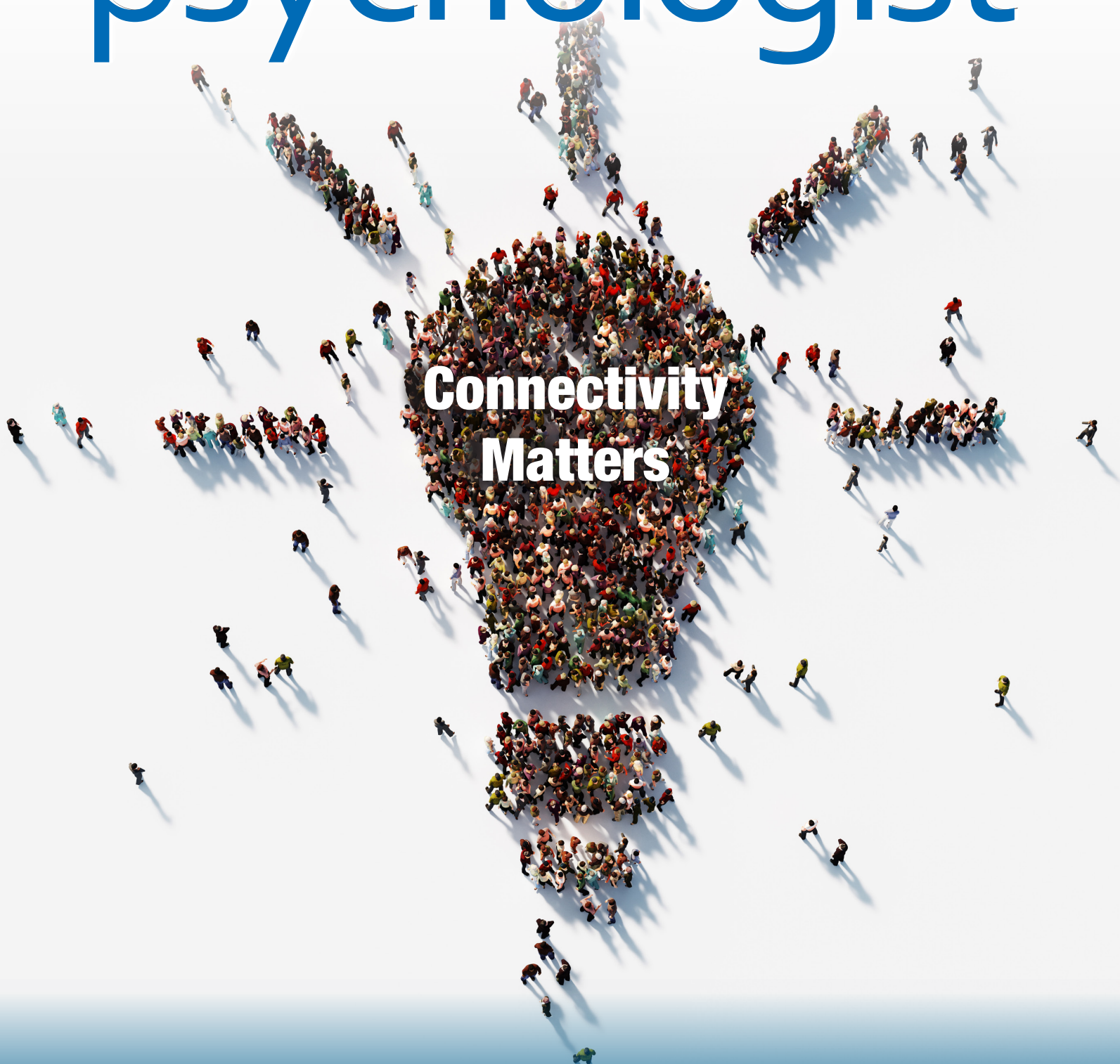




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# psychologist



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## A NOTE FROM THE PRESIDENT

# Connectivity Matters

**ALICE ANN HOLLAND, PHD, ABPP**

Children's Medical Center Dallas / UT Southwestern Medical Center, Dallas, TX

### CONNECTIVITY AT CONVENTION

**G**reetings once again! It was a pleasure connecting with many of you who attended the Annual Convention. There was a fantastic lineup of keynote speakers and workshops from experts spanning a wide range of topics. I want to give a special thanks to Dr. Bryan Kolb, one of the most famous names in neuropsychology as a pioneer of that field, who took a long drive and two flights to get from his home in the mountains outside of Lethbridge, Canada all the way to San Antonio, Texas and also kindly declined to accept any speaking fee. His research-based talk on social justice issues related to brain development was a fascinating illustration of how we can (and should) apply research to both clinical practice and social policies. I also was so impressed by how many of you embraced the Halloween spirit and showed up in costume to the Texas Psychological Foundation's hilariously fun evening event and fundraiser. It was such a festive time on the Riverwalk!

### REACHING OUT TO RESEARCHERS

Just as we as individual clinicians seek out continuing education to stay up-to-date on research to guide our clinical work, it is imperative for every professional psychological organization to base all actions on scientific knowledge. For this reason, at the start of my term as TPA President this year, I created TPA's first-ever Science Committee to provide consultation and support to the TPA Board and our other committees with respect to public statements, legislative advocacy work, and any other formal position/vote under

consideration by the TPA Board. I'm also pleased to announce that at our meeting in April, the Board of Trustees approved the creation of a new membership category: Psychological Researcher. This membership category is intended for career academicians who have obtained a doctoral degree in psychological sciences and/or neuroscience and are not licensed to practice as a psychologist.

We recognize that this is just the first step toward making TPA more of a home for basic science researchers and academicians,

**It is imperative for every professional psychological organization to base all actions on scientific knowledge..I'm also pleased to announce..the creation of a new membership category: Psychological Researcher.**

whose needs TPA has not served well historically. As we grow this aspect of TPA, please help us spread the word to any colleagues who may be eligible for this new membership category!

### ADMINISTRATIVE UPDATES

I hope you all read my email update on June 27 regarding the TPA Board of Trustees' vote to retain Evolve Advocacy, an association-focused consulting firm, to assist with strategic management of TPA and to help us secure a new Executive Director during this transition period. Evolve Advocacy's assessment of TPA internal operations has been eye-opening and is already guiding TPA toward a stronger future.

Regarding the hiring of a new Executive Director, we are making significant progress on that front. With the help of Evolve Advocacy together with recruitment emails sent to all TPA members on May 8 and June 27, we received applications from 33 impressive candidates. Our Search Committee has been hard at work reviewing applications and conducting interviews via video conferencing. The full Board will interview our top candidate(s), and our new Executive Director will be selected by full Board vote. We are hoping to have secured a new Executive Director by the end of 2019 and will keep you all updated on this front.

### IN CLOSING

Even in the wake of a disappointing Sunset outcome, I have great optimism for the future of TPA and the profession of psychology in Texas. Your TPA leaders are already working hard to ensure that the practice of psychology in Texas continues to grow and flourish. With the guidance of the Evolve Advocacy team, we are building TPA into a stronger, more effective organization that will be well equipped not just to overcome any future challenges but also to take on exciting new initiatives that will promote the future of psychology and mental healthcare in Texas.





# From the Editor's Desk

JENNIFER ROCKETT, PHD  
Private Practice, Bryan, TX

Colleagues,

The Summer has been long and hot, as per usual here in Texas. With the heat, there have been many changes this year at TPA. I hope the change will breathe new life and excitement in our identity as psychologists in Texas. We have faced many challenges over the last several years, and many more are likely on their way, while some challenges remain.

For instance, many testing psychologists who accept insurance, are struggling with the new testing code procedures. Thus, I would like to make a special call-out to those of you who have been successful in getting reimbursed for your testing services. I would love for you to collaborate and submit a particular article for the Fall issue talking about how you have been successful. While APA published a "how-to,"

many psychologists have still not been successful in obtaining reimbursement for their services.

In closing, as you are basking in the sun and looking forward to cooler weather, I hope you enjoy the articles I've chosen for the issue. I will look forward to seeing some scary, weird/quirky, and funny costumes at Convention!

Jennifer

*Continued from page 2*

It has been a privilege to serve as your President this year, and I know TPA will be in excellent hands under the leadership of Dr. Megan Mooney next year. Although my remaining time as President is short, as I have said in my past two columns, please contact me at any point with feedback, suggestions, or questions: [TPAPresident2019@gmail.com](mailto:TPAPresident2019@gmail.com). I will remain on the TPA Executive Committee through 2020, and I would love to hear from you at any time.

