veteran's Affairs System. Dr. Hall also discusses a new initiative that will focus on planning for the future of TPA. Finally, she provides information concerning how TPA decides whether to respond to social and public interest issues and includes a reprint of TPA's Social Issues Policy created in 2016.

TPF continues to do great things! Dr. Green presents a review of upcoming events sponsored by the Foundation, and he reviews available scholarships and awards, including the Jennifer Ann Crecente Memorial Grant opportunity. And, in keeping with Dr. Hall's reminder to engage in self-care, Dr. Green invites us to join TPF for an evening of Painting with a Twist at the Annual Convention. I hope to see you there!

In this issues' Forensics column, Dr. Jennings discusses the use of the words "capacity" and "competency" within the context of civil and criminal proceedings. Dr. Jennings also discusses duty to warn and duty to protect issues involving clients who present with homicidal or suicidal content, or both, in this issues' Ethics column. Our student column showcases an article on sex trafficking written by Ms. Wilson-DeVries and her supervisor, Dr. Reutter. And, lastly, in our Multicultural column, students Abigail Nuñez-Saenz, Andy Torres, Jose Garcia, Paola Salazar, Stephanie Arellano, and co-chair of the Psychology of Diversity committee, Dr. Alfonso Mercado, discuss a timely issue, that of working with DACA recipients and their families, and the challenges they and clinicians may face.

Finally, on behalf of all Texas psychologists, congratulations to Drs. Betsy Kennard and Walter Penk for being selected as the National Registrar's 2018 recipients of the Alfred M. Wellner, Ph.D., Lifetime Achievement Award.

Enjoy reading and have a great rest of the summer! ■

HEYWARD GREEN, PSY.D.
Texas A&M Health Science Center
and Baylor Scott & White Health

A NOTE FROM THE FOUNDATION

Thinking Forward to Convention

It so happens that 140 years ago this year, G. Stanley Hall became the first American to earn a Ph.D. in psychology. Also, during that year, John B. Watson was born. Twenty years later, Edward Thorndyke developed the Law of Effect, arguing that "a stimulus-response chain is strengthened if the outcome of that chain is positive." Sixty years later in 1958 Harry Harlow published "The Nature of Love," describing the importance of attachment in rhesus monkeys. In 1968 the first Doctor of Psychology (Psy.D.) professional degree program in Clinical Psychology was established at the University of Illinois at Urbana-Champaign.

Unless the reader is interested in numerology and embraces the idea of the number eight being associated with an understanding of human nature and the concept of mind over matter, the coincidence of several milestones of psychology occurring in years ending in the number eight is not significant on its own. Instead, consider how each of the events has influenced the science, practice and politics of our field today. Hall went on to found APA. The work of Thorndyke and Watson established foundations of behaviorism. Harlow's work is classic, and many of us can poke our visual memory to summon the picture of wire and terrycloth monkey mothers found on the pages of our introductory textbooks. The Psy.D. has become well established as an effective training model and a legitimate professional degree.

Why mention all this? These milestones illustrate some of the roots of our relatively young science, as well as demonstrate how far we have come in our understanding of behavior. They remind us how concepts that seem commonplace and widely accepted now derived from the pioneering research of those persons named. The applicability and durability of their findings have helped establish the legitimacy of our science. And that brings us into the neighborhood of TPF.

TPF's mission is to stimulate interest and knowledge of psychology to the public. Part of how we approach that goal is through recognition of scholarly achievement, encouragement of novel techniques and innovative programs for providing psychological services, promoting basic and/or applied research through grants and awards and providing materials to the public that provide information about psychological topics.

One way we fulfill that mission is through our work with the poster session during the TPA convention each year. Another way is through the research awards and grants we offer to deserving graduate students. This year TPF is offering three research awards and one grant:

» **ROY SCRIVNER RESEARCH AWARD** ($1000) for the best student paper demonstrating research and scholarship related to LGBT issues.

» **GRADUATE PROPOSAL AWARD** ($1000) to provide funding for a graduate student's research proposal related to the broad area of psychotherapy.

» **BO AND SALLY FAMILY PSYCHOLOGY RESEARCH AWARD** ($1000) for research and scholarship in family psychology.

» **JENNIFER ANN CRECENTE MEMORIAL GRANT** ($1200) for research addressing potential causes and/or prevention of violence against women. Given in memory of the first dating violence homicide victim in Austin in 2006, an 18-year-old young woman whose plan was to study psychology in Texas.

In addition to the grant and award monies, recipients receive funding to support attendance at the 2018 TPA Annual Convention in Frisco. Recipients will be invited to attend the awards luncheon during the convention, where they will be recognized individually for their accomplishments. More information can be found on the TPF pages on the TPA website (bit.ly/tpa-awards). The deadline for submission of applications is September 30, 2018.

TPF is especially pleased to fulfill this part of its mission to recognize the efforts of budding psychologists and their contributions to our science and practice. Our exploration of other ways to advance professional education in psychology continues. We are hopeful of launching some new opportunities in the months ahead.

None of what we do happens without the generous financial support of our friends and donors. We welcome that support at any time, of course. Giving may be done online on the TPA website (bit.ly/tpa-donate). We also are planning an activity during the TPA Annual Convention in Frisco that provides an evening of fun while also supporting TPF. We invite you to join your friends and colleagues to discover your inner Rembrandt

or Picasso or O'Keeffe for an evening at Painting with a Twist. We will share food and beverage while we each create a masterpiece to take home. If you have done this kind of thing before, you already know how much fun it can be. If you are unfamiliar with it, please be reassured that skill and talent are not prerequisites as the leader will guide us through the steps of producing our paintings. We invite you to join the fun and camaraderie while also sustaining the future of psychology. How good is that?

If you are already a contributor to TPF, we offer our sincere gratitude for your support. If you want to know more about TPF, please visit our pages on the TPA website or email me at hgreen.tpf@gmail.com. ■

Multicultural Diversity

Effectively Working with DACAmented Youth & Adults

Abigail Nuñez-Saenz, B.S., Andy Torres, B.S., Jose Garcia, Paola Salazar, B.S., Stephanie Arellano, B.S., & Alfonso Mercado, Ph.D., University of Texas–Rio Grande Valley

In late 2012, The United States granted work permits to qualifying undocumented young immigrants brought to the country by their parents. Only those that were currently in the country by the time of the creation of the program, had been residing continuously for at least seven years, and were enrolled in school or completed high school/GED were able to submit a $465 (now $495) application fee to the Department of Homeland Security. Among these and other requirements, applicants were screened for full background check (biometrics) (United States Citizen and Immigration Services [USCIS], 2018a). After a 6–12 month wait, recipients could legally work and travel within the United States as they were now protected from deportation (USCIS, 2018a). As per USCIS (2018b), the work permits are valid for only two years and must be renewed around 120 days before expiration. DACA never provided a pathway to U.S. residency/citizenship (USCIS, 2018a). However, it allowed almost 800,000 young immigrants to pursue their academic and/or professional endeavors, to become business or home owners, and to be relieved of a constant fear of being deported. Given the recent changes in DACA policies, the aim of this article is to provide a broad picture of the afflictions and mental health of DACAmented individuals and provide clinical insight to better provide mental health services to this stigmatized population.

