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A NOTE FROM THE PRESIDENT

A Season for Growth

ALICE ANN HOLLAND, PHD, ABPP
Children’s Medical Center Dallas / UT Southwestern Medical Center, Dallas, TX

The difficult thing about writing my column for this particular issue was that my deadline was in mid-March, yet by the time this hits your mailboxes, it will be nearly summer. No matter how this legislative session has ended, I want to thank you all for your incredible response to our action alerts. Your individual emails and phone calls added up to a veritable flood of communication that truly got legislators’ attention every time we sent out a call for action. Thank you!

To those of you who made the extra effort to travel to Austin to provide testimony at hearings, you should know there is no better way to get legislators’ attention than to sit and wait patiently—sometimes for more than 10 hours—for your chance to speak. We all owe an immense debt of gratitude to those of you who took the time to be part of those hearings, including those who attended without providing oral testimony. Your mere presence in the room showed legislators just how important these issues are to psychologists. Thank you!

I also want you all to know that no matter how this legislative session turned out, we would not have even come close to success without our Government Relations consultants, Jerry Phillips and Kevin Stewart. Their knowledge of the inside political scene in Austin and their personal connections with numerous legislators and staffers at the Capitol paved the way for TPA to be part of legislative conversations at a level we have never been before. Jerry and Kevin were our boots on the ground at the Capitol. They worked doggedly, tirelessly, day in and day out (yes, evenings and weekends too!) meeting with key legislators and staffers, drafting and editing letters on short notice, and orchestrating our efforts with impressive precision (e.g., activating particular individuals to contact particular legislators at specific times throughout the process).

Even though I write this without knowing how this legislative session concluded, I can say with complete confidence that Jerry’s and Kevin’s legislative expertise and nuanced understanding of Austin politics have been invaluable. Jerry and Kevin, I can’t thank you enough for the hard work and long hours you spent—over the last five months in particular, but also throughout all of the previous year as we prepared for this legislative session—tirelessly advocating on behalf of TPA.

I also want to give a huge thank you to our Legislative Committee Chair, Dr. Megan Mooney, and our Grassroots Committee Chair, Dr. Anne Morton. These two women are easily two of the hardest-working, most passionate, and most dedicated advocates for psychology at our State Capitol. Drs. Mooney and Morton, thank you so much for everything you did not only this session, but also in the months and years leading up to this session. Your leadership has been—and undoubtedly will continue to be—invaluable to TPA.

Thank you also to the individual members of our Legislative and Grassroots Committees, who faithfully attended bi-weekly conference calls, responded to urgent emails, and in general played a key role in galvanizing TPA’s advocacy efforts. I am so grateful for each and every one of you. A special shout-out to our Austin-area psychologists who went above and beyond by not only attending TPA Legislative Days but also making special trips to the Capitol to meet with key legislators. Last but certainly not least, I want to thank the TPA staff for their incredible help planning and organizing our Legislative Days.

FAREWELLS

As you all know, TPA’s executive leadership team, David White (Executive Director) and Sherry Reisman (Associate Executive Director), recently moved on to other opportunities. I personally have known David and Sherry for close to ten years, and we shared many good times at TPA events and the APA State (now Practice) Leadership Conference. I want to thank them for an incredible 25+ years of service to TPA, and I wish them both all the best in their new endeavors.

CHANGE AND GROWTH

The departure of David and Sherry is clearly the biggest change that TPA as an organization has faced in over 25 years, but I encourage you all to view this as an incredible opportunity for growth for TPA. Just as the brain matures through processes of pruning and adapting neuronal structures to develop new connections and realize new potentials, I believe that TPA will similarly grow as we move forward with new executive leadership.
new potentials, I believe that TPA will similarly grow as we move forward with new executive leadership.

Due to this column’s mid-March deadline, I write this without knowing how this legislative session concluded and thus cannot comment on specific outcomes and how we will move forward. However, I hope you know that I have great optimism for the future of TPA and the profession of psychology in Texas, and there are many who will attest that I am not alone in that belief.

There may be threats we have overcome. There may be changes to which we must adapt. There almost certainly are future challenges ahead. Regardless of the particular situation at this moment, I can promise you that your TPA leaders are already working hard to ensure that the practice of psychology in Texas continues to grow and flourish.

Thank you for being a TPA member. Every single membership helps, and the more members, the more we’re capable of. I’m not just talking about legislative efforts. Just as last year’s Strategic Plan outlined, I envision TPA being more involved in sharing the science and practice of psychology with the general public. I envision TPA doing a better job of meeting the needs of our diverse membership. I envision TPA having more minority involvement and more diversity in our leadership. I envision TPA becoming more of a home for psychologists whose needs we don’t currently serve well, such as basic science researchers and academicians.