I want to leave you with one final reminder: TPA is your state organization. Make it yours! Join a Division, submit a workshop for Convention (Nov. 12-14, 2020 in Austin), ask about a committee appointment, attend a Legislative Day, participate in the Board elections process (even if just casting a vote)... and above all, remember that TPA leaders are charged to represent you, the members. All TPA Board members' emails are listed on the website every year. Let them know what's important to you and what your priorities are for TPA! Like neurons in the brain, we can accomplish so much more if we're all working together. ■

**TPA is your state organization. Make it yours! Join a Division, submit a workshop for Convention, ask about a committee appointment, attend a Legislative Day, participate in the Board elections process**

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## A NOTE FROM THE FOUNDATION

# TPF at TPA: A Convention Preview

**HEYWARD L. GREEN, PSYD**

Texas A&M Health Science Center and Baylor Scott & White Health

**T**PF is planning a more visible presence at the TPA Annual Convention in San Antonio this year. Please look for us in the lobby area and stop by to visit. There will be recognition of those persons who have become heroes, friends, and donors to TPF. When stopping by, you will have the opportunity to have your name join the others who are providing support for research and scholarship by students in Psychology and helping to advance information, public education, and innovation in our field. If you are not attending the convention, you can still be recognized for your support by visiting the Foundation page on the TPA website and selecting the Donations link.

### HALLOWEEN PARTY AT THE TPA CONVENTION

Our Board is excited with the opportunity to provide a stimulating and fun experience for convention attendees with a Halloween Party held on the first night of the 2019 Convention, October 31. We invite you—as well as any children who may be accompanying you—to join the festivities, enjoy some treats, and try your luck with games and other activities we think will be fun for both participants and those watching. We hope those attending will join us in the spirit of Halloween by wearing a costume. The party also is intended as a fundraising activity for TPF, and as such we will sponsor a silent auction and/or raffle for attendees. Awards will be presented for best costumes. Our vision is to provide an experience that promotes camaraderie and revelry among TPA members that also will spotlight TPF

and encourage financial support. Further details about the evening's activities will be coming via other means as well.

### SYMPOSIUM FOR GRADUATE STUDENTS AND ECPS

Comments received from current graduate students, as well as past and present interns familiar to us suggested who are completing training and are entering our field are well versed in knowledge of theory and techniques, but often experience a good deal of uncertainty and related anxiety about the day to day activities, pace, and other pragmatic aspects of psychological practice. Given that part of the TPF mission is to promote professional education in Psychology, we are focusing on that need.

At the 2019 TPA Convention, the Texas Psychological Foundation will present a symposium presenting information of particular relevance to graduate students in training to become psychologists. The presentation may also hold appeal for early career psychologists. Members of the symposium panel include Dr. Kelly Arnemann, Dr. Michael Ditsky, Dr. Bonny Gardner and Dr. Heyward Green who will address issues related to business of practice, ethics, professional relationships, cultivating referral sources, roles and settings for psychologists, community activities, maintaining personal balance and well-being, and more. We hope to create a highly user friendly, informative, and interactive experience for attendees.

The symposium will have a basic structure in which each panel member will present basic information about specific topics. Dr.

Arnemann will address evidence-based practice and work in the VA healthcare system. Dr. Ditsky will present on professional relationships, cultivating referral sources and forensic matters. Dr. Gardner will focus on a range of business of practice topics including office space, fee negotiation, insurance issues and specialization of services. Dr. Green will address community engagement, roles in different settings and self-care. We will encourage questions from attendees to generate further discussion of specific concerns and interests. Additionally, other members of the TPF Board of Trustees will be present and available to provide additional perspectives on topics that come up for discussion. Please consider joining us whether you are a graduate student or ECP with questions, or a seasoned clinician who might offer additional insights and perspective during discussion.

### AWARDS AND GRANT

As we do every year, TPF offers a grant and research awards to be presented at the TPA Convention. The offerings this year include the Roy Scrivner Gay/Lesbian/Bisexual Research Award, the Graduate Proposal Award, the Jennifer Ann Crecente Memorial Grant, and the Bo and Sally Family Psychology Research Award. This program is a fundamental part of what TPF does, and we strongly encourage application for these funds. More information about the specific focus and requirements of each grant or award, as well as the application process itself, can be found on the Foundation page on the TPA website. The application deadline is September 30, 2019. ■



# House Speaker Greg Bonnen & Empower Texans

Legal Kevin Stewart, Esq.  
TPA Legal Counsel

As I am sure many of you have heard by now, there is quite a bit of news coming out of the Texas House of Representatives. The controversy arose from a meeting that took place between House Speaker Greg Bonnen and a political activist named Michael Quinn Sullivan. Sullivan is the CEO of Empower Texans, a far-right political advocacy organization. Empower has long sought media credentials in the House for its media arm, the Texas Scorecard.

After the meeting took place, Sullivan claimed that Bonnen offered him media credentials in exchange for Empower targeting a list of ten republicans during their elections. Bonnen initially claimed that these allegations were false, at which point Sullivan claimed that he had recorded the whole meeting. Sullivan then allowed a few Representatives to listen to the tape, and they all corroborated Sullivan's account.

Bonnen has since apologized publicly for the fiasco, and is meeting with his fellow House members to smooth things over. Some have accepted his apology, but others have not. The House General Investigating Committee held a special meeting to discuss the issue, and ultimately referred the matter to the Texas Rangers for a more thorough investigation.

It is unclear at this point how the dust will settle. Bonnen had what many consider a successful session. He got his major initiatives passed, and he seemed to work well with Lt. Governor Patrick and Governor Abbott. But this, along with what could be a tough election cycle for the GOP, may lead to a shakeup before next session.

Even without a shakeup, we know some faces will be changing. On the federal level, Ted Poe (R-Houston), Sam Johnson (R-Richardson), Jeb Hensarling (R-Dallas), Joe Barton (R-Ennis), and Lamar Smith (R-San Antonio) have all announced that they will not be seeking reelection. Rest assured that a number of state legislators are eyeing those seats and calculating their chances.

We will keep you apprised of all of these developments and more as the interim progresses. In the coming months, we should also start getting some information on the formation of the Behavioral Health Executive Council, House and Senate Interim charges, and state and federal races. So stay tuned! ■



## Call for submissions

The *Texas Psychologist* is seeking submissions for upcoming issues.

We are seeking content in the following areas:

Independent Practice; Ethics; Multicultural Diversity; Forensic Issues; and Student and Early Career.

Collaborations with students are encouraged. 1000–2000 word count; APA Style.

Send to [drjenniferrockett@gmail.com](mailto:drjenniferrockett@gmail.com) by 1/6/2020 for the winter issue.



# Little Bits of Paper

By Elizabeth Richeson, Ph.D., M.S. PsyPharm  
 Advisory Board Chair, Jennifer Ann's Group  
 Beata Krembuszewski, BCJ  
 Graduate Student, Sam Houston State University

Where do you start an article when you feel as if your heart has been broken. I have called El Paso my home for more than 36 years and the recent shooting has destroyed the peace and serenity of the city. What makes the feeling more intense is knowing this story is way too common with a multitude of places suffering the same fate. As of this writing, there have been more than 2,000 mass shootings since Sandy Hook in 2012 and 306 mass shootings in 2019 alone (Gun Violence Archive, 2019).

The definition of “mass shooting” is not universally agreed upon. The definition used by the FBI is an act of violence committed with a firearm resulting in at least four deaths, not including the perpetrator, that occurs at the same time or over a relatively short period of time (Keeney & Heide, 1995). The FBI regularly chronicles active shooter incidents but because there is no set definition of a mass shooting, the data can appear different depending on the source. Mass shootings further fall into three categories: familicide mass shootings, felony-related mass shootings, and public mass shootings. Familicide shootings typically occur in a private residence and most of the victims are members of the offender's immediate or extended family. Felony-related mass shootings occur in the context of criminal activity, such as gang violence or robberies. Public mass shootings are shootings that occur in public areas, such as businesses, workplaces, or schools, and the shooting is not related to other criminal activity (Capellen & Gomez, 2015).

Typologies of mass shooters have also been identified and can be split into three categories: the autogenic shooter, the victim specific shooter, and the ideological shooter. The autogenic shooter is motiveless and attacks people due to disrupted internal processes. The victims of an autogenic shooter are often strangers, but they may be proxies symbolizing points of contention in the offender's life. The victim specific shooter is motivated by seeking revenge from one or more victims. This offender has clear targets in mind but once the shooting occurs, they may target other, unknown victims. Lastly, the ideological shooter is motivated by political or racist beliefs and attacks individuals who oppose their views (Osborne & Capellen, 2015).

Shootings noted took place primarily in venues in which the victims were not related to or known by the perpetrator. Interestingly, none of these account for “four or more” in the context of domestic violence. How many more incidents would there be if those were included?

The typical archetype of a mass shooter includes a Caucasian male in his late teens to early 20's, he is autogenic, and commits his crime in a public area (Fox, 2013). Recent research converges on offender gender, 96.1% of recent mass shooters have been male, but only 55.7% of them are Caucasian. Furthermore, 56.1% of recent mass shooters are categorized as being victim specific and are motivated by revenge (Osborne & Capellen, 2015). Between the years 2009-2016, in about half of the mass shootings, the offender's victims

included a current or previous intimate partner or family member (Everytown for Gun Safety, 2017; Huffington Post, 2015; Mayors Against Illegal Guns, 2013).

The mass shooting in El Paso is now considered one of the most deadly public shootings in the United States. But there is another side of this issue that has too often been ignored. The mass shooting in El Paso is unique because the shooter was not motivated by revenge and the shooting had no relation to domestic violence or dating abuse. The shooter was motivated by racist ideologies, targeting Mexican individuals (Hutchinson, Katersky, & Margolin, 2019).