DACA IN NUMBERS

Estimates indicate that around 800,000 individuals became DACA recipients with countries of origin ranging across Latin America, Europe, Asia, and Africa – however, about 90 percent of recipients are of Latin American origin (USCIS, 2017; Lopez & Krogstad, 2017). Additionally, of the overall population, 80 percent of the recipients are Mexican nationals (USCIS, 2017; Lopez & Krogstad, 2017). Lopez and Krogstad (2017) reported that "three-quarters of DACA recipients live in 20 U.S. metro areas… [and] nearly half (45%) of current DACA recipients live in just two states: California (29%) and Texas (16%)." As of September 2017, about 53 percent of the recipients were female, about 83 percent reported being single, and about 66 percent were 25 or younger (Lopez & Krogstad, 2017).

THE RISE OF THE UNCERTAINTY OF DACA: A TOLL ON MENTAL HEALTH

Despite the benefits that DACAmented individuals have received, there is much fear within this population because of the uncertainty of the program. DACA was rescinded in September of last year, but that rescinding has been overturned by multiple federal judges (Valverde, 2018). As of May 2018, USCIS is currently accepting renewals but is not accepting new applications (USCIS, 2018c). The uncertainty of the continuation of the program has created fears of deportation among DACA recipients, their parents, and their relatives. For instance, it has been reported that these populations are at risk of psychological distress, depression, and anxiety among other mental health disorders (McCraig, 2017). As reported by McCraig (2017), these populations live in critical conditions for extended periods of time and without proper access to mental health services.

When DACA was enacted, it reduced the chances of an individual reporting moderate or worse psychological distress (Venkataramani et al., 2017). This can be attributed

to the ability of obtaining a job that can provide access to a better quality of life. Patler and colleagues (2015) reported that DACA recipients were less likely to report feeling sadness, embarrassment or shame, or worry about discovery in comparison to non-recipients. Their study also found that this population was also four times less likely (9%) to report worrying about being arrested or deported when compared to non-recipients (40%) (Patler et al., 2015). Nonetheless, the recent rescinding of DACA has had detrimental effects on mental health (Venkataramani et al., 2017). Reports indicated that uncertainty of immigration status, stress from increasing family responsibilities, and the deportation risk of undocumented family members have played a significant role in mental health (Siemons et al., 2017). One study revealed that U.S. citizen children of DACA-qualifying mothers had a decrease in anxiety and adjustment disorders by 4.3 percent when compared to undocumented mothers (Hainmueller et al., 2017). The threats to the program and the ongoing uncertainty surrounding it could imply a worsening mental state not just for the recipients but for their children and relatives as well (Hainmueller et al., 2017).

WORKING WITH THE DACA POPULATION

When working with the DACA population, there are multiple considerations for psychology professionals. As reported by Raymond-Flesch and colleagues (2014), the population reported "concerns that doctors were only motivated by money and lacked understanding about their immigration status." The already aforementioned fluctuating status of DACA itself can pose a challenge to the public health system itself, given that it can reduce the likelihood of recipients seeking medical and psychological services due to fear of "coming under scrutiny by immigration authorities" (Venkataramani et al., 2017). Language and cultural barriers among mental health providers have been identified as a substantial issue in the U.S. (Chen & Vargas-Bustamante, 2011). Pragmatic solutions can include reminding the clients that their information is safe and will not be shared with authorities – other than for established legal mandates, fully acknowledging their immigration status and situation in the United States.

Clinicians can also benefit by asking about the client's family immigration status and fears and working on said fears and related psychopathology (La Roche et al., 2017). Additionally, immigrant clients such as the DACA population can benefit by working on safety plans and developing coping techniques that are suited for the client's cultural background (La Roche et al., 2017; Garnici et al., 2017 [Dreamers]).

Garcini and colleagues highlight multiple important clinical considerations for working with DACA recipients. It is vital to validate the DREAMers' experience by building therapeutic relationships based on sincerity, empathy, and unconditional acceptance of the background of the recipient (Garcini et al., 2017). Additionally, facilitating the development of coping strategies that are culturally sensitive and incorporating family and group therapy in the therapeutic interventions is important to address their mental health needs (Garcini et al., 2017).

Finally, clinicians should take it upon themseleves to proactively learn about immigration policies and refer clients to additional forms of services as a means to optimize the psychological services this population receives (La Roche et al., 2017).

A RIO GRANDE VALLEY PERSPECTIVE

The Rio Grande Valley has a primarily Hispanic population, housing 3% of the DACA recipients in the country (USCIS, 2018). Therefore, it is important for this region to be aware of the current sociopolitical issues and mental health of this population. The RGV Mental Health Coalition held a conference in McAllen highlighting the experiences of DACAmented individuals through the sharing of their stories. The purpose was to increase mental health awareness within the University of Texas Rio Grande Valley (UTRGV) and local Rio Grande Valley community about DACA recipients/immigrants. Additionally, UTRGV is also opening a Dream Center on campus. This is a program where DACAmented students can find resources like counseling and guidance with financial aid opportunities (Perez-Hernandez, 2018). It is difficult for these individuals to find these services, particularly financial aid, because of their legal status. In addition, the Texas Psychological Association's Diversity Division led a national mental health task force alongside the National Latino Psychological Association and United We Dream, Org. in Washington D.C., to generate a mental health resource list for DACA youth around the United States.

CONCLUSION

The lives of DACAmented individuals are incredibly complex and with the constant changes of immigration policy, this population lives in fear of deportation and of losing their lives and their homes. Working with DACA recipients is a challenge; therefore, clinicians should have an understanding of the experiences of this population and provide therapy that is culturally sensitive and tailored to the unique situation of the client. ■

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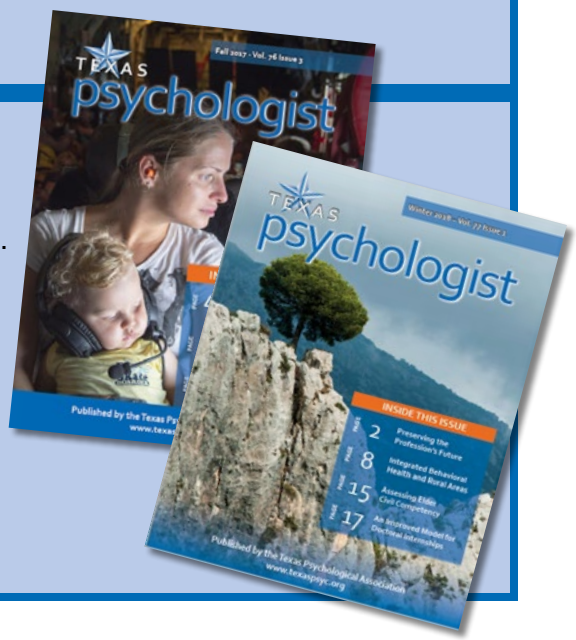

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Yes, Virginia, There Are Psychologists Prescribing in Texas

Lynette A. Pujol, Ph.D., and Bret A. Moore, Psy.D., ABPP
Warrior Resiliency Program, U.S. Army Regional Health Command–Central, San Antonio

Disclaimer: The view(s) expressed herein are those of the author(s) and do not reflect the official policy or position of U.S. Army Regional Health Command-Central, the U.S. Army Medical Department, the U.S. Army Office of the Surgeon General, the Department of the Army and Department of Defense, or the U.S. Government.