Broadly speaking, I envision TPA not just overcoming any future challenges but also taking on exciting new initiatives to promote the future of psychology and mental healthcare in Texas.

In closing, as I said in my last column, please don’t hesitate to contact me at any point with feedback, suggestions, or questions: TPAPresident2019@gmail.com. Especially if you want to get more involved in TPA, please email me. TPA is your professional organization. Make it yours! It’s easier to get involved in TPA than you might think. There’s no better time to get involved in TPA than right now, in this season of growth and the opportunities that change brings.

From the Editor’s Desk

JENNIFER ROCKETT, PHD
Private Practice, Bryan, TX

Colleagues,

I begin the Spring 2019 Editor’s column on the edge of my seat wondering how this legislative session will end; it is almost as intense as watching Game of Thrones’ Night King battle. Let us hope our fate is as Arya’s and the sunsets on BHEC.

Let me take a moment and personally thank each psychologist in Texas (and those of you providing support from afar) who called, emailed, tweeted, and visited with legislators. Whatever the outcome, I know we fought hard; we may not have defeated the Night King (sorry for the continued Game of Thrones references), but then again, maybe we did! Mr. Stewart and Mr. Phillips are hard at work at the Capital, trying to make things happen; as such, you will not see a lobbyist column this issue. Things are changing by the hour.

Before you begin reading the issue’s awesome and varied articles, I did want to briefly update you on TPA’s advocacy for psychologists who do testing in their practices. For those of you who may not be aware, in January, there were changes made to the testing billing codes, and a nightmare ensued. For instance, some psychologists have not been paid for work they have completed back in January, and some claims have been outright denied. Moreover, insurance companies have been slow to update their policies, and have taken the opportunity to reduce their reimbursement rates—an unanticipated effect of the changes that APA touted as good for psychologists, with the hope that the changes would lead to increased reimbursement.

In response to the problems caused by these changes, the TPA Executive Committee and Board of Trustees wrote a detailed letter to APA leadership to ask for their assistance in remediing the problems. At the time of this writing, APA has responded in a formal letter to our organization and has stated their commitment to helping us with the problems. In March, APA surveyed psychologists across the country about the problems we are facing with the testing coding changes. I hope by the time of the next issue of the Texas Psychologist, we will have implemented solutions.

Finally, as you have read in Dr. Holland’s column, by the time you are reading this, you will have come to know of the departure of two long-term employees of TPA—Mr. David White and Mrs. Sherry Reisman. I wanted to send a personal thanks to David and Sherry for their efforts over the many years they have been with our organization.

As always, I hope you enjoy this issue’s columns; thank you to the authors for their work. I look forward to seeing your submissions; keep them coming!

Happy Spring,

Jennifer
A NOTE FROM THE FOUNDATION

Connectivity: A Timely Idea

HEYWARD L. GREEN, PSYD
Texas A&M Health Science Center and Baylor Scott & White Health

Connectivity has been announced as the theme for the 2019 Texas Psychological Association Convention in San Antonio. What an appropriate and timely idea it is for our field in multiple ways. It ranges from the cellular level of neuronal connections to brain-behavior relationships to relating our science to everyday experience to our interactions as colleagues in various ways including, but not limited to research, public service, advocacy, and even political action.

The Texas Psychological Foundation Board of Trustees continues in its work to support psychology in Texas. Thanks to the insight and effort of board members Dr. Courtney Banks, Ms. Anna Abate, and Ms. Cassie Bailey, a revision in the grant and award application process has been completed and will appear on the website later this year in advance of the September 30 deadline. We invite current graduate students to consider application for the funds, and encourage faculty members to alert their students to the availability of our support.

The entire board has focused on hosting a social gathering and fundraising event at the TPA Convention in San Antonio later this year. We hope to create a fun activity that brings together TPA members for a little celebration and revelry as the start of the convention coincides with Halloween. By providing an opportunity for merriment, sharing of food and drink, games, and conversation, we believe the event becomes an expression of connectivity for attendees, embodying the theme of this year’s convention. Watch for further details as the convention date approaches!

Another expression of connectivity is being gestated by the TPF Board through a proposed symposium and panel discussion at the TPA convention aimed at interests identified by graduate students and interns. Their comments have suggested those 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 and pace of work—that is, the practical nitty gritty of psychological practice. Our panel of experienced psychologists expects to address topics including professional relationships, cultivating referral sources, practice settings and roles for psychologists, forensic issues, maintaining balance in professional and personal life, community activities, and other matters that may surface during open questions and answers. The discussion we envision is likely to be of interest to early-career psychologists, whose perspective based on recent entry into our profession may provide further facets and depth to the discussion.