The El Paso shooter's motivation has been described as “hatred and bigotry”, and it aligns with White Supremacist views. However, the other most deadly shootings were predominantly committed by men whose history included domestic violence and/or dating abuse or rejections (Brueck & Lebowitz, 2019).

Some have reported mass shootings as a mental health issue – or an issue related to violent video games. Brueck (2017) reports the United States has rates of mental health disorders equal to the rest of the world, but the percentage of Americans who are killed by guns is ten times higher than other advanced civilizations. Upon closer look, the relation between mental health and gun violence is not as strong as one might think. Between 2000-2015, only

42.9% of mass shooters were suspected of having a mental illness (Capellen & Gomez, 2017).





However, impulsivity and anger issues do not warrant a mental health disorder (Brueck, 2017). Regardless of the shooter's categorization, i.e. ideological, victim specific, or autogenic, all mass shooters share an experienced grievance and are suffering from a mental health issue or some type of generalized strain. The difference among them is the target of their grievance; autogenic shooters experienced internal grievances, victim specific shooters experienced a grievance with a specific person, and ideological shooters experienced a grievance with a certain group (Capellen & Anisin, 2018). Likewise, violent video game releases, popularity, and internet searches for violent video games were not correlated with incidents of mass violence (Markey, Markey, & French, 2015). While we can assume that there may be a peripheral issue of one or both of these, the predominate underpinning is pure aggression. These offenders are men (typically), ages 14 to 66, who are angry, and who have chosen to take out their aggressions in the most egregious ways.

Even though we do not concern ourselves as readily with those individual murders by boyfriends, ex-boyfriends, husbands and ex-husbands, crimes of domestic violence are still important. Scattered around my work station are little bits of paper with names of those victims; some of whose family members have contacted Jennifer Ann's Group for help, our resources, or just for consolation. I do not know how many little bits of paper I have collected in the 13 years I have worked on this issue, and I realize there is a part of me that does not want to know. I know there are too many.

My granddaughter was a murder victim at 18 when she was shot by an ex-boyfriend in Austin in 2006. The non-profit Jennifer Ann's Group is named after her and is run by her father who returned to school for a law degree to educate himself and be a better advocate regarding this issue. We believe that by educating our youth, we can create a future with a lower tolerance for abusive relationships and, in turn,

fewer aggressors. We need to end the mass shootings where they start: at the roots of dating and domestic abuse.

The use of video games, paradoxically, is one of our main "reach outs" to teens, teens and young adults. We discovered years ago that this is a preferred method of connecting with this group. With over 20 free-play educational video games covering a variety of topics that are hosted on our websites, we get more than 30,000 novel contacts per month from around the world.

This year we were chosen as finalists by Games for Change in New York in the category "Most Significant Impact" for our consent game Rispek Danis (Respect Dance) which was a transliteration of our consent game "How to Blobble Blobble." When we were contacted by Vanuatu, an island off the coast of New Zealand, to redesign our game to fit their cultural set, we were glad to do so. The game was translated to bislama, their native language, and the characters' dress and environment set in Vanuatu settings. Additionally, one of our video games has been set up for a "walk through" experience in Adelaide, Australia at their MOD museum.

While Jennifer Ann's Group is a small organization, we have great knowledge and a big heart. As we work diligently to end dating abuse and its associated mass shootings, we must begin to resolve the myriad of causative factors that give rise to this unacceptable display of aggression. We want to see the decrease in mass shootings, regardless of the motivation, and we want to see it now.

For more information and access to our free resources go to:  
[www.jenniferann.org](http://www.jenniferann.org)  
[www.JAGga.me](http://www.JAGga.me) #stopTDV ■

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## Online resources

Find resources for coping up with disasters (e.g., mass shootings, hurricanes) on our website: advice for how to talk to kids, a call for a public health approach to gun problems, managing traumatic stress after disasters, and more. [bit.ly/tpa-disaster-resources](http://bit.ly/tpa-disaster-resources)



# Vida Clinic's Innovative Approach to School Mental Health

Elizabeth P. Minne and Gregory Gorelik  
Austin, Texas

## VIDA CLINIC'S INNOVATIVE APPROACH TO SCHOOL MENTAL HEALTH

Vida Clinic's School Mental Health Clinics (SMHCs) provide intensive clinical services across K-12 grade school systems in Texas and are distinct from other programs or interventions offered on campus. The work of SMHCs is complementary to other school programs and we collaborate closely with school professionals such as counselors, administrators, nurses, and educators to coordinate care. Clinical services on campus give school staff the peace of mind that individuals in distress have access to the mental health care they need, which, in turn, helps students and families feel supported and satisfied. Vida Clinic's services contribute to the school district's Whole Child mission of supporting all aspects of the child's development, including mental health, in an inclusive educational process.

## VIDA CLINIC'S INCLUSIVE, ECOLOGICAL, MULTISYSTEMIC, MULTITIERED SERVICES

According to Bains & Diallo (2016), uninsured and government-insured youth are more likely to receive mental health services when they are made available in schools. Vida Clinic's SMHCs enable all individuals, including those who have historically experienced barriers to mental health treatment, to access it. Furthermore, multicomponent programs that incorporate parents and teachers in the treatment process are associated with social, behavioral, and academic improvements

among students (Montañez, Berger-Jenkins, Rodriguez, McCord, & Meyer, 2015). Vida Clinic's ecological approach to psychological care (see Figure 1) acknowledges the multiple systems (e.g., school and home environments) that affect children's development. This approach fosters meaningful connections within and across systems to promote a culture of empathy and resilience.

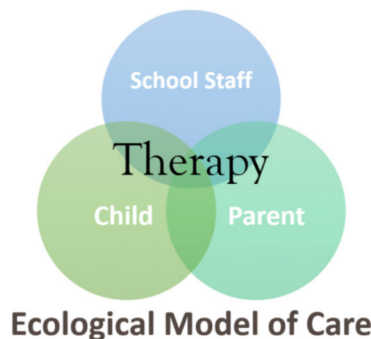


Figure 1. Vida Clinic uses an ecological approach to school-based therapy.

Our combination of multisystemic, multitiered services yields promising and long-lasting results by engaging parents and teachers in the treatment process. In Vida Clinic's method of care, student, parent, and teacher programs are organized as system-wide modules, each of which contains a menu of evidence-based services that can be customized to form a dynamic, comprehensive program that is unique to the needs of each school. Service programs are implemented in campus-wide, small group, and individual tiered formats. The intensive small group and individual formats make

an intrinsic impact on individuals, whereas campus-wide presentations are most useful for introductions of new concepts and surface-level information sharing. Our approach enhances a community culture of resiliency and empathy and fosters greater understanding of the impact that adverse events have on the lives of youth and families.

## IMPLEMENTATION

### JOINING WITH THE SCHOOL SYSTEM: A COLLABORATIVE AND EXPEDITED PROCESS

Cultivating positive working relationships with school personnel facilitates fast and seamless implementation of mental health services on campuses. Vida Clinic's flexible framework tailors services to the needs of groups and individuals. Programs are customized and quickly implemented in cooperation with school communities. Vida Clinic places utmost importance on customer service, collaboration at all levels, and being an overall positive partner with school communities.

### CLINICAL THERAPISTS ON EACH CAMPUS

Each of our full-time high school SMHCs is staffed by a team of clinically licensed providers (Licensed Psychologist, Clinical Social Worker, or Licensed Professional Counselor). Therapist teams are committed to meeting the strong and growing demand for these services to ensure that all needs of students and adults are being met. Because the intersection of behavioral health services



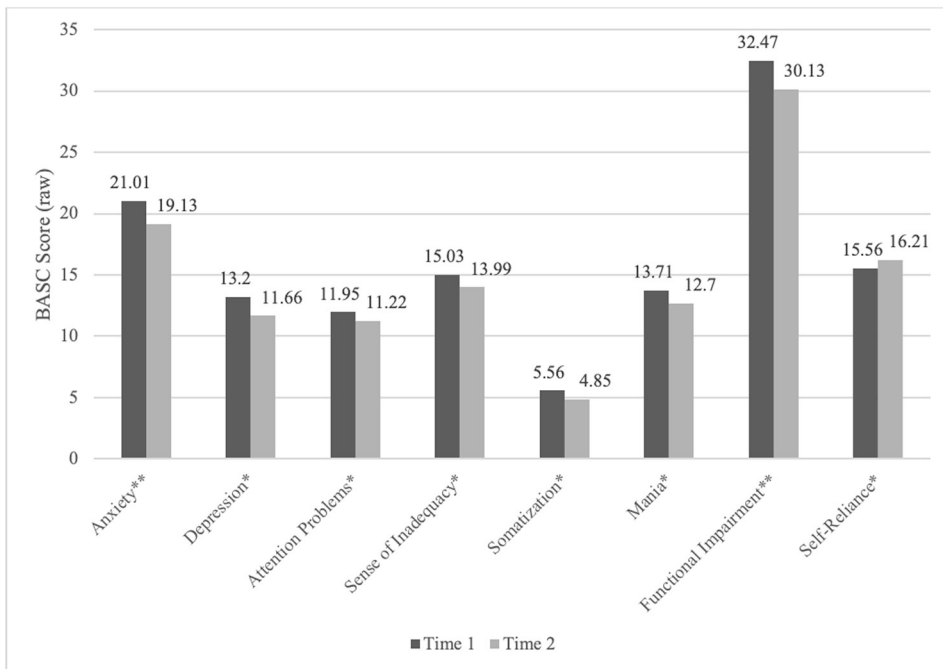


Figure 2. Psychological improvements among high school students from assessment at intake (Time 1) to mid-treatment (Time 2).