Nearly 45 million American adults experienced a mental health disorder in the past year (Lipari, Van Horn, Hughes & Williams, 2017) and approximately 10 million people suffered from a serious mental illness (i.e. mental, behavioral or emotional disorder that significantly disrupts major life areas) (Substance Abuse and Mental Health Services, 2015). It is no wonder that prescriptions of psychotropic medications are on the rise. For example, approximately 1 in 6 adults took a psychiatric drug at least once in 2013 (Moore & Mattison, 2017).

Given these statistics it is not surprising that clinical psychologists frequently find themselves faced with patients taking psychiatric medications and are often informally consulted about effectiveness, adherence, and side effects related to psychopharmacological care. This reality, combined with the fact that many communities across the country do not have access to regular psychiatric services, fueled the passage of legislation for psychologists to prescribe in five states (New Mexico, Louisiana, Illinois, Idaho, Iowa) and within certain federal institutions (Department of Defense, Indian Health Service).

The aim of this article is not to review the extensive literature on the history of prescribing psychology as this can be found elsewhere (see Sammons, Levant & Paige, 2003; McGrath and Moore, 2010). Our present goal is to briefly share the backgrounds of two Texas psychologists who are currently practicing psychopharmacology.

PRESCRIBING AND THE FEDERAL SYSTEM

We both currently work as clinical and prescribing psychologists for the Warrior Resiliency Program (WRP) in San Antonio. The WRP is the regional tele-behavioral health organization that supports the U.S. Army Regional Health Command-Central. Along with two psychiatrists and three psychiatric nurse practitioners, and covering ten military treatment facilities across eight states (Texas, Oklahoma, Louisiana, Missouri, Kansas, California, Colorado, Arizona), we provide virtual medication management services within the region from our location in San Antonio. We primarily treat active duty service members, although some child services are provided by one of the organization's psychiatrist.

You may be wondering how psychologists who reside in Texas (where there is no legislation allowing psychologists to prescribe) provide psychopharmacology services to other states that do not have legislation either. In the federal system, at least for the Department of Defense and Indian Health Service, there is a path to independent prescribing. Federal healthcare facilities have the ability to develop institutionally unique credentialing and privileging guidelines for healthcare providers. And in the case of prescribing psychologists, the Department of the Army has its own educational and training guidelines that allow properly trained psychologists to provide psychopharmacological services between military treatment facilities. We are both credentialed and privileged to provide these services.

THE JOURNEYS OF TWO TEXAS PRESCRIBING PSYCHOLOGISTS

LYNETTE PUJOL, PH.D.

My journey toward prescribing began in an unlikely manner. Armed with a two-year postdoctoral fellowship in health psychology, I began my career at an anesthesiology-based outpatient pain center that was part of a large medical school. My colleagues were physicians and I could not imagine taking on the responsibility of prescribing. Not able to imagine how a psychologist could manage patients with multiple medical problems, I was adamantly opposed to prescription privileges for psychologists.

Then came the complicated circumstances of some of my patients. Depression and anxiety that commonly coexist with intractable pain were ubiquitous in patients I treated. Pain physicians were reluctant to prescribe psychotropic medications and I was encouraged to refer to a psychiatrist. Even in the large metropolitan area in which I operated and in a medical school setting, the wait could be very long, especially since the origination of the pain condition might have involved an automobile or work accident, thus involving insurance that was not readily

accepted by psychiatrists. I saw the very real effects of patients suffering due to difficulties obtaining psychotropic medications.

I didn't really think about prescribing until I changed work settings 13 years later and my supervisor was in the process of completing his supervision. When I was looking for a new professional challenge, he encouraged me to think about psychopharmacology. I accepted. School was all-consuming combined with a job, but well worth the time and effort.

I currently prescribe to two installations in Texas under the supervision of a psychiatrist and prescribing psychologist, although I am privileged at other installations. We learn in school that the "power to prescribe is the power not to prescribe," and as a psychologist, there is a unique advantage to adding the ability to prescribe to psychotherapy treatment.

BRET A. MOORE, PSY.D., ABPP

I had always been interested in the neurobiological bases of behavior, which in part is why I did my initial doctoral training in clinical neuropsychology. However, two things happened that caused me to shift directions – my joining the Army and my first deployment to Iraq. As a doctoral student readying my applications for the 2003–2004 internship match cycle, I found myself unsure of which direction I wanted my career to take. I knew what I *didn't* want to do, but had no strong convictions related to what I wanted to do, save one: after watching a local newscaster interview an Army psychologist talk about his work post 9/11, I knew I wanted to serve my country.

While serving my first deployment to Iraq as an Army psychologist, and still interested in the neurobiological bases of behavior, I applied for the neuropsychology fellowship at Tripler Army Medical Center. I was fortunate enough to be selected. However, I eventually passed on the fellowship opportunity and decided to pursue my training in psychopharmacology. Working alongside a physician assistant and pediatrician in the same clinic, I was regularly consulted on psychotropic medication issues even though I had little experience in this area. I enjoyed this area of collaboration and consultation. So, I applied to the master's in psychopharmacology program at Fairleigh Dickinson University and began my training while deployed to Iraq. I eventually graduated, left active duty service in the Army, and went to work for the Indian Health Service where I gained my supervision from two separate Indian Health Service hospitals. In 2010 I found my way back to the Army (as a civilian) and have actively prescribed in San Antonio since 2013.

CONCLUSION

Just like Francis Church assured eight-year-old Virginia O'Hanlon in his timeless 1897 editorial that yes, there is indeed a Santa Clause, we can assure you that there are indeed psychologists prescribing safely and competently in Texas. As RxP (psychopharmacology) legislation moves forward in Texas, there will be opposition, questions and concerns. However, it might be good to know that prescribing psychologists already are prescribing to patients in Texas (and elsewhere throughout the country) through the federal system.