TPF is pleased to welcome Dr. Linda Ladd to our Board of Trustees. Dr. Ladd is a Professor of Family Therapy at Texas Woman’s University in Denton, and has been a longtime supporter of TPF and our activities.

TPF is the entity of the TPA organized exclusively for charitable, educational, and scientific purposes. We endeavor to recognize and support research through grants and awards each year, as well as through the poster session at the TPA convention each year. Because we are a 501(c)(3) organization, funds donated to TPF are considered tax-deductible to the extent permitted by law.

Connectivity for psychology in Texas is enhanced by the generosity and vision of those persons who have provided support for our mission of promoting interest and knowledge of psychology. As we offer this recognition along with our deep gratitude to those who have contributed to TPF over the past year (see below), we invite you to join their ranks this year.

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The biannual meeting of APA’s Council of Representatives (COR) was held in Washington, DC, from February 14–17. The council addressed three issues that have very far-reaching implications for APA (and by extension for TPA).

**STRATEGIC PLAN**

The first foundational action taken by the COR was the resounding endorsement (96% in favor) of the new strategic plan. This will drive APA’s policy decisions for the next several years. The plan was the culmination of more than a year’s work during which APA solicited input from its governance, members, and the public. The plan enjoins APA to:

» Utilize psychology to make a positive impact on critical societal issues.
» Elevate the public’s understanding of, regard for, and use of psychology.
» Prepare the discipline and profession of psychology for the future.
» Strengthen APA’s standing as an authoritative voice for psychology.

Guiding principles call for APA to ground its efforts in the best available psychological science, to champion diversity and inclusion to respect and promote human rights, and to embrace a global perspective.

APA’s CEO, Dr. Arthur Evans, indicated that in August COR will be presented with extensive metrics with which to hold the association accountable to this plan. The devil is in the deliverables.

**THE MERGER**

The second, very momentous issue facing APA is the merger of the C-3 and C-6 operations under the newly reorganized model. Although no votes were taken, more of the operational details of the merger were presented to Council. The merger is necessary to better manage APA’s advocacy activities. Under the new model, all lobbying (practice, education, science, public interest, etc.) previously done by APAPO will now happen under the auspices of the Advocacy Coordinating Committee (ACC). This ACC has more money available to it than was previously devoted to advocacy, but is also responsible for all advocacy on the Hill (e.g. advocating for science, education, public interest as well as practice). In setting priorities, the ACC will determine how well an initiative meets the following thresholds:

» Is the advocacy goal consistent with APA’s mission to advance science and profession and promoting health, education, and human welfare?
» Does psychology possess recognized expertise on the issue?
» Is the issue consistent with our strategic plan?
» Has Council created a position?
» Have committees or divisions created a position?
» Will our role be unique or an important factor?
» What is the probability that a significant action will take place?
» Are there other benefits to the association (e.g. building alliances)?
» What resources are needed?

The merger is going to solve a major finance and budget conundrum and the decision principles outlined above make sense, but once again the details are still evolving. There is general optimism that APA’s advocacy efforts will be more effective, but APA is a big entity comprised of a lot of constituencies that will be competing for finite resources under this new model.

**MASTER’S CURRICULUM ACCREDITATION**

Council voted to receive an interim report regarding master’s programs in health-service psychology. This is a controversial issue, so it is important to understand the larger context in which it has arisen.

It has long been the position of APA that the educational standard for being a psychologist is the doctorate. Nothing in this report changes that in any way. It has also been the position of APA that the accreditation of training modules is and ought to be the purview of the APA. Thus, APA has a model training curriculum for the doctorate, for the bachelor’s degree, and for a high school curriculum in psychology. APA’s failure to develop a standard curriculum for the master’s degree has left the association in a
weak position as the nation tries, belatedly, to face many unmet mental health needs in our society.

As we know, there are many training programs that offer a terminal master’s degree in psychology. Indeed, many of our fellow psychologists teach in these programs. These programs developed without input or oversight from APA, leaving a big hole in the training sequence. Several entities have rushed to fill this gap, most notably the Council for the Accreditation of Counseling and Related Educational Programs (CACREP). CACREP has taken the position that “counseling is not psychology” and they will deny accreditation to any training faculty that is not comprised of CACREP-trained teachers. While this is an affront to reason, it is an effective tactic, insofar as a number of regulatory bodies and even a couple of court cases have stipulated that treatment providers should be CACREP-approved. These policymakers needed to define basic competencies and training standards for individuals in the front lines of some of society’s most costly and neglected mental health challenges (e.g., prisons, substance abuse treatment, behavior analysts, etc.). Because of APA’s historic refusal to deal with the master’s level issue (we’re PhDs, we’re above all that), CACREP is claiming to be the go-to source for mental health expertise. Uh, without using psychology. (I know, right?)