\*Significant difference at  $p < .05$ .

\*\*Significant difference at  $p < .01$ .

and a school-based environment is unique, we seek out highly qualified clinicians for this specialized position.

## SERVICE MODULES

### STUDENT SERVICES

Clinical Student Services are the key component of a full-time School Mental Health Clinic. Vida Clinic's fully licensed therapists are trained in school mental health practices and provide psychotherapy services to students who are referred to the SMHC. Our offices are embedded within the school and programming is available year-round.

Youth are generally seen weekly, and therapists flex their treatment format and schedule in response to patient need. Generally, student services are provided during school hours, which is typically the most convenient time for students and families. Vida Clinic therapists partner with school staff to offer appointment times with minimal class-time interruption. Therapists maintain a presence on their campuses during summer months and some school holidays to avoid service disruption.

Vida Clinic continually provides therapists with evidence-based training opportunities in therapeutic techniques such as cognitive behavioral therapy, play therapy, and trauma-informed care. Unique among school mental health providers, we frequently assess patients' psychological and behavioral outcomes to monitor intervention effectiveness, improve our services if needed, and communicate findings with scholars, mental health practitioners, school districts, and community members.

Vida Clinic uses multiple scales to assess student well-being, including the Behavioral Assessment System for Children (BASC) (Reynolds, 2004) and the Strengths and Difficulties Questionnaire (SDQ) (Goodman, 2001). We also supplement our assessments with district-level data on students' academic and disciplinary performance. We are proud to report improvements in mental health outcomes such as anxiety, depression, attention problems, sense of inadequacy, somatization, mania, functional impairment, and self-reliance (see Figure 2), as well as improvements in disciplinary and academic outcomes such as school attendance,

suspension and expulsion rates, and standardized test scores (see Figure 3) among the high school students we serve.

**Family-school meetings.** Vida Clinic therapists facilitate family-school meetings during which students, parents, and teachers engage in thoughtful, mutually respectful conversations about promoting satisfaction and success in the school environment. These therapeutic conversations are intended to provide students, parents, and educators opportunities to collaborate, build positive connections, and ultimately improve youths' school and treatment experience. Parents remain closely involved in the treatment process through ongoing communication with the therapist and through opportunities for family therapy.

## PARENT SERVICES

**Group work.** Parents have opportunities to participate in group sessions in which licensed clinicians lead conversations about the ways in which mental health and parenting intersect. Examples of group sessions include how to talk with youth about mental health and applications of stress recognition and stress management to positive parenting. Parent groups provide opportunities for parents to receive guidance from licensed professionals as well as support from their peers.

**Individual work.** When caregivers have issues that are impacting their personal health and wellness, they can engage in individual therapy services for themselves at our clinics. Therapeutic goals may target several areas, including personal, relationship, work, or parenting-related issues. A licensed therapist will work one-on-one with caregivers to determine the focus and scope of treatment.

## STAFF SERVICES

**Consultation program.** Vida Clinic's mental health professionals provides customized, real-time consultation and skill-building support so that staff feel competent in helping young people learn through positive teacher-student relationships. The therapeutic consultation model gives staff the opportunity to articulate their work-related needs in a non-judgmental space and to engage in discussions about how to



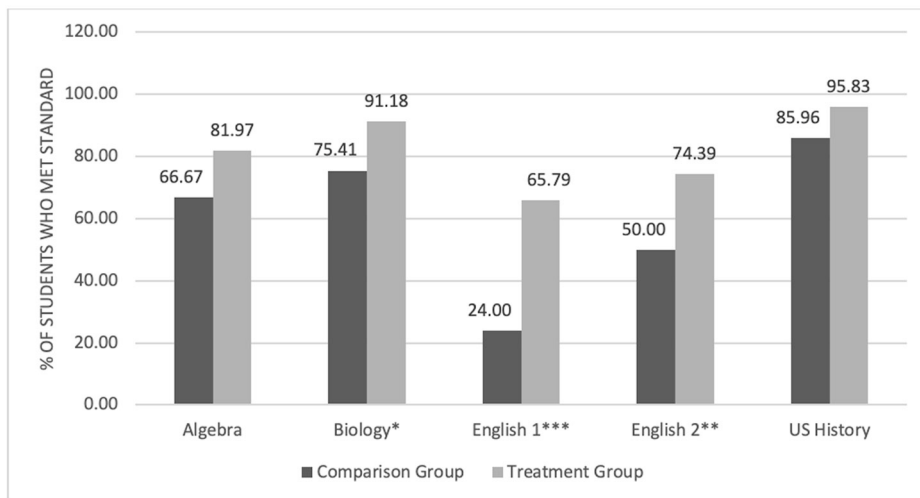


Figure 3. State of Texas Assessments of Academic Readiness (STAAR) outcomes by group and academic subject. A sample of 281 students participating in therapy services at Vida Clinic were compared to the outcomes of 269 demographically matched students who were not receiving services.

\*Significant difference at  $p < 0.05$ .

\*\* Significant difference at  $p < 0.01$ .

\*\*\*Significant difference at  $p < 0.001$ .

compassionately address needs. The model places emphasis on strengthening self-regulation skills that staff can then model in the classroom. This service typically includes staff participation in focus groups to enable the clinical consultants to customize the consultation model for each campus. As one educator stated following participation in a Vida Clinic consultation program, "It's made all of the difference for me in my job."

#### Customized personal wellness groups.

Individual campuses may request customized group sessions when unique mental health needs emerge. These group opportunities are offered in staff-wide formats for the introduction of new concepts, and in small group formats for deeper learning and processing of trauma-informed approaches to caring for self and others. Teacher groups focus on three overarching goals: (1) promoting effective responding to student behaviors, (2) promoting staff self-regulation of emotions, and (3) creating opportunities for peer-support and community building. To address Goal 1, Vida Clinic provides group sessions on trauma-informed practices designed to raise awareness of how psychological

adversity impacts brain development and classroom behavior and help teachers to empathically respond to chronically stressed students. To address Goal 2, the our team runs group-based sessions on teacher stress and wellness, with a focus on the development of mindfulness and self-regulation techniques. To address Goal 3, our group facilitators implement sessions in an interactive format designed to foster sharing and positive support opportunities among staff. Staff who participate in these groups also have opportunities to take part in individualized mental health coaching with a clinician.

**Therapy.** Teachers and school staff are eligible to receive individual therapy services by self-referring to a school-embedded Vida Clinic therapist. Psychotherapy sessions are scheduled at a time most convenient for the staff member, services are confidential and separate from school activity, and treatment plans and goals are personalized. Common therapy topics include work-life balance, relationships, grief and loss, and stress.

We likewise collect data on staff members' self-reported levels of victimization within the school community, their attitudes toward

trauma-informed care, and their perceived stress levels. We discovered that staff members' perceived stress was positively related to levels of community victimization (Minne & Gorelik, in preparation). We also discovered that staff-members' positive attitudes toward trauma-informed care predicted significant reductions in stress levels, suggesting that having a positive attitude toward trauma-informed care can reduce stress associated with campus-related victimization. Research suggests that trauma-informed care benefits students' academic and psychological outcomes (Bartlett et al., 2018; Hamre & Pianta, 2005). Our findings suggest that, in addition, the benefits of trauma-informed care extend to caregivers themselves. Taking into account the observed relationship between teacher and student stress (Oberle & Schonert-Reichl, 2016), an effective implementation of a trauma-informed care training program at the school level may lead to direct and indirect benefits for students by not only giving them opportunities to thrive in a non-punitive environment but also reducing their stress by reducing their caregivers' stress.

#### A VIEW TO THE FUTURE

The need for accessible mental health services for young people is becoming increasingly clear amid the increase in major depressive episodes, serious psychological distress, and suicide-related outcomes among adolescents and young adults (Twenge, Cooper, Joiner, Duffy, & Binau, 2019). Because children spend much of their time in school, School Mental Health Clinics offer a convenient and effective solution to the mental health needs of students and their caregivers. Vida Clinic's goal is to ensure that accessible, culturally-sensitive, and high-quality mental health treatment is made available in every school. ■

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# When Minor Separation Becomes Major: Our Clinical and Ethical Border Crisis

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Sheresa Wilson-DeVries PA-C.

Sergio arrived in the US with his father, but they were detained at the border. Their belongings were confiscated, the group was divided, and they were ushered into separate vehicles. Sergio was directed to a different vehicle than his father, with assurances that they would be together again shortly. At the time of his interview, it had been 45 days since Sergio last saw his father. Sergio was taken to a shelter for migrant children, and it was over a month before he was allowed to speak to his father on the phone. In his interview he stated (via translator), “I worry about him every day and every night. I can’t sleep well at all because I worry so much about my family. I have only spoken with my father a total of 20 minutes in these 45 days” (Silva, 2018).