Moreover, it might be beneficial to know that patients appreciate increased access to care, a one-stop shop, and the focus on evidence-based treatment, whether it is medication alone or integrative treatment. Prescribing psychologists also make a differences to installations that have too few or no psychiatric prescribers. Our job is rewarding and we are truly humbled to be able to serve such an incredible segment of our population to the best of our professional abilities. ■

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Threats by Patients

Floyd L. Jennings, J.D., Ph.D., ABPP

THE SCENARIO

It is Friday afternoon (everything happens on Friday afternoon), the secretary left early and your 3pm patient is a 45-year-old, white male in the throes of a turbulent divorce. He has been agitated and depressed and increasingly angry. But now things have taken a more troubling turn: with quiet menace, he begins to tell you of his haunting and repetitive thoughts of taking his own life, but first killing his wife, if not both her and her lover. Yet after a while he begins to backpedal and insists that he doesn't intend to do anything, so if you tell anyone, he says "I will sue your a––." You obtain assurances that he indeed will call you if the urges become unmanageable. In this case you know this patient is prominent in the community, moneyed, and respected, but his quiet menace raises the hackles on your neck. After he leaves, you look out the window and see him open the door to his vehicle, picking up what appears to be a handgun from the door pocket.… What do you do?

Or, we could conceive of a similar scenario involving a disaffected and troubled 16-year-old who has thoughts about a school shooting. Either raises major concerns – both technical and legal and ethical. In the following I will leave aside the technical issues of risk assessment and threat assessment (which are different matters) and focus upon the ethical and legal issues – about which there is sufficient confusion to warrant revisiting this issue.

Let us also assume that in either case, the person is not psychotic and you believe he may not meet criteria for civil commitment (see Tex. Health & Safety Code §574.034). And let us also assume that you do elect to call the local police department – which sends a squad car after an hour or so, and the officer tells you, speaking of your patient, "if he does that, we will prosecute him to the fullest extent of the law." (To be sure, if it is an adolescent, the response might involve a visit to the household.) Thus, for purposes of this brief note, I will focus only on the conceptual, and not the practical issues – because no matter what you do, it will be troublesome in one manner or the other!

DUTY TO WARN

In Texas, do you have a "duty to warn" the third party or parties either named or readily identifiable in the foregoing scenario? The answer is no. The operative word, however, is "duty."

In *Thapar v. Zezulka*, 994 S.W.2d 635 (Tex. 1999) the Supreme Court of Texas considered a case involving a Houston psychiatrist who treated Freddie Ray Lilly for several years and during six psychiatric hospitalizations, in the last of which he expressed his intent to kill his stepfather. The records also show Lilly stating "he will not do it but that is how he feels." One month after release, he shot and killed Henry Zezulka. The treating doctor, Renu Thapar, M.D., was sued. However, the Texas Supreme Court held that Dr. Thapar had no duty to a third party (Zezulka) because he was not part of the treatment relationship and that the statute is very firm in stating she "may" notify medical or law enforcement personnel if the professional determines that there is a probability of imminent physical injury by the patient to the patient or others or there is a probability of immediate mental or emotional injury to the patient. Tex. Health & Safety Code 611.004 (2014). In that statute, any reference to a third party is omitted.[1]

DUTY TO PROTECT

The next question is, "If I don't have any duty to warn a third party, i.e. possible victim, do I have a duty to protect the patient?" The answer is yes. And protection may well include filing an affidavit and petition for civil commitment – which would allow the opportunity for several other professionals to view the patient and make an independent judgment about dangerousness and mental illness. This is true even if you believe, clinically that the patient is not psychotic and may not – ultimately – be subject to civil commitment.

WHAT IS THE LEGAL CONSEQUENCE TO ME?

This is the nub of the issue: What liability would I incur if I do notify law enforcement, or – for that matter – the identified victim, or file for civil commitment?

This is a great deal of fear – as well as misinformation about this matter. Let us – very briefly – unpack each issue, starting with notification of a third party.

THIRD PARTY WARNINGS

In Texas, because there is no legal duty to warn a third-party, possible victim of a patient's aggressive acts, such a warning would constitute a breach of confidentiality. Ethically, however, could you live with yourself if you failed to warn a person whom you had reason to believe would be a victim, and that person was injured or lost their life? Would you not rather face a board complaint for breaching confidentiality, or even a lawsuit, than deal with the knowledge that you failed to act and loss of life resulted?

1 There is a plethora of case law on this topic of duty to third parties, which cannot be reviewed in this brief note, *Tarasoff v. Regents of Univ. of Cal.*, 551 P.2d 334, 345-47, (Cal.1976), *Currie v. United States*, 644 F. Supp. 1074 (M.D.N.C. 1986), *Bird v W.C.W.* 868 SW.2d 767 (Tex. 1994), *Van Horn v. Chambers*, 970 S.W.2d 542 (Tex. 1998).

So, yes, you might face some action. On the other hand, the likelihood of such is not great if the actor were arrested because of his/her threat.

NOTIFYING MEDICAL OR LAW ENFORCEMENT AUTHORITIES

In this case the consequences are essentially nil. It is true that a person could be sued for almost anything, even if there is a statute authorizing the conduct, stating that the professional is immune from liability. But, contrary to popular belief, such a statute, if existing would not protect the professional from a complaint or suit, but both would be likely dismissed – not quickly, never quickly, but nonetheless, likely.

It may be helpful to note what it takes for some person to recover damages from a professional:

» You must have a duty.
» You must have breached that duty.
» And because of your breach there must be demonstrable damages.

In the case of notifying medical or law enforcement authorities, the law clearly states that your acts are permitted, as the text reads that you may disclose confidential information "to medical or law enforcement personnel if the professional determines that there is a probability of imminent physical injury by the patient to the patient or others, or there is a probability of immediate mental or emotional injury to the patient."[2] Note that "imminent" is not defined and trades on common definitions.

But how about liability? It was earlier pointed out that a complaint or suit must be predicated upon a breach of duty and in this case the Health and Safety Code's language is that there is an exception to the duty to maintain confidentiality, i.e., no duty exists which would justify a complaint or suit when the above conditions are met.

So back to stage one: could you be sued, or could a complaint be filed? Of course, but that is always the case – in any circumstance, it is – but such a complaint or suit would in all likelihood be rapidly dismissed. You would be called upon to justify your actions, but upon so doing, you would prevail as a matter of law. And, with regard to civil commitment, there is immunity for good faith filings.[3]

CONCLUSION

More than 500 years ago, Martin Luther wrote, "Sin bravely!" Whatever you do, act in a fashion consistent with your conscience and what you understand the law to be, and let the chips fall as they may. In the case, however, when it comes to notifying medical or law enforcement authorities of the likelihood of imminent harm, the law specifically permits such notification and it would be difficult for any complaint or suit to prevail – when the law is so very specific. ■

2 Tex. Health & Safety Code §611.004(2).

3 See Tex. Health & Safety Code §571.019ff.

Forensic Issues

Legal Terms Are Sometimes Not Well Defined

Floyd L. Jennings, J.D., Ph.D., ABPP

Legal terms are sometimes not well defined, and it may come as a shock to many that statues are also not well crafted. This is the case despite the fact that lawyers, in general, are extremely concerned about nuances in language.