So, if APA wants to own the application of behavioral science across all levels of training and application, it is imperative to develop a model curriculum for psychology at the master’s level, just like we have at the doctoral or baccalaureate level.

How to begin? The Report of the Board of Educational Affairs Task Force to Develop A Blueprint for APA Accreditation of Master’s Programs in Health Service Psychology discusses possible pathways APA could use to establish accreditation of master’s programs in psychology. In addition, the report identifies the necessary expertise needed to constitute an accreditation decision-making body. The report will inform the development of standards for accreditation of master’s programs in health service psychology.

The next step will be to identify and operationalize the competencies that a basic master’s degree student should be able to demonstrate. This is distinct from making any recommendations about licensure at the master’s level. That will remain an issue for state legislatures, but if APA doesn’t articulate a policy about master’s level competencies then psychology will not have a seat at the table when the regulators ask for input about master’s level credentialing and scope of practice.

OTHER MATTERS
In addition to several housekeeping issues, Council approved:

» A resolution on physical discipline of children stating that, the preponderance of research evidence supports the conclusion that physical discipline is harmful, that caregivers should use alternative forms of discipline, that there is a need for culturally sensitive training in alternative discipline, and that further research is needed to better understand several aspects of physical discipline. I spoke to APA staff and they have assured me that they are preparing talking points to help us deal with the likely blowback (cf. the “toxic masculinity” fiasco).

» A resolution on child and adolescent mental health calling for the development of more funding for research, training, coordination with allied provider groups, and direct services for primary mental health care.

» Clinical Practice Guidelines for the Treatment of Depression Across Three Age Cohorts. This was opposed by some folks who object to the over-reliance on randomized control studies (RCT) to the exclusion of other studies. It was noted that these guidelines are part of the three-legged stool: empirical evidence, patient preference, and clinical experience. For a discussion of Clinical Practice Guidelines vs Professional Practice Guidelines, see apa.org/practice/guidelines/clinical-practice.

READ THE REPORT
apa.org/ed/governance/bea/masters-accreditation-blueprint

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

We are seeking content in the following areas:
Independent Practice; Ethics; Multicultural Diversity; Forensic Issues; and Student and Early Career.

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

Send to drjenniferrockett@gmail.com by 7/5/2019 for the summer issue.
THE BASICS OF DISASTER RESPONDING

 Traditionally, disaster response efforts have focused on meeting the basic needs of survivors including shelter, food, water, and medical treatment. However, the events common to disasters—including threats to life, exposure to death and injury, loss of possessions, and dislocation (Shultz, Espinel, Galea, & Reissman, 2006)—are all psychologically stressful as well. While emotional responses vary, people find themselves trying to manage extreme emotional responses, while dealing with a disrupted environment, a lack of routine, and the complex financial and logistical efforts necessary to rebuild or relocate your life. It is at this point that talking to a mental health provider who is not overwhelmed and stressed can be very helpful. As a result, disaster response efforts now often include mental health components.

Federal agencies such as Homeland Security and the Federal Emergency Management Agency (FEMA) typically collaborate to provide emergency support to disaster survivors (Department of Homeland Security, 2012). Most communities also rely on nonprofit disaster response organizations. The Red Cross is the most well known of these groups and offers mental health services and training in addition to their other relief functions (redcross.org). The Green Cross Academy of Traumatology (greencross.org) focuses exclusively on providing mental health support. This nonprofit humanitarian assistance organization responds to requests for disaster stress management and mental health support by communities affected by disasters. The American Psychological Association also has a longstanding Disaster Resource Network (apa.org), which works jointly with the Red Cross.

DISASTER MENTAL HEALTH

Most disaster mental health efforts are based on the principles of Psychological First Aid (PFA; Brymer et al., 2008, Vernberg et al. 2009). PFA is based on core actions, which include establishing contact with community members in non-intrusive ways, addressing immediate safety and practical concerns, helping people to manage emotional distress, creating recovery and action plans, and linking survivors to sources of long-term support. Disaster response interventions focus on helping people deal with the acute stress they are experiencing.

Responders talk to people where they are, in the shelter, in their neighborhoods or communities, and even standing in line for supplies. They may find themselves handing out water, helping people connect with resources, or helping other disaster responders to cope. The key is to reach out to others, to let them know that you are there to provide disaster stress management, and to meet them where they are. Before deployment, the responder should already be aware of the cultural, ethnic, and regional differences relevant to the particular disaster they are working and offer help accordingly. It is crucial to remember that survivors do not have to talk if they do not want to, and you are not there to ask them to relive their trauma. Basically, the responder’s role is to help the survivor figure out how to cope with a disorienting, abnormal situation.