Sergio has been informed his father has been slated for deportation, and that is all he knows. He would like to go home with his father, but feels powerless and invisible in the process. In his interview with Danielle Silva, he reported, “I do not want to be here anymore, especially since I know how much my father is suffering... The way I have been treated makes me feel like I don’t matter, like I am trash” (Silva, 2018).

Nearly 3,000 such children have reportedly been separated from their families upon their arrival and detainment at the US borders, in accordance with a spring 2018 zero-tolerance policy instituted officially by the Department of Justice and the Department of Health and Human Services (DHS, 2018). However, the increase in documented cases of such separations dates back to 2017, even before the policy

was legally implemented. The policy was subsequently reversed in June of 2018, and the families were ordered to be reunited. Hundreds of children have, in fact, reconnected with their families (DHS, 2018; OIG, 2019). However, this task has proven difficult due to challenges in identifying and tracking the children, and then locating the parents, some of whom have already been deported. Numerous other children are still awaiting familial reunification, and there are reports of additional children being separated from their parents, even following the termination of Zero-Tolerance legislation (OIG, 2019).

## SEPARATION ANXIETY

Separation anxiety is a normal developmental phenomenon of infancy, wherein a child displays distress at the “loss” of a caregiver or attachment figure, as they disappear from direct view. This stage usually concludes at approximately age two, when the child comes to comprehend permanency, and the idea that the caregiver will eventually return (American Academy of Pediatrics, 2000).

However, separation anxiety is considered pathological when this reaction becomes disruptive, and when it occurs in a child who has developmentally exceeded the toddler stage. These children may experience insomnia, as exacerbated by nightmares; may be clingy and persistently worry about separation from the caregiver; and may be unable to spend time alone, or in settings away from the attachment figure. These children may also display a variety of physical symptoms (ranging from

headaches and nausea to vomiting and palpitations) while experiencing difficulty in concentration, extreme homesickness, specific fears and phobias, or panic attacks (APA, 2013; Bernstein, 2018).

While it is not completely clear what causes pathological levels of separation anxiety, there seems to be increased susceptibility in individuals with a family history of anxious or depressive symptomatology. Furthermore, this phenomenon may be related to major stressors in the child’s life, including death, divorce, change in schools, or some devastating event that separates children from their family or loved ones. This is especially true when the child is young and the circumstances surrounding the separation are traumatic (Bernstein, 2018).

## TRAUMATIC SEPARATION

Based on these factors, it stands to reason that a traumatic separation will predispose a child to pathological levels of separation anxiety. Examples of traumatic separation include parental incarceration, immigration, deportation, military deployment, or termination of parental rights (NCTSN, 2016). Parental incarceration alone has been independently linked to such outcomes as learning disabilities, speech and language impairment, inattentiveness / hyperactivity, behavioral or conduct problems, and developmental delays (Turney, 2014).

Children exposed to these events respond similarly to those who have experienced traumatic grief and/or Post-Traumatic Stress Disorder. However, the primary distinction between traumatic grief versus

traumatic separation occurs when (in the latter case) the child seems to maintain hope for reunification (whether realistic or otherwise), since the parent has not ostensibly deceased. Unfortunately, this expectation for reconnection can complicate their adjustment to interim care, or inhibit healthy coping, since they are simply “in waiting” for their parent or caregiver to return—which may or may not transpire (NCTSN, 2016). More specifically, symptoms of traumatic separation include intrusive thoughts; nightmares; avoidance of triggers or reminders; re-enactment in play; negative or self-destructive beliefs, thoughts, or feelings related to the incident; self-blame; difficulty concentrating; or somatic symptoms such as head pain, stomach aches, and insomnia (NCTSN, 2016).

Additional complicating factors can occur when children have witnessed their parents being beaten, raped, arrested, detained, or otherwise mistreated throughout the circumstances of their separation. For example, these children are more likely to demonstrate persistent anxious ideation regarding their parents, and especially regarding the uncertainties of not knowing their present wellbeing, nor the duration of the ongoing separation (NCTSN, 2016).

Even on a post-reunification basis, some children and families have continued to struggle. Depending on their age, length of separation, and myriad other compounding or contextual factors, some children have remained emotionless, avoided their parents, or even failed to recognize them (Riley, 2018). In addition, chronic problems resulting from childhood traumas in general are well-established, with far-reaching implications ranging from mental, emotional, behavioral, and addictive dysfunction to cancer, heart, lung, liver, and skeletal diseases (Felitti, et. al.)—and especially in women, autoimmune disorders (Dube, et.al.). In short, traumatic separation can undoubtedly cause both acute and chronic problems for the children and families involved.

## BACK AT THE BORDER

A representative from the Center for Human Rights and Constitutional Law Foundation acknowledged that the increasing numbers

of children in their facilities have strained fundamental resources, including potable water, edible food, mats, blankets, and basic toiletries. The same representative reported that the children frequently show signs of trauma and emotional distress, such as anxiety, nightmares, difficulty sleeping, and depression (Silva, 2018). These ocular observations are consistent with the empirical research referenced throughout this article.

For centuries we have prided ourselves as a nation of law and order. Indeed, the primary reason for this long-standing deference to legality has been the protection of individual rights (and especially those of vulnerable populations). As psychologists, we aspire to an even higher mandate than our legal structures. In all decisions within our professional roles, we are compelled to pursue the highest ideals of beneficence—or at the very least, non-maleficence. Our ethical codes further mandate that we do not discriminate based on race, ethnicity, culture, language, or socioeconomic status. As a profession, we do not support the unnecessary perpetration—or perpetuation—of human suffering (including and especially the most vulnerable among us).

Do we have a crisis at the border? Yes. Is this crisis minor or major? Yes. We have a major ethical and clinical crisis of minors. And any sub-ethical, sub-clinical treatment of minors (irrespective of migratory status) will only ensure that the major crisis continues: Perhaps for decades, perhaps for life, and perhaps for generations.

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# Warrior Resiliency Program: Delivering Tele-behavioral Health Services from Texas to Military Personnel throughout the Country

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*The views expressed herein are those of the authors and do not reflect the official policy or position of 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, the Department of the Air Force and Department of Defense or the U.S. Government<sup>1</sup>*

## WARRIOR RESILIENCY PROGRAM: DELIVERING TELE-BEHAVIORAL HEALTH SERVICES FROM TEXAS TO MILITARY PERSONNEL THROUGHOUT THE COUNTRY

Although a relatively new approach to behavioral health care delivery, as noted by Hailey and colleagues (2008), tele-behavioral health (TBH) has been utilized in a variety of settings for a wide array of mental health concerns. Moreover, TBH seems to have found a place within the realm of “mainstream” behavioral healthcare delivery models. For example, as a result of the increased acceptance and utilization of TBH as a means of service delivery, the American Psychological Association has released practice guidelines in telepsychology (American Psychological Association, 2013).

Initial concerns regarding the efficacy of TBH versus in-person behavioral health care have mostly been addressed. In general, virtual delivery of psychological treatments are considered as effective as

face-to-face care (Landry-Poole, Pujol, & Moore, 2016; O'Reilly, Bishop, Maddox, Hutchinson, Fisman & Takhar, 2007). This includes specialty behavioral health care as well. For example, Morland and colleagues (2015) found that providing psychotherapy to diverse groups of veteran and civilian women with posttraumatic stress disorder (PTSD) resulted in similar outcomes when compared to face-to-face care. Moreover, in this same study it was noted that TBH increased access to specialty behavioral health care for women in remote areas. TBH also appears to be effective with regard to the delivery of evidence-based psychotherapeutic interventions for children (Nelson & Patton, 2016).

There are many reported benefits of virtual behavioral health care delivery (Landry-Poole, Pujol, & Moore, 2016). The one most often noted by proponents of TBH is how it is a potential solution for the effects of uneven distribution of mental health providers across states. Due to higher concentrations of mental health professionals choosing to live and work in urban areas, fewer clinicians are available in remote parts of the country. As a result of this provider imbalance, those in rural communities often experience reduced access to care to include increased wait times to see a provider or a complete unavailability

of mental health services. The same holds true for the military. Military bases and posts are scattered across the country. Depending on the branch (i.e. Army, Navy, Air Force, Marine Corps), these installations may be located in larger cities with ready access to mental health care like Naval Base San Diego in California. In contrast, at sites in more remote areas such as Fort Hood Army post in Killeen, Texas, access to care may be limited. Historically, compared to more urban settings like San Diego, remote installations such as Fort Hood have greater challenges recruiting and maintaining sufficient numbers of mental health providers to take care of the military personnel, family members, and civilians assigned to the area. The Warrior Resiliency Program (WRP), a TBH organization based out of San Antonio, Texas, is one of the Army's top solutions for improving access to care for Soldiers at Fort Hood as well as other military installations across the United States.