In the following, we will look at "competency" not in the criminal sense but in the civil sense – this note having been spawned by an excellent survey article in *Texas Psychologist*'s winter issue by Geri Maria Harris, Ph.D., and Gerald E. Harris, Ph.D., entitled "Assessing Elder Civil Competency." A good article is one that stimulates thinking, and this article did precisely that; for I found myself wondering how the term "competency" is used in Texas civil statutes.

I discovered that – with regard to civil proceedings, and excepting only witness competency – psychologists would be more precise were we to talk about "capacity," leaving "competency" to the criminal side of the house.

This note will focus upon the use of the term "competency" in the Texas Estates Code and the Rules of Evidence, with attendant implications.

THE DATA

The table on the following page summarizes all occasions in which "competency" or "competent" appears in the Texas Estates Codes (citations omitted).

In sum, there are only 32 such occasions in the Estates Code – some 22 of which trade on the "usual and customary use" of the term competency, e.g. a court of competent jurisdiction – simply meaning the court has the legal authority to hear a dispute or do a specific act. Three occasions refer to competency to make an oath, one to make a will, one to administer an estate, one referring to mental competency regarding

legal matters, one referring to suitability to be a guardian, one to a competent tribunal (relating to a foreign court), and one to competent legal advice. In no case is the legal standard clearly defined in the statute itself! One additional set of standards are the Texas Rules of Evidence, which speak to the "competency of a witness."

THE LEGAL STANDARDS

WILLS AND TESTAMENTARY CAPACITY

Psychologists conducting evaluations to be used, or potentially used, in a legal proceeding, may experience some consternation that the standards for offering a reasoned opinion to a court may not at all be clear. For example, Tex. Estates Code §251.001 states that a person of sound mind who is 18 years of age or older, is or has been married, or is a member of the U.S. armed forces, or Maritime Service, may execute a will. "Competency" is not a term that is utilized save in passing, and that in 251.002. Rather, the standard is to be found in case law and refers to "testamentary capacity" and not "competency" per se. Consequently, I argue that "competency" or "competent" should be rarely utilized in civil proceedings, where a more precise term is available.

"Testamentary capacity means possession of sufficient mental ability at the time of execution of the will, (1) to understand the business in which the testatrix is engaged, the effect of making the will, and the general nature and extent of her property, (2) to know the testatrix's next of kin and the natural objects of her bounty, and (3) to have sufficient memory to assimilate the elements of the business to be transacted, to hold those elements long enough to perceive their obvious relation to each other, and to form a reasonable judgment as to them."[1] The *Harris* article nicely outlines the ethic and procedures for such evaluation; herein is merely the language of the standard.

And, were the psychologist asked to opine on the mental state of the testator or testatrix with an eye toward undue influence, the standard "has three elements: (1) an influence existed and was exerted, (2) the exertion of the influence subverted or overpowered the mind of the testator at the time she signed the will, and (3) the testator would not have made the will but for the influence. See *Rothermel v. Duncan*, 369 S.W.2d 917, 922 (Tex. 1963); In re Estate of Woods, 542 S.W.2d 845, 847 (Tex. 1976); *Guthrie v. Suiter*, 934 S.W.2d 820, 831 (Tex. App.—Houston [1st Dist.] 1996, no writ). To satisfy the first element, the party contesting a will must show that an influence existed and was exerted."[2]

GUARDIANSHIPS

As well, the capacity of a proposed ward in a guardianship proceed is best described simply as "capacity" and not as "incompe-

1 *Guthrie v. Suiter*, 934 S.W.2d 820 (Tex. App. – Houston [1st Dist] 1996, no writ), see also *Prather v. McClelland*, 76 Tex. 574, 13 S.W. 543, 546 (Tex. 1890); *Hoffman v. Texas Commerce Bank, N.A.*, 846 S.W.2d 336, 340 (Tex. App. – Houston [14th Dist.] 1992, writ denied).

2 *Yost v. Fails*, 2017 Tex. App., 534 S.W.3d 517 (Tex. App. – Houston [1st Dist.] 2017)

USE OF THE TERM "COMPETENT" IN TEXAS ESTATES CODE

TX ESTATES CODE	FREQUENCY	USAGE
34.002	2	Court of competent jurisdiction
51.051	1	Competent to make an oath
112.103	2	Competent to make an oath
123.151	1	Court of competent jurisdiction
251.002	1	Competent to make a will
252.204	1	Court of competent jurisdiction
305.102	1	Competent person (to administer an estate)
309.057	1	Court of competent jurisdiction
309.0575	1	Court of competent jurisdiction
355.101	1	Court of competent jurisdiction
356.599	1	Court of competent jurisdiction
359.101	1	Court of competent jurisdiction
360.303	1	Court of competent jurisdiction
362.052	1	Court of competent jurisdiction
505.052	1	Court of competent jurisdiction
505.101	1	Competent tribunal1
551.102	1	Court of competent jurisdiction
751.203	1	Mentally competent (to transact legal matters)2
752.051	1	Obtain competent legal advice
1002.022	1	Court of competent jurisdiction
1022.008	1	Court of competent jurisdiction
1051.051	1	Competent to make an oath
1104.054	1	Suitable and competent3
1105.103	1	Competent person (to serve as guardian)
1157.10	1	Court of competent jurisdiction
1168.599	1	Court of competent jurisdiction
1204.202	1	Court of competent jurisdiction
1252.051	1	Court of competent jurisdiction
1353.103	1	Court of competent jurisdiction
1355.002	1	Court of competent jurisdiction

1 Appertaining to a foreign juridical entity.

2 Appertaining to the language of a Durable Power of Attorney, presented by an agent, who certifies that the principal (person executing the instrument) is "mentally competent to transact legal matters and not acting under undue influence."

3 Relating to the selection of a guardian, by a child 12 years of age or older.

tency" because *Koehler v. State*, 830 S.W.2d 665 (Tex. App. – San Antonio 1992) held that incapacity as relates to guardianship and incompetency in criminal proceedings are entirely different proceedings such that findings in either case have no bearing on the other. For clarity's sake it would be far better had the legislature acknowledged such by using terms of "incapacity" in the one case and "incompetency" in the other.

The legal standard for guardianship is twofold – the standard for appointment (or disqualification) and the standard to establish a guardianship. In the interests of space, I will focus upon the latter, save only to say that appointment is intensely fact based.[3] A person may require a guardian either of his person or estate, or both.