The development of posttraumatic stress disorder (PTSD) following a disaster is always a risk (Neria, Nandi, & Galea, 2008). Although many people exhibit symptoms of the disorder immediately following a traumatic event, most people experience a diminution in symptoms by one-year post disaster (Blanchard et al., 1996). Rates of depression and anxiety also increase after a disaster (Palinkas et al., 1993). Disaster victims may also experience disturbances in sleep, appetite, and libido, as well as somatic complaints including GI problems and headaches (Young et al., 1998). People who have lost a loved one may exhibit responses characteristic of bereavement. Typically, disaster responders focus on helping the bereaved to understand their feelings, meet their basic needs, take care of their families, and manage the logistics of losing a loved one in a disrupted world. Disaster mental health treatment is not intended to be long-term therapy. Survivors who need sustained support should be helped to find more permanent therapy options.

Children and adolescents are also affected by the trauma surrounding disasters (Child Mind Institute, 2017). In addition to the stress of living through the event, they too deal with loss, grief, and an uncertain future. Further complicating the situation is the fact that young children may not be able...
to verbally express their feelings, and older children may be unwilling to do so. Signs to watch for include irritability, excessive crying, disturbed sleep, nightmares, lack of emotional expression, replaying aspects of the disaster, acting fearful or clingy, and reverting to behaviors such as thumb-sucking or bedwetting.

Older children and adolescents may withdraw from friends or activities, become preoccupied with the event, become anxious or depressed, have trouble concentrating at school, experience sleep problems, complain of somatic discomfort such as headaches or nausea, internalize guilt, or increase rebellious or risk taking behavior. Normalizing their responses, helping children communicate their feelings, providing opportunities for play and socialization, and helping families to reestablish schedules and structure are all helpful post-disaster strategies (Greenman, 2005; La Greca, Silverman, Vernberg & Roberts, 2002). Disasters may escalate prior family conflicts including parental discord or mental health issues, substance use, financial concerns, and custody conflicts, all of which can have a negative effect on children. Older children may also feel they cannot express their concerns to their parents because they are already under so much stress. Mental health responders also need to be aware that when children are living in communal shelters, they may also be at risk for abuse. Recognizing, responding to, and reporting suspected abuse is crucial in disaster settings.

It is also important to be aware of the politically charged atmosphere often apparent during a disaster. As distress levels rise, frustration about perceived governmental response failures, complaints about aid agencies, and political blame often become endemic. As a mental health responder it is your role to remain neutral when such topics arise, and to urge people to focus on solving immediate problems rather than allocating responsibility for failure. Discussing such topics with your fellow aid workers may be necessary for self-care, but doing so with the people you are there to help may only serve to make the situation worse for them. While professional responders such as law enforcement, fire rescue, and emergency medical technicians are accustomed to dealing with life-threatening and stressful situations, the urgent, concentrated nature of disasters can take a toll on them as well so they may also benefit from support and the opportunity to process their responses to the things they are seeing.

The press is also an integral component of modern disaster response scenes. While they often play a key role in communicating health and safety warnings, survivors are frequently frustrated by their presence, and suspicious of their motives. As responders you may be photographed in your role, or asked for interviews. To avoid possible conflict or comments being taken out of context you need to know the press policies of the organization you are working with, and to consult your organizational supervisors for guidance.

Most disaster organizations have their own policies for documenting individual and team actions, numbers of contacts with the public, and problems as they arise. Daily situation reports or logs serve as a useful metric for later evaluating the efficacy of the deployment, and identifying policy changes for the future. Accustomed as we are to living in an electronically connected world, the lack of access to power and wi-fi are often disorienting, and require that we develop alternative means of coping.

**SELF-CARE**

The mental health of first responders is also an important facet of disaster mental health care. Repeated exposure to stressed, traumatized people, especially when you are dealing with your own responses to the situation, can result in compassion fatigue (Figley, 1995). This condition is associated with diminished sensitivity to the needs of others, rising rates of depression, anxiety, stress, and increased interpersonal conflict. Clearly, such emotional distress has the potential to disrupt the responder’s efforts to help others, and to take a toll on their own well being.