The WRP was formed in 2008 after receiving Congressional funding earmarked for programs with a focus on psychological health and/or traumatic brain injury. Originally established as a center of excellence to test pilot programs related to psychological resilience and wellness, the organization shifted its focus due to the

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Army's need to increase clinical services to Soldiers and military families at remote installations. In fact, it was the success of its pilot TBH program that propelled the WRP into the thriving virtual clinic that it is today. Currently, the WRP operates as the largest Regional Health Command TBH hub for U.S. Army Medical Command (MEDCOM) and serves 16 sites across MEDCOM's Central and Atlantic catchment areas. On an ad hoc basis, the WRP provides services to select Air Force and Naval installations.

The WRP consists of thirteen clinical psychologists, two prescribing psychologists, three advanced practice psychiatric nurses, two psychiatrists, one social worker, and a variety of support staff. In addition to pharmacotherapy, the organization provides a wide array of evidence-based therapies for conditions such as PTSD and depression. Moreover, approximately one-third of the organization's clinical work consists of conducting different types of psychological examinations to include Drill Sergeant, Recruiter, Sniper, and Security Clearance evaluations. The WRP also assists with redeployment screenings and disaster response missions such as the 2009 and 2014 shootings at Fort Hood.

On average, the WRP offers between 400 and 500 clinical appointments each week to remote installations across the country. Since the program's inception, it has provided approximately 70,000 total encounters. But clinical work is not all the WRP does for the Army. Over the past three years,

staff have secured roughly \$300,000.00 via grants to study novel and effective means of virtual behavioral health care delivery. Its first funded initiative studied the feasibility of providing Problem Solving Training (PST) remotely to an addiction medicine intensive outpatient program at Fort Hood, Texas. PST is a short-term, solution-focused intervention that teaches people how to effectively manage a variety of common life problems. Its second project, which is currently underway, assesses the effectiveness of remote delivery of Cognitive-Behavioral Therapy for Insomnia, also to Ft. Hood. Its longest, enduring non-clinical program involves suicide risk mitigation. Referred to as the Suicide Reduction Initiative, since 2010, the WRP has overseen a large-scale training mission related to reducing suicide behavior in active duty military personnel. Over the past several years, hundreds of active duty and civilian mental clinicians have been trained in specific interventions aimed at reducing suicidal ideation, attempts, and completions.

In sum, the San Antonio, Texas based Warrior Resiliency Program has shown to be an organization that is flexible, effective at improving access to care, and able to deliver the same behavioral health interventions that are typically provided in a traditional behavioral health outpatient clinic. As the Department of Defense's largest TBH organization, the WRP is improving the lives of military personnel and their family members not only within Texas, but across the entire United States. ■

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# Considerations for The Aspiring Trauma Focused Therapist

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There is a substantial body of research that indicates that professionals treating traumatized clients or patients may suffer from burnout, compassion fatigue, or secondary traumatic stress, and that those who are most empathic tend to be most vulnerable (Butler, Carello, & Maguin, 2017; Merwe & Hunt, 2019). These findings suggest that while therapists may find their work rewarding, which often involves exposure to traumatic clinical content, such exposure may also evoke distress. A proper understanding of the secondary effects of trauma are essential to developing competent and healthy trauma-focused and trauma informed therapists. The current article provides a brief overview of trauma-informed and trauma-focused therapy, two

therapists' experiences in providing trauma therapy, and suggestions for implementing effective self-care strategies.

Being 'trauma-informed' involves noticing and embracing that trauma is the expectation, not the exception; it is an awareness of how trauma affects the body, brain, spirit, and sense of the world (National Council for Community Behavioral Healthcare). Trauma-informed therapists conceptualize behaviors as attempts to cope and survive, help minimize attempts at re-victimization or re-traumatization, and facilitate recovery for clients in a culturally sensitive manner.

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines trauma-focused therapy as "a program, organization, or system that is trauma-informed: 1) realizes the widespread impact of trauma and understands potential paths for recovery; 2) recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; 3) responds by fully integrating knowledge about trauma into policies, procedures, and practices; and 4) seeks to actively resist re-traumatization." A trauma-focused approach is based in understanding the connection between the trauma experience and an individual's emotional and behavioral responses. The goal of a trauma-focused therapist is to offer skills and strategies that assist individuals in better understanding, coping with, processing emotions and

memories tied to traumatic experiences with the end goal of enabling individuals to create a healthier and more adaptive meaning of the experience that took place in his/her life.

Interventions and skills that trauma-focused providers regularly use include: establishing safety, identifying triggers, developing healthy coping skills, and reducing traumatic stress symptoms via "processing" the trauma. Common, evidence-based modalities for such processing include Prolonged Exposure (PE) therapy, Cognitive Processing Therapy (CPT), and Eye Movement Desensitization and Reprocessing (EMDR). Based on the nature of the trauma, therapists could likely experience some level of distress in response to the trauma content.

## BELOW ARE TWO ACCOUNTS OF TRAUMA THERAPISTS' EXPERIENCES WORKING WITHIN THIS ROLE.

"My clinical work was largely focused on reducing PTSD symptoms in victims of interpersonal violence and patients with spinal cord injuries. While constantly balancing the busy schedule of a graduate student, I naïvely entered into therapy sessions without a full understanding of the toll this would take on me. Helping clients to revisit their pain in a supportive and safe environment meant having to share in their pain with them, albeit to a much smaller degree. It was rough. One day, I had

to mentally remind myself to keep my jaw from dropping as I heard a patient give a detailed account of being raped as a child for 30 minutes. Sitting across the room from someone who had their freedom, independence, and dignity stripped from them often left me feeling helpless. After all, what could I possibly offer them?

My experience as a trauma-focused therapist has been colored with a vast array of emotions, ranging from horror and anger to immense gratitude and hope. Over time, I felt my capacity for compassion deepen. I learned to modify my expectations, and focus on listening and understanding, above all else. I developed a deeper appreciation for the human spirit. I bore witness to the evil acts some people commit and realized that violent acts are not just committed by “criminals” off in some tucked away recess of humanity; they are committed by human beings.

As I began clinical practicums and rotations, I often avoided allowing myself to fully feel the weight of what I was experiencing on a regular basis. I received regular supervision, but after particularly challenging days, I began seeking additional consultation from co-workers. I expressed the emotions I felt during session and listened to others’ experiences. I also utilized expressive writing regularly, jotting down the thoughts and feelings I was experiencing in order to process them and bring some structure to my psyche.

Witnessing suffering in the most extreme forms helped me to identify and work with it in lesser forms with patients in other settings. Overall, I felt humbled, and inspired. I learned that there is no “ideal” human state... that we are all simply goal-oriented beings who yearn for incremental, positive change. Whether it is dunking a basketball for the first time or gaining an extra few degrees of rotation in your neck following a motor vehicle collision, the feeling of accomplishment is nonetheless satisfying. Working with these clients had a mirroring effect on me; I was forced to face my own limitations and fragility. This realization

led me to modify my own expectations and make self-care a priority.” -Nicholas Curcio, BSM

“When I initially started working with individuals who had experienced a trauma or complex trauma, I recall feeling extremely fatigued much of the time. Hearing the experiences of these individuals was surreal and I was soaking it up like a sponge. Psychologists and other therapists who do this work are second responders in the sense that we hear and revisit these traumatic experiences alongside our clients. We have established a relationship with our clients that allow us to empathically immerse ourselves in the content and envision what they experienced and felt in that state. While we as psychotherapists understand that we will never fully experience what it is like to have lived it first-hand, we are not immune from feeling the weight and gravity of those situations and emotions. Having done my own work in therapy still did not prepare me for the emotional charge that was felt when hearing clients’ experiences. I recognized quickly that it would be a multi-faceted active process (mind, body, and soul) to remain balanced and healthy in this work. After all, in order to help another, we must first learn how to care for and help ourselves so that we can be open and fully present to their experiences.

Outside of my personal time in therapy to process, I frequently sought supervision not only to conceptualize cases, but also to share the emotions I was carrying from the previous session/s. In the near future, I believe it will be crucial to be a part of a consultation group that shares in working with a similar population. While balancing a hectic schedule in graduate school, I have learned to be mindful of my diet and engage in a consistent exercise regimen. I make a point to travel regularly so that I can unplug, slow down, and recharge as I have personally found it difficult to disconnect from work and graduate school. Incorporating daily meditation to practice gratitude has also been helpful in orienting myself to be present for this difficult but incredibly rewarding work.” -Andrea Wierchowski, MA

The 2017 version of the Ethical Principles of Psychologists and Code of Conduct instructs psychologists to maintain an awareness of “personal problems that may interfere with their performing work-related duties adequately” and to take “appropriate measures, such as obtaining professional consultation, and determine whether they should limit, suspend, or terminate their work-related duties.” Mental health professionals frequently enter the profession out of a desire to help others in a meaningful way. As trauma-focused therapists, we acknowledge the gravity of assisting our patients overcoming challenges and processing their trauma. It is a balancing act to care for ourselves while also caring for others. Without engaging in our own self-care, we limit our ability to effectively assist others; therefore, it is imperative that practitioners, educators, and students alike practice good and consistent self-care to maintain and promote mental, physical, and emotional well-being. This also promotes the modeling of a healthy lifestyle and behaviors for patients.