"Before appointing a guardian, the court must find by clear and convincing evidence (1) the proposed ward is an incapacitated person, (2) it is in the best interest of the ward to have the court appoint a guardian, and (3) the rights of the ward or the ward's property will be protected by the appointment of a guardian. Tex. Prob. Code Ann. § 684(a). An incapacitated person is defined, in part, as an adult individual who, because of a physical or mental condition, is substantially unable to provide food, clothing, or shelter for himself or herself, to care for the individual's own physical health, or to manage the individual's own financial affairs. Tex. Prob. Code Ann. § 601(14)(B)(Supp. 2011). The court must find by a preponderance of the evidence that the ward is totally without capacity as provided by the code, or lacks the capacity to do some, but not all, of the tasks necessary to care for himself or herself or to manage the individual's property. Tex. Prob. Code Ann. § 684(b)(4). The court may not grant an application to create a guardianship for such an adult proposed ward if applicant fails to prove incapacity by evidence of recurring acts or occurrences within the preceding six-month period and not by isolated instances of negligence or bad judgment. Tex. Prob. Code Ann. § 684(c)."[4]

WITNESS COMPETENCY

This issue (both civil and criminal) employs the term "competency." The rule concerning witness testimony is Tex.R.Evid. 601, which states in part that every person is competent to be a witness; exceptions (that is, those who are incompetent to be a witness) include "insane persons," who are defined as "in an insane condition of mind at the time when they are offered as a witness, or who, in the opinion of the court, were in that condition when the events happened of which they are called to testify."[5]

While most of the case law applying this rule deals with the competency of a child witness, it sets the parameters within which the rule has been applied. The courts have ruled that Rule 601 creates a presumption that a person is competent to testify. Courts have further held that the party objecting to a witness's competency has the burden of proving incompetency.[6]

However, the meaning of the term "insane person" is not self-evident. It is an arcane term, not used in the Probate Code or the Mental Health Code. Nor is the term commonly used in psychiatry or psychology, as it is not part of common diagnostic vernacular. Its meaning is more discernible in case law: *Freeman v. Am. Motorists Ins. Co.* states, "Generally, persons of unsound mind and insane persons are synonymous. The term 'unsound mind' refers to a legal disability, although it is not limited to persons who are adjudicated incompetent."[7]

It is reasonable to argue, then, given the presumption of competency, that all witnesses are of sound mind – that is, not "insane"– unless found so by a court, and even then, the incapacity is narrowly related to the issue before the court.

The standard for witness competency is discussed more specifically in *Watson v. State*, where the court stated that witness competency has three components, plus an additional one that is presumed: perception, recollection, communication/narration, and truthfulness.[8]

Perception refers to whether the witness had the ability to intelligently observe the events in question at the time of their occurrence. Recollection refers to whether the witness has sufficient present capacity to recall those events accurately. Communication/narration refers to whether the witness has the capacity to communicate, either through narration or other means, his recollections, and truthfulness means whether the witness understands the meaning of the oath and truth-telling. Note, however, that the "truthfulness" component goes to credibility if it goes beyond the mere awareness of a moral obligation to give truthful testimony. ■

3 Under the estates code, a person may not be appointed guardian if she, because of inexperience, lack of education, or "other good reason," is incapable of properly and prudently managing and controlling the person or estate of the ward. Tex. Est. Code Ann. § 1104.351(2) (West 2014). Likewise, a person may not be appointed guardian if she is "found by the court to be unsuitable." *Id.* § 1104.352 (West 2014); *In re Guardianship of Rombough*, No. 02-11-00181-CV, 2012 Tex. App. LEXIS 3716, 2012 WL 1624027, at *6 (Tex. App. – Fort Worth May 10, 2012

4 *In re Guardianship of Winn*, 372 S.W.3d 291 (Tex. App. – Dallas 1992)

5 *Reyna v. State*, 797 S.W.2d 189 191 (Tex. App—Corpus Christi 1990, no writ)

6 *Foster v. State*, 155 S.W.2d 938, 940 (Tex. Crim. App. 1941), compare Tex.. Code Crim. Proc. Ch. 46B

7 *Freeman v. Am. Motorists Ins. Co.* 53 S.W.3d 710, 713 (Tex. App.—Houston [1st Dist.] 2001, no writ)

8 *Watson v. State*, 596 S.W.2d 867, 870-871, (Tex. Crim. App. 1980)

USAGE	FREQUENCY
Court of competent jurisdiction	22
Competent to make an oath	3
Competent to make a will	1
Competent person (to administer estate)	1
Competent – mentally (viz. legal matters)	1
Competent & suitable (to be guardian)	2 (to selected by minor & to be appointed)
Competent tribunal	1 (relating to foreign juridical entity)
Competent legal advice	1

Truth or Scare? Setting the Record Straight on Sports and Sex Trafficking

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Kirby Reutter, Ph.D., Licensed Psychologist
Gateway Woods Family Services

The media have sensationalized claims of dramatic spikes in human trafficking activity during major athletic events (such as the Olympics), perhaps to the point of "urban legend." Research suggests that labor trafficking may experience dramatic increments in some parts of the world, but studies have not yet corroborated similar claims for spikes in the sex trade.

This article posits a middle path between dramatic upswings in the sex trade versus no increases at all. Research suggests that rates of general crime do indeed experience modest to moderate increments on "game day," including both violent and financially motivated forms of criminal behavior. Since the sex trade is both violent and financially motivated, it seems reasonable to presume that this particular form of crime also experiences modest to moderate increments during major sporting events.

However, victims of general crime are much more likely to report criminal acts than are the victims of human trafficking, leading to the chronic problem of underreporting in the sex trade, which researchers seem to universally lament.

Regardless, the problem of human trafficking (for both labor and sex) is – at its baseline – already ubiquitous, already epidemic, and already year-round. Therefore, sensationalizing inaccurate claims of dramatic spikes in only certain locations at certain times may deleteriously serve to deflect attention away from the true magnitude of this problem the rest of the year.

SPORTS & TRAFFICKING: TRUTH OR SCARE?

We all know that motor vehicle traffic is a massive problem whenever a big game comes to town. But what about human trafficking? It has become a widely held belief that major sporting events provide irresistible temptations for money-hungry gangs and traffickers who transport large numbers of vulnerable persons to the region for the purposes of sexual exploitation, often with estimates well into the tens of thousands of trafficked individuals.

The recent Winter Olympics once again brought stories of North Korean cheerleaders moonlighting as sex slaves, known colloquially as the "Pleasure Squad" (O'Neill, 2018). In further support of these allegations, some sources claim that during the 2004 Olympics in Athens, the sex trade exploded, exceeding the normal rates by 95% (Ridley, 2016). Similar sources had predicted that the 2010 World Cup in South Africa would garner an extra 40,000 trafficked sex slaves (Skoch, 2010).

In spite of widespread media attention and sensational projections, the empirical data thus far have not corroborated these claims. In the case of Athens, the numbers seem to be misrepresented. Greece reported 93 instances of trafficking in 2003 compared with 181 in 2004, but these were annual statistics, and none of the cases were linked specifically to the Olympic Games themselves. This apparent spike could also be attributed to improved awareness of and attention to the issue, improved methods of identifying victims, and/or improved reporting on the part of the Grecian authorities (GAATW, 2011). A few years later in Germany, estimates in the range of 30,000–60,000 trafficked individuals were anticipated to arrive in time for the 2006 World Cup (Milivojevi & Pickering, 2008). However, a review of this period indicates that only 33 cases of trafficking were investigated. Of these instances, only five cases of trafficked individuals were identified as directly linked to the World Cup itself (German Delegation, 2007).