Knowing what to pack for a disaster is challenging. If you are going to be living and working in the field you will want to wear comfortable clothing and shoes. Khakis or jeans and layered t-shirts, long sleeved shirts, and jackets are useful as they allow you to respond to changing conditions across the day. Closed-toe shoes, hats, sunglasses, rain gear, and cold weather attire may all come into play depending on the nature of the crisis. If you are going to be meeting with officials or doing more formal training, you may want to include a business casual outfit as well.

It can be helpful to bring your own sleeping bag and towels if you are not sure what will be available. You should also bring an excess supply of your medications as well as basic self-care items including soap and toothpaste. A flashlight, backpack, battery-powered alarm clock or radio, sunscreen, bug spray, and even basics such as toilet paper can be useful. However, you will probably have to carry your own suitcase or duffel bag throughout the trip, so careful packing is required.

While you are unlikely to have a lot of time to relax while working a disaster, it is essential that you take time each day to rest, decompress, sleep, and eat. Bringing headphones and music, a portable craft like coloring or embroidery, or an escapist novel can help you calm down. If you are a light sleeper, then earplugs or a sleep mask may be helpful. You may want to pack a supply of snacks that do not need refrigeration such as crackers, hard candy, trail mix, or other things that can be transported and eaten on the run. Fortunately, bottled water is usually available at disaster settings.

Perhaps the most important thing you can do for self-care at a disaster is to take advantage of the social support provided by your colleagues. Talk openly about how you each cope with stress and how you like to be treated when you are upset (distracted, left alone, fed...). Although each team member should be mindful of their own boundaries in an ongoing crisis, emotions
can outstrip logical thought. If you feel that you or a colleague should take a break from a situation, or are starting to think in terms of case management instead of acute care, speak up in an honest and caring way. In the event that a team member or leader is resistant to such efforts, you may need to consult with your supervisors (whether on- or off-site) to determine the best course of action. A key component of an effective disaster response is to make sure that the interpersonal dynamics of your team do not become an impediment to your mission. If after you return from the mission you find yourself experiencing negative emotions, difficulty sleeping, flashbacks, or other components of compassion fatigue, you should seek professional help before such symptoms become entrenched.

**IS DISASTER MENTAL HEALTH FOR YOU?**

Researchers universally agree that people thrive when they feel needed, are able to help others, and engage in meaningful activities. Disaster mental health responders can feel all of these things, but only if they go prepared with a flexible attitude, an awareness of how to function effectively in an unfamiliar and changing situation, a willingness to engage in self-reflection, and to talk honestly about how they feel. Friendships forged in stressful settings can be very strong, but interpersonal conflicts escalate quickly. Preparing before you deploy, recognizing that you are going to find yourself in uncomfortable situations, and putting the energy into building a team culture of support can make all the difference. It is unlikely that the rate of natural or man-made disasters are going to slow down in the near future. Unfortunately, this means that we are going to need to continue to develop a pool of trained disaster mental health responders, who are willing and able to help others in times of crisis.

**REFERENCES**


**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](bit.ly/tpa-disaster-resources)
The Unique Role of Servicewomen in the Military: History, Barriers, and Treatment Considerations

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HISTORY AND EVOLUTION OF WOMEN’S ROLES

“It’s as if anything I could have done, as a woman, can’t be nearly as important as a man’s. It’s to the point that I rarely even mention my service.” (U.S. Army, Intelligence Analyst, Staff Sergeant, personal communication, 2019).

This statement, and others like it, highlight women’s sometimes underappreciated history in the U.S. military. In fact, women have been serving in the U.S. military since the Revolutionary War, serving in roles such as nurses, seamstresses, cooks, or water bearers. While these roles are not characteristic of combat and trauma exposure, they did not preclude women from such experiences. Women also served as spies during the Revolutionary War, relaying messages or transporting materials. It was also common for women to disguise themselves as men to operate in combat roles. During World War I, more than 25,000 American women served overseas. Many of these women were nurses, but women also served as administrators, secretaries, and telephone operators. The creation of the Women’s Army Corps around the time of World War II was one of the most significant gender events in military history and expanded women’s roles to military intelligence, parachute rigging, and piloting aircraft.

In 1975, the U.S. Congress authorized the admission of women to the U.S. military service academies, and the first female cadets entered classes in the summer of 1976. During the 1980s and 1990s, the role of servicewomen continued to evolve with the disestablishment of the Women’s Army Corps and integration of women into all branches of the U.S. military. In 2013, the direct ground combat exclusion rule was terminated and women were integrated into combat units. Beginning in 2016, women gained equal rights to choose any military occupational specialty, including ground combat, which was previously not allowed.