Individual preferences for and access to self-care may differ greatly among therapists, thus effective self-care strategies are broken down into several categories below. The topic and conversation of self-care requires constant revisiting, as the implementation of self-care strategies become more challenging during stressful and busy times. The following are resources from various forms of media to assist with implementing consistent self-care that the authors have found useful. ■

## INDIVIDUAL STRATEGIES

- APA – where to Find a Mentor: <https://www.apa.org/gradpsych/2005/01/mentor-find>
- Self-Care Vacations – whether on a budget or a little more lux, some of us need to go away in order to unplug. Travel has been freeing and something to look forward to in this sometimes-taxing work.
- Find a consultation group – see APA for current groups in your area.





- Utilize Expressive Writing, as put forth by James Pennebaker, PhD – Instructions can be found at: <https://www.psychologytoday.com/us/blog/write-yourself-well/201208/expressive-writing>

## WEBSITES

- MayoClinic – learn how to use relaxation techniques to reduce stress and bring calmness into your life.
- Headspace – live a happier, healthier life with just a few minutes of meditation a day.
- YogaGlo – yoga videos and classes from the top yoga instructors.

## APPS

- Pacifica – designed to use the principles of Cognitive Behavior Therapy and Mindfulness to help with daily stress, anxiety and depression.

- Sweat – equipped with workout routines and meal plans to help balance exercise and diet without a nutritionist or a personal fitness trainer.
- Insight Timer – features guided meditations, music, and talks posted by contributing experts.
- Calm – designed to help improve sleep and reduce stress and anxiety with the help of guided meditation, soothing music, and bedtime stories.

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# Daubert Challenges to Psychological Testimony: What You Need to Tell the Lawyer who Calls You to Court

Michael Flynn J.D. Ph.D.

**R**ecently, a psychologist with many years' – and many assessments' – experience with the courtroom expressed his concern about an upcoming Daubert Challenge to his appearance and his testimony. He had a clear idea what a Daubert Challenge entailed, and he was, reasonably, concerned that if he did not provide correct answers, his testimony would not be admitted and his client's interests would suffer, thereby. Exclusion of unwanted testimony is the goal of a Daubert Challenge. If a lawyer can convince a court that your assessment and your opinions fail the Daubert Challenge the court may, at its discretion, exclude your testimony and your report. You and your clients will have wasted a good deal of time and money.

Until the mid-1990's an expert's testimony was considered simply under the Texas Rules of Evidence §702, and its close cousins, §§703 - 705. The old rule, essentially, defines an "expert" witness and exempts the expert witness from ordinary restrictions regarding opinion testimony:

A witness who is qualified as an expert by knowledge, skill, experience, training, or education may testify in the form of an opinion or otherwise if the expert's scientific, technical, or other specialized knowledge will help the trier of fact to understand the evidence or to determine a fact in issue.

Although the language loosely defined who qualified as an expert, the definition of expert was secondary to the rule's real purpose which was to clarify who would be allowed to offer opinion testimony. In

addition to Rule 702, the Federal "Frye Test" ruled that for it to be admissible, expert testimony had to be based on science that was "generally accepted" in the field. *Frye v. U.S.* 293 Fed. 1013 (D.C. 1923). In 1923 that seemed sufficient guidance to the courts. For decades the Frye Rule and Rule 702 provided the substantial guidance to courts regarding what was admissible as expert testimony and who was an expert. The bar preventing the qualification of an expert was low, as was the bar to allow expert opinions. Think bite mark testimony.

## LEGAL HISTORY AND BACKGROUND

During the 1990's Daubert and its progeny led to a host of cases and questions that are important to understanding a Daubert challenge, and how a psychologist should answer the challenge. *Daubert v. Merrell Dow Pharmaceuticals, Inc.* 509 U.S. 579 (U.S. 1993). In the Daubert matter the litigants argued over whether certain expert testimony should be admitted. In its decision, the U.S. Supreme Court laid down standards that would qualify certain expert testimony as admissible, and conversely, guidance regarding expert testimony that fails. As happens with any Supreme Court decision, some of questions raised were answered by SCOTUS and others addressed later by Federal Circuit Courts; Texas issues were addressed by the Texas Supreme Court and Texas Appeals Courts. Texas adopted the Daubert standard, little changed, in *E.I. du Pont de Nemours and Co., Inc. v. Robinson*, 923 S.W.2d 549 (Tex. 1995).

The standards laid down in Daubert were best suited to "hard science" testimony, but they proved more difficult to apply in the "soft sciences." In the ensuing years and cases, questions were raised and answered about when the standards applied, and what kind of testimony and what witnesses would be held to the standard. What would be the court's role and responsibility? Over time, the language moved from simply expert testimony to scientific testimony, and back to the question of what was accountable as expert testimony and who was an expert – and not. A brief discussion history is in order before considering what a psychologist must know and must do in the face of a Daubert Challenge.

According to the U.S. Supreme Court, the trial court serves as the gatekeeper, allowing expert testimony or excluding it. Trial courts enjoy considerable discretion in deciding whether to admit expert testimony. The essential charge given to the trier of fact was to consider whether the testimony was reliable and relevant, and whether the expert is qualified. These are not particularly complicated ideas to understand – perhaps, until lawyers begin to argue over them.

The question of whether an individual is qualified to testify as an expert is heavily loaded toward the principles, methods, and procedures. An initial question, of course, is whether the field has identifiable, respectable principles, methods, and procedures. Psychology enjoys all three, and among most courts, psychology enjoys some measure of respect. Bite mark testimony and astrology,



on the other hand enjoy none of those things. A person cannot qualify as an expert simply on his or her ipse dixit claim to be an expert. First, is there a field with recognized principles, methodology, and procedures? Second, can the witness show sufficient knowledge and experience in dealing with those three things? A witness may show that knowledge by education or experience, or both. The current version of Texas Rules of Evidence §702 addresses “scientific, technical or other specialized knowledge”:

If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education may testify thereto in the form of opinion or otherwise.

The issue of opinion testimony remains in the language, but the emphasis is more proscriptive of expert testimony, and in practice, more burden falls on the expert to show qualification. In its 1993 decision the U.S. Supreme Court in *Daubert* established a two-step series of factors for a trial court to consider when deciding whether to admit expert/scientific testimony. The court is a gatekeeper with considerable discretion, but it should consider, first whether the testimony to be offered is reliable and whether it is relevant. If the methodology underlying the testimony can show evidence of scientific validity, the court will regard it as reliable. Reliable testimony is admissible – if it is also relevant. The fact that a hair test or urinalysis will reliably show the level of a given drug in a defendant’s system does not automatically make it relevant. A blood alcohol level is certainly both reliable and relevant to the question of whether a driver is guilty of a DUI offense. Regardless of reliability, blood alcohol levels are less relevant to the question of guilt or innocence

in the commission of a felony murder. To be admissible, expert testimony must answer both questions affirmatively.<sup>2</sup>

Following *Daubert* and *Robinson*, a set of factors guides the court’s determination of whether testimony is reliable: Has the theory or technique to be presented been empirically tested? Has it been subjected to peer review and is there some body of literature that supports the technique or theory? Can the potential error rate be known, or at least estimated? Finally, is the theory or technique “generally accepted” by the scientific community? Those questions are known generically as the “*Daubert* Factors.” In its *Robinson* decision, the Texas Supreme Court largely adopted the *Kelly* and the *Daubert* factors. The expert must be qualified and her testimony must be reliable and relevant. Has the theory been tested? To what extent does the technique rely on subjective interpretation of data? Has the technique or theory published in peer reviewed journals? Is there a measurable error rate? Does the theory or technique enjoy acceptance in the relevant scientific community? The Texas Court added a factor that wonders whether the technique is applied or used outside the context of litigation.

It is not hard to see that psychological testimony often finds itself hard-pressed to show adherence to all the *Daubert* and *Robinson* factors (Often, now simply called “*Daubert/Robinson* factors”). Especially in matters of family law, how does a psychologist determine, much less offer compelling testimony regarding the potential error rate of a child custody evaluation? Lawyers often challenge the clinical interpretation of test results as “subjective.”<sup>3</sup>

## THE “SOFT SCIENCES”

In 1997 the Fifth Circuit Court, in *Moore v. Ashland Chemical, Inc.* 125 F.3d 679 (5th Cir. 1997) observed that not all admissible

expert testimony would readily supply qualified answers to the *Daubert* questions. “The *Daubert* factors, which are techniques derived from hard science methodology, are as a general rule, inappropriate for use in making the reliability assessment of the expert clinical medical testimony.” *Id.* at 686-687. The *Moore* Court continued, “Thus, the proffered opinion of any expert in a field of knowledge, in order to be evidentially reliable, must either be based soundly on the current knowledge, principles and methodology of the expert’s discipline or be soundly inferred or derived therefrom.” *Id.* at 687. The courts recognized that hard science methods of validation, including the assessment of potential error rates and extensive peer review do not apply so easily to all forms of expert testimony and opinion.