Another study reviewed rates of trafficking in Vancouver following the 2010 Olympics, but once again the researchers failed to document evidence of new or trafficked sex workers in the period of the Olympic Games. However, this study did note significant changes in patterns of safety as well as the risk of HIV or other sexually transmitted diseases. The researchers attributed these shifts to increased police surveillance during this time period, which drove the sex workers into "off-street" venues, thus increasing the likelihood of violence and vulnerability (Deering, et al., 2011).

South Africa also braced itself for the projected forecast of tens of thousands of human trafficking victims in anticipation of the 2010 FIFA World Cup (Skoch, 2010). Researchers noted slight (but not statistically significant) increments in overall online sexual advertisements, as well as a small yet statistically significant increase in the number of foreign sex workers throughout this time period. Regardless, researchers

once again failed to document evidence for the magnitude of the original projections (Delva, et al., 2011).

However, sex trafficking is clearly not the only concern when it comes to mega sporting events. Reports indicate an influx of thousands of migrant workers who arrived in Sochi from Armenia, Kyrgyzstan, Serbia, Tajikistan, Uzbekistan, and Ukraine in preparation for the 2014 Winter Olympics. According to Hepburn (2017), these workers were forced to work inhumane hours for no more than $2.60 per hour. To make matters worse, these wages were often significantly delayed or sometimes never dispersed at all. Russian authorities admitted to upwards of $8 million of unpaid labor associated with the 2014 Sochi games, and requested that companies pay out their dividends. Tragically, however, these measures arrived too late: By then, many of the workers had been detained or deported, making it unlikely that they would ever receive their pay (Hepburn, 2017; Rocco, 2014). Three thousand kilometers to the south, Qatar is already producing reports of labor trafficking, as preparations are underway for the 2022 World Cup in Doha. Critics are calling for FIFA to regulate this work more stringently, but thus far no significant changes have been implemented (Amnesty International, 2016).

For all the media attention directed at mega-event sex trafficking, there is remarkably little evidence to support a dramatic upswing in activity. Empirical data is still lacking from Rio de Janiero, host of the 2016 Summer Olympics, as well as from the 2014 FIFA World Cup, which was also hosted by Brazil. As usual, speculation arose surrounding the potential for increased sexual exploitation around this time, especially considering the nation's pervasive problems with poverty and childhood sexual exploitation in general. Concerns also circulated regarding the increased risk for displaced and separated families in light of the high risk of labor trafficking for construction projects (Hazeau & van Kranen, 2014).

Admittedly, trafficking numbers are difficult to estimate. Following the 2012 London Olympics, a Met Police spokesperson stated that she did not believe that there was an increase in trafficking during the event, but admitted that this problem was "difficult to measure" due to the covert manner in which victims are exploited. In addition, coercion tactics often leave the victims confused about whether they are being trafficked or if their experiences are even out of the ordinary (Mollins, 2012).

Notably, this same spokesperson proceeded to posit that trafficking as a whole is quite rare (Mollins, 2012.) Tragically, this is where the data are no longer in her favor. As one example to the contrary, a recent University of Texas study estimates that there are nearly 79,000 minors involved in sex trafficking in Texas alone, and another 234,000 involved in labor trafficking in the same state (Busch-Armendariz, et al., 2016).

Let's be clear: The problem of human trafficking is already epidemic. However, there seems to be a disconnect between anecdotal speculations of massive spikes in human trafficking during major athletic events versus the actual empirical evidence. There are several possible interpretations for this incongruence. One possibility is that the anecdotal fears are correct, but the researchers are not. In other words, there really are dramatic spikes in trafficking, but the underground nature of this activity continues to elude empirical scrutiny. Another possibility is that the researchers are right, while the anecdotal fears are completely unjustified. In other words, there is absolutely no rise in human trafficking during these events.

However, there might be yet another explanation that has not yet been considered in the literature. Based on our own clinical experience and intuition, we would like to posit a third possibility: perhaps there are indeed modest to moderate increments in illicit sexual activity during large-scale athletic events, but perhaps these increases still fly under the radar – as does most of the industry, for that matter. Here's our logic: whenever there are more humans congregated in a single metropolitan locale, it only stands to reason that there will be more crime in general.

Not surprisingly, research suggests that general crime does indeed increase modestly or moderately during major athletic events. For example, Campaniello (2011) found that "hosting the Football World Cup leads to a significant increase" in both personal and violent crime (p. 2). It is fascinating to note that the same researcher, after documenting a "significant increase" in crime in general, proceeds to state: "The crimes of drugs and prostitution are extremely difficult to measure in official statistics" (p. 14), suggesting that certain forms of crime may be harder to detect than others. More recently, Kalist and Lee (2014) studied daily crime rates in eight large cities with NFL teams by comparing criminal activities on game day versus nongame days. These researchers reported a 2.6 percent increase in total crimes on game days, with increments in financially motivated crimes ranging from 4.1 and 6.7 percent.

It should not come as a surprise that an increased concentration of people in conjunction with heightened arousal would result in higher rates of criminal behavioral. Therefore, if crime in general increases during congregations of hyper-aroused masses, it follows logically that illicit sexuality would also increase as one aspect of the overall crime. The previous two studies indicate modest to moderate increments in both violent and financially motivated crimes during major athletic events. Human trafficking is both violent and financially motivated. Therefore, it seems reasonable to presume that human trafficking would also experience modest to moderate increases on "game day." However, whereas other crime victims tend to involve free citizens who are likely to report the crimes, this luxury does not seem to extend to the victims of human trafficking! Hence the problem of under-reporting.

Even if this hypothesis is correct, the current research still seems to indicate that the magnitude of dramatic spikes in human trafficking on "game day" have been sensationalized beyond accuracy. In the end, sensationalizing the magnitude of these spikes during certain events may actually hurt (rather than help) the battle to combat this problem. Human trafficking is clearly a worldwide epidemic that occurs year-round. As previously noted, the University of Texas estimates that 79,000 minors are being sexually trafficked in the state of Texas alone. In the U.S. as elsewhere, human trafficking disproportionately affects the most vulnerable populations: foster

kids, runaways, homeless, and the abused (Busch-Armendariz, et al., 2016). To only focus on this problem at certain times of the year may serve to deflect attention away from the same problem throughout the rest of the year. Analogously, Christian pastors frequently begrudge the spike in Christian fervor during Christmas and Easter. Of course, they are not actually lamenting the increased focus on those two days; rather, they are lamenting the lack of focus on all the other days. Giving undue attention to the problem of human trafficking only at the Super Bowl or World Cup may have the same effect.