While only having the opportunity to officially serve in ground combat roles in the U.S. military since 2013, women have been serving in a variety of roles in combat zones for a number of years. The implication for this is that servicewomen have been exposed to trauma in a combat zone despite not serving in combat arms or in an official combatant role. Previous research has documented that combat exposure can occur in military noncombatants (Peterson, Wong, Haynes, Bush, & Schillerstrom, 2010). Nurses and other medical personnel are often tasked with treating wounded or dying soldiers. Servicewomen may go out on missions in order to interact with local women in Iraq or Afghanistan. Servicewomen may also be exposed to mortars or gunfire on forward operating bases. Working in combat support (e.g., military intelligence, military police, etc.) or combat service support (e.g., transportation, medical, etc.) roles does not preclude servicewomen from combat or trauma exposure.

CHALLENGES FOR SERVICEWOMEN IN THE U.S. MILITARY

While servicewomen’s expanding roles in the military allow for the acquisition of skills in traditionally male-dominated occupations, such as the military police, convoy support, being in charge of prisoner of war facilities, artillery, and mechanics (Murdoch et al., 2006), they are also accompanied by additional support needs necessary to help navigate associated stressors of being in a masculine culture. In addition, servicewomen are inundated with gender-specific challenges that can negatively impact their well-being (Vogt, Pless, King, & King, 2005). Common occurrences more likely to affect servicewomen than servicemen can include sexual harassment (Vogt et al., 2005), sexual assault (Kimerling, Gima, Smith, Street, & Frayne, 2007), gender harassment (Street, Vogt, & Dutra, 2009), readjustment issues (Vogt et al., 2005), and lack of social and leadership support (Vogt et al., 2005). As such, having a support network is paramount not only in achieving goals, but also for daily functioning.

Social support provides assistance and encouragement, which can be a protective factor for those in times of stress. Positive relationships and support during deployment is crucial for managing emotions and
As the role of women is expanding in the military, it is imperative for medical and mental health practice to evolve and adapt.

behaviors as the absence of perceived social support (e.g., unit cohesion, leadership support) while in the deployed setting has been found to be associated with mental health concerns, PTSD in particular, for servicewomen (Brailey, Vasterling, Proctor, Constans, & Friedman, 2007; Vogt et al., 2005). Support is also fundamental as a resiliency factor as servicewomen may have attempted to dually balance familial and military duties while deployed, adding to the current stressors associated with their service (Street et al., 2009).

Reintegration support for servicewomen may also pose unique challenges. Given that women are the minority in the military and constitute about 16% of the enlisted forces and 18% of the officer corps in the U.S. military (Reynolds & Shendruk, 2018) (Marines = 7.5%; Army = 13.5%; Navy = 16%; Air Force = 19.2%; Coast Guard = 13.1%) (Captain, 2016), there are less data regarding treatments and outcomes than are available for men. Being in the minority can also result in limited access to specific mental health, financial, and housing services. For instance, access to women specific mental health services may not be available in every Veteran’s Administration Hospital and some veterans-based housing programs do not provide options that include women or children. In addition, servicewomen typically are the primary caregiver in families and may need added support for the reintegration process (Street et al., 2009). Further, servicewomen may be at a disadvantage regarding public perception of being in the military as the current culture may not believe that servicewomen are exposed to “actual” danger or combat situations, which can be invalidating, thus exacerbating mental health concerns (Fontana, Schwartz, & Rosenheck, 1997; Street et al., 2009).

Your military role, your wife role, your mom role. It’s difficult to juggle and I think there’s more of an expectation that women should be good at it while all the guys seemingly have to focus less on family life as it is the expectation that women will handle the home front” (U.S. Air Force, Intelligence Analyst, MSgt, personal communication, 2019).

CONSIDERATIONS FOR BEHAVIORAL HEALTH PROVIDERS

As the role of women is expanding in the military, it is imperative for medical and mental health practice to evolve and adapt. Research indicates that approximately 60% of veterans never seek care at the Veteran’s Administration. This suggests that the majority of health care for veterans occurs outside of the Veteran’s Administration. To date, there is a dearth of research on U.S. servicewomen, and the specific needs of servicewomen in these new roles is not well understood. With women making up more than 16% of the current forces (Reynolds & Shendruk, 2018) and women projected to make up 15% of the veteran population by 2035 (National Center for Veterans Analysis and Statistics, 2011), it is important that psychologists enhance their knowledge of military culture, the unique experiences of military servicewomen, and evidence-based treatments. There are a number of challenges and considerations in treating U.S. military servicewomen, and a full review of this is beyond the scope of this brief article. However, there are a few considerations that are essential in providing psychotherapy to military service members and servicewomen.