The following year, the Texas Court of Criminal Appeals provided support and language regarding expert testimony from expert fields outside the “hard sciences.” *Nenno v. State*, 970 S.W.2d 549 (Tex. Cr. App. 1998). In *Nenno*, the Court looked back to its own decision in *Kelly*, a decision that pre-dated *Daubert*. *Kelly v. State*, 824 S.W.2d 568 (Tex. Crim. App. 1992). In *Kelly* the Texas Court of Criminal Appeals held that expert testimony had to satisfy a three-prong test to be admissible: “(1) the underlying scientific theory must be valid; (2) the technique applying the theory must be valid; and (3) the technique must have been properly applied on the occasion in question.” *Id.* at 573. In discussing the *Kelly* holding, the *Nenno* court observed that the test for the admissibility of expert testimony was flexible, and the Court acknowledged that not all expert testimony comes from hard science, and created guidelines to apply to “soft science.”

The *Nenno*<sup>4</sup> case involved expert testimony regarding a defendant’s future dangerousness. The Court found that the expert’s reliability had been sufficiently established by his

<sup>1</sup> Remember that courts and lawyers use the idea of “reliability” to describe what psychologists call “validity.”

<sup>2</sup> In 1992 the Court of Criminal Appeals used slightly different language, asking whether the technique or theory was properly applied. That language has been subsumed in the *Daubert* and *Robinson* cases, but is relevant, especially in regard to “soft science” testimony. *Kelly v. State*, 824 S.W.2d 568. (Tex. Crim. App. 1992).

<sup>3</sup> Forensic psychologists should always be prepared to distinguish their clinical application of the principles of test interpretation and to avoid allowing a cross-examining lawyer to characterize testimony or analysis as subjective.

<sup>4</sup> *Nenno* was an appeal from a finding in the mid-1990s. An expert in 2019 would be held to a more rigorous standard.

testimony regarding several factors. *Id.* at 562. The expert asserted that “his analysis was based upon his experience studying cases.” *Id.* The expert testified that he “had studied in excess of a thousand cases” related to the question of future dangerousness. *Id.* The Court held that the field of prediction of future dangerousness of sex offenders was “a legitimate field of expertise.” *Id.* “Through interviews, case studies, and statistical research, a person may acquire, as a result of such experience, superior knowledge concerning the behavior of such offenders.” *Id.* In a key statement, the Court specifically addressed the absence of peer review, asserting that “the absence of peer review does not necessarily undercut the reliability of the testimony.” *Id.* If a court decided that the absence of peer review shed doubt on the testimony that would be a question concerning the weight of the evidence, not its admissibility. The *Nenno* opinion simplified the language from *Kelly* in applying *Daubert* questions to:

the social sciences or fields that are based primarily upon experience and training as opposed to scientific method... The appropriate questions are (1) whether the field of expertise is a legitimate one, (2) whether the subject matter of the expert’s testimony is within the scope of that field, and (3) whether the expert’s testimony relies upon and/or utilizes the principles involved in that field. *Nenno* at 561.

Framed in the *Nenno* language a psychologist may readily show that her testimony is reliable. Psychologists commonly form opinions based upon psychological tests, clinical interviews, and record reviews. There are science and protocols of practice behind psychology’s techniques and the information we offer based upon those techniques. The techniques of psychology are accepted among practitioners of a legitimate scientific field. The three *Nenno* factors eliminate the requirement that psychologists must show that their work has been peer-reviewed and error rates have been predicted.

In the end, to be admissible, a psychologist’s testimony must meet the standards of reliability and relevance. On the other hand, the factors suggested in the *Daubert*

and *Robinson* cases should be viewed as flexible guidelines, not as absolutes. The trial court enjoys considerable discretion, as the gatekeeper, to decide what testimony and what expert qualifies under Rule 702. Consider the questions a psychologist must answer: 1) Is there a valid, scientific theory underlying the testimony? 2) Is the subject matter of the testimony within the scope of the underlying theory or technique? 3) Did the expert apply a valid technique? Consider, then, how a psychologist may answer a *Daubert* challenge. The lawyer must show the court that the *Nenno* factors are applicable to psychological testimony. The psychologist must show reliability and relevance according to those factors.

### A FINAL HURDLE, THE GATEKEEPER, AND THE ANALYTIC GAP

Courts are neither perfect nor uniform in their application the *Daubert* standards or the *Kelly/Nenno* standards to experts or to expert testimony. In reality, some courts value psychological testimony; others are less favorably inclined to consider what psychology has to offer. Because the Court acts in the role of gatekeeper lawyers must know the court’s preferences and sensibilities. In some courts, any *Daubert* challenge is sufficient to exclude expert testimony. Compared to hard science, “soft science” testimony is especially subject to rejection.

All expert testimony must be able to reach across the “analytic gap,” but failure to make the leap is particularly fatal in courts unfriendly to psychological testimony. A psychologist who conducted a child custody evaluation may be able to show that a parent clearly displays traits and conduct that are characteristic of a diagnostic label, but the court needs to know how that label relates to the child’s welfare. Is there research to support the prediction that a depressed parent is likely to be a bad parent? How does that research apply to the immediate facts? In a competency examination reporting that a defendant has a low IQ or exhibits psychotic thinking does not necessarily answer the important question. Can the defendant assist counsel?

Crossing the analytic gap is central to accomplishing relevance, and finally crossing the gap. Showing that testimony will “assist the trier of fact” to clarify uncertainties about the facts and the legal question will determine whether the testimony is admissible. Every legal matter before the court devolves to an identifiable legal question. The question is not whether the defendant is psychotic. The court’s question asks whether, and how, the defendant’s impaired thinking prevented him from understanding the wrongfulness of his act. The forensic psychologist must be more than just an expert in the psychology and psychological techniques and procedures. To be effective a forensic psychologist must understand the question of law before the court. Understanding the legal question will allow a psychologist a better chance to cross the analytic gap and to provide the assistance the trier of fact seeks.

A psychologist can be prepared, and can help lawyers prepare, to weather a *Daubert* challenge.

First, the psychologist must be able to show her own competence and knowledge of the relevant field. Rule 702 states that “a witness qualified as an expert by knowledge, skill, experience, training, or education may testify...” [Emphasis added.] Never go to a hearing or a deposition without your current curriculum vita. Both the Texas Criminal Code (in §46b.022 and §46c.102) and the Texas Family Code (in §107.104-.105) offer specific language that describes the necessary qualifications. Your CV should show clearly that you have the needed training and experience. Get relevant continuing education, and be prepared to show it. Get supervised experience and document it. Prepare yourself and your attorney (in cases where that is allowed, and with lawyers open to the idea) properly, to prove by your testimony that your training and experience meet the state-mandated requirements. In friendlier courts, and familiar courts the burden of proving your qualifications is less, but always be prepared to answer the challenge of cross examination.<sup>5</sup>

<sup>5</sup> Make sure your CV is up-to-date, but more important make sure it is complete and completely factual. A simple challenge to a date or to a claim of practice made in a CV can be fatal to an expert’s credibility. “The truth, the whole truth, and nothing but the truth” applies to your CV as much as it does to any verbal testimony.





Second, know the field, and be able to defend its “reliability” to the court. For psychologists, that means being able to show, with research and standards of practice, that what you have done is a “legitimate field of study.” When courts use the word “reliable,” remember that is what psychologists call “validity.” Be ready to testify that there is research that supports the validity of applying your tools to the legal question at hand. Psychologists have dependable tools and techniques that can be applied to acquiring information helpful to the court’s understanding of the facts. <sup>1</sup>

Over the past decade it has become more commonly necessary to be able to cite specific research studies. Under cross examination by a skilled and experienced lawyer it is not sufficient, simply to assert that “there is re-search that shows [something].” A psychologist must be able to name and to describe specific studies and reviews. The number of questions and issues that are likely to arise in a given practice area are not limitless. Keep a few brief-ing books that contain published articles and take them with you to depositions and hearings. In

family law, for ex-ample, keep articles at hand that are related to the impact of geographic restrictions, the value and importance of parent-to-parent cooperation and routine time and shared activities, and the specific research regarding differences between test norms in forensic settings. Keep a briefing notebook with the Daubert cases, language, and infor-mation.

Third, apply the techniques that the profession has determined are the proper and desirable ones. Both the Criminal Code and the Family Code clearly describe the steps that are necessary to an evaluation. Follow the codes. The first step to showing that you applied proper techniques is to know what those are, and why those techniques are accepted. Use tests that are known and that have been proven to provide relevant information. Be able to show, with your record, that you followed accepted assessment standards and be able to show that your testimony follows from those steps. Show, with your record, that you gave the accepted tests, interviewed the informants who had meaningful information to offer.

After applying the proper techniques be prepared to show that you reached your conclusions according to the data obtained.

Finally, remember the analytic gap. An expert’s written report and testimony should clearly apply the in-formation to the legal question before the court. A psychologist cannot stop, simply, with a diagnosis, a label, or a description of what the subject said or did. Many argue that diagnostic labels are out of place in the courtroom. An effective expert must understand the legal question(s) that are before the court. Being an expert witness necessi-tates a knowledge of relevant legal standards. To be effective, and to be admissible, findings and conclusions must be directed to resolution of the legal question. If the expert is qualified by training and experience, and if the expert applies accepted techniques to address the legal question before the court, then Daubert should not be an insur-mountable challenge. ■



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