Vulnerable populations are ubiquitous, and current estimates are universally limited by laws and policies, reporting rates and methods, reliance on self-reporting surveys, and difficulty in identifying victims of an often misunderstood and underreported crime (Farrell & Reichert, 2017). While it may be good news that no robust causal relationship has yet emerged between increased sex trafficking and major athletic events, the risk for trafficking amongst the most vulnerable populations is far too high, even on a "normal" day. Perhaps American foster youth and the "cheerleaders" of North Korea may have something to teach in this regard. After all, North Korean cheerleaders still need to return to "work," long after the Olympics have ended. ■

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KEYNOTE

Alan L. Peterson, Ph.D., ABPP

Enhancing Psychological Resiliency after Trauma Exposure

Dr. Peterson retired from the U.S. Air Force in 2005 after 21 years of active duty including service as the Chair of the Department of Psychology and the Director of the American Psychological Association-accredited Clinical Health Psychology Postdoctoral Fellowship Program at Wilford Hall Medical Center.

While on active duty he deployed in support of Operation Noble Eagle, Operation Enduring Freedom, and Operation Iraqi Freedom.

Dr. Peterson has clinical and research experience in the areas of behavioral medicine, clinical health psychology, and combat-related stress disorders. He has conducted research in the areas of post-traumatic stress disorder (PTSD), psychological risk and resiliency, Tourette Syndrome, tobacco cessation, pain management, insomnia, weight management, and managing suicidal behaviors.

He is also Research Health Scientist at the South Texas Veterans Health Care System in San Antonio and a Professor in the Department of Psychology at the University of Texas at San Antonio where he teaches and mentors doctoral students in the Ph.D. program in Military Health Psychology.

Dr Peterson is an avid ultra-endurance trail runner.

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KEYNOTE

Rosie Phillips Davis, Ph.D., ABPP

Persisting in the Face of Poverty

Rosie Phillips Davis, Ph.D. ABPP, is former Vice President for Student Affairs and current Professor of Counseling Psychology at the University of Memphis. She earned a doctorate in Counseling Psychology from The Ohio State University. Her primary practical and scholarly passions are the power of inclusion, multicultural vocational psychology, ethics, and living well in a diverse society. She currently serves on the American Psychological Association Finance Committee and the American Psychological Foundation Board.

She previously served on the APA Board of Directors, The Council of Representatives for Divisions 1 and 17, and is past President of the Society of Counseling Psychology (17). She has served on the editorial boards of several journals, including current service on the Journal of Career Assessment, and is the author of numerous articles and book chapters on career counseling and has co-edited two books.

Her awards include the Janet E. Helms Award for Mentoring and Scholarship, the Authur S. Holman Lifetime Achievement Award, the Charles and Shirley Thomas Award (Division 45, 2004), the Dalmas A. Taylor Award, the National Multicultural Conference Certificate of Appreciation (2007), the APA Society for the Psychological Study of Lesbian, Gay, and Bisexual Issues (2007). Dr. Bingham has received an APA Presidential Citation, was named an Elder by the National Multicultural Conference and Summit and received the Distinguished Professional Contributions to Institutional Practice for APA Award, 2015.

Dr. Davis, along with Drs. Lisa Porche-Burke, Derald Wing Sue, and Melba Vasquez is a founder of the National Multicultural Conference and Summit.

KEYNOTE

Christine Runyan, Ph.D.

Leveraging The Tend-and-Befriend Response to Manage Cumulative Secondary Stress in Professional Practice

Dr. Runyan is the director and primary clinical supervisor of the Primary Care Psychology Fellowship at University of Massachusetts Medical School. She joined the faculty as Associate Director of Behavioral Science and is the Behavioral Science Director for the Worcester Family Medicine Residency. She has extensive experience in health psychology in primary care. She has been a leader in developing integrated primary care in the Air Force and has experience in teaching and academic leadership in health psychology graduate training.

Her primary clinical interests are in the role of trauma in primary care and physician wellness, including teaching mindfulness based skills to residents.

INVITED

Beth Rom-Rymer, Ph.D.

First Person – Prescribing Psychologists: Who We Are, What We Do, and How We Are Changing the World

Dr. Rom-Rymer received her undergraduate degree in psychology from Princeton University in 1973, as a member of the first class of women there. She received her M.A. and Ph.D. in clinical psychology from The University of Illinois, with an emphasis on community organization and gerontology. Dr. Rom-Rymer did her internship training at The Vanderbilt University Medical Center, where she did rotations in the transsexual diagnostic surgical center as well as with the Metropolitan Police Department, working with adult and child survivors of sexual assault.

Dr. Rom-Rymer currently has a national consulting practice in forensics, working as a forensic expert witness in civil litigation in which there are allegations of sexual abuse and physical abuse, sexual and physical harassment, and other forms of violence: in nursing homes, in the context of child custody litigation, in the workplace, and on pleasure cruises. She has helped to create the field of forensic geriatrics and has published multiple articles in this area. Dr. Rom-Rymer is on the editorial board of the Journal of Child and Adolescent Trauma. She has recently been appointed co-chair of the Division 56 (Trauma) Inter-divisional Task Force on Ethical Practice with Traumatized Populations in Forensic Cases.

One of Dr. Rom-Rymer's passions is expanding the scope of practice for psychologists. She is currently working nationally to create training and practice opportunities for prescribing psychologists in public service venues: state hospital systems, federal and state prisons, military bases, and Indian reservations. Dr. Rom-Rymer was co-chair of a mini-conference at APA San Diego 2010 in which the partnership between Prescribing Medical Psychologists and the Indian Health Service was celebrated with symposia and a cultural hour of tribal performance. Dr. Rom-Rymer continues to work with Indian tribal representatives and the Federal Indian Health Service (IHS) to expand mental health services for Native Americans and to provide broader opportunities for practice for psychologists.

INVITED

Lisa Blue Baron, Ph.D., J.D.

How to Communicate to a Modern Jury: The Pitfalls of Being a Psychologist in Court

As partner with her late husband Fred Baron is one of the largest environmental law firm in the U.S., Blue's accomplishments have been nationally recognized. She has been named one of the Top 100 Most Influential Lawyers in America, one of the Top 50 Women Litigators in the U.S. by National Law Journal, and received numerous other state and national recognitions for her legal expertise. She served as president of the American Association for Justice from 2014-2015 and was inducted into the National Trial Lawyer Hall of Fame In 2015.

Blue received her undergraduate degree from the University of Georgia and two master's degrees from the University of Virginia in Counseling Psychology. After a brief teaching career, she returned to school and earned a Ph.D. in Counseling Psychology from North Texas State University and a Juris Doctorate from the South Texas College of Law.

After completing law school, Blue joined the Dallas County District Attorney's office where she prosecuted more than 125 cases to verdict and later advanced to the DA's Organized Crime Division. In 1985, she moved to the law firm Baron & Budd where she specialized in environmental and toxic tort law. Lisa and her husband, Fred Baron, supervised 800+ employees and managed all financial aspects at Baron & Budd, the largest environmental law firm in the United States.

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Beth N. Rom-Rymer, Ph.D.
Lisa Blue Baron, Ph.D., J.D.

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