One important consideration is military cultural awareness. Military culture is unique, and it can be challenging for any provider who has not experienced a combat deployment or lived in the context of a military unit to establish rapport with a service member. Each branch of the military has a set of core values, guidelines, expectations of behavior, and set of norms that can influence a service member’s beliefs, attitudes, and behaviors. There are also an unbounded number of idioms, acronyms, abbreviations, and terminology that can be unique to each branch of the military (e.g., the term “soldier” is specific to the Army). Increased understanding of military culture can mitigate the divide between patient and provider. Research has found that 13% of community providers were identified as “competent” in understanding military culture and values (Tanielian et al, 2014). The Center for Deployment Psychology and the PSYCHARMOR Institute are two organizations that offer resources (e.g., webinars, workshops, and presentations) to enhance knowledge of military culture of community mental health providers. While training and knowledge of military culture can be beneficial in developing rapport with a patient, it is also important for providers to understand the service member’s own personal experiences in the military.

Additionally, providers may lack the knowledge and training on the unique stressors and mental health difficulties faced by servicewomen, specifically those now serving in direct combat roles. For example, combat exposure rather than deployment itself may have an impact on disordered eating and weight changes in servicewomen, as shown in the study by Jacobson and colleagues (2009). How servicewomen are specifically impacted by menstruation and pregnancy, parenthood, and social support are other areas that many providers are not specifically trained to address.

Another consideration for providers working with military service members is understanding the common mental health problems and best practice treatments. Combat-related posttraumatic stress disorder (PTSD) is the hallmark diagnosis in military personnel who have deployed to an operational combat theater. Research studies have estimated that between 13 and 30% of post-deployments U.S. military service members meet criteria for PTSD (Kok, Herrell, Thomas & Hoge, 2012; Thomas et al., 2010), which is above the U.S. civilian average of 6-8% (Kessler, Berglund, Demler, Jin, & Walters, 2005).

Prolonged Exposure and Cognitive Processing Therapy are two first-line, evidence based treatments for combat-related PTSD. Training in Prolonged Exposure and Cognitive Processing Therapy is almost exclusively available through the Veteran’s Administration and Department of Defense. Finley and colleagues (2018) found that only 15% of community-based providers in Texas reported conducting psychotherapy.
for PTSD that followed a treatment manual and less than half reported any use of evidence-based treatments for PTSD. This shows that there is a gap between the number of providers treating veterans and military personnel, specifically those with PTSD, and providers using evidence-based therapies. The STRONG STAR Training Initiative (South Texas Research Organizational Network Guiding Studies on Trauma and Resilience, or STRONG STAR), is a collaborative learning community dedicated to the dissemination, training, and implementation of evidenced treatments training to providers and organizations that serve veteran communities. Under the leadership of the University of Texas Health Science Center at San Antonio and the STRONG STAR Consortium, the STRONG STAR Training Initiative offers evidence-based treatments for PTSD among community-based providers in Texas. Psychological Services, 15, 442–452.


SUMMARY

The expansion of roles for servicewomen presents a unique challenge for providers that work with this population. Research is currently lacking in the specific challenges faced by servicewomen in combat roles. Additionally, many behavioral health providers do not have the opportunity for additional training in working with servicewomen, training in evidence-based therapies to treat PTSD and related issues, and training in military culture that would allow them to best serve these individuals. We have provided information for resources that may help address this gap in training for community providers.

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Treating the 93%: SCJS Juvenile Sex Offender Outpatient Treatment Program

Jim Brown, LCSW, and Paul Andrews, PhD

ABSTRACT

Statistics suggest that although only about 7% of juvenile sex offenders commit another sexual offense, there is usually mandated treatment for all. Treatment programs, based on confrontation of denial in a group setting and a “containment” model assuming lifetime pathological risk, were uncritically adopted for treatment of juveniles with sex offenses. Our negative experience with such a model prompted us to shift to an evidence-based treatment modality of family therapy with a heavy emphasis on attachment theory and internalization of pro-social values for treatment of juveniles with sexual behavior problems. Consistent with other research, 95.5% of the juveniles did not commit another known sexual offense in the follow up time (average 6.5 years). Remarkably, only 7.5% of the juveniles went on to commit any other type of known offense in the follow up time although large scale research has found 40–45% general recidivism for such youth.

INTRODUCTION

In the past few decades in the United States there has been much discussion and great effort to address problems of sexual abuse and sexual violence. As much of the impetus for change came from social response to notorious cases of serial offending by sexual predators and rapists, strong reactions occurred both in legislation and in judicial sentencing. Perhaps out of fear that “nothing works,” a strong model of containment, labeling, harsh confrontation, and ostracizing has come to be normative for dealing with adult sex offenders. Unfortunately, this model has also been extended to adolescents and youth without sufficient justification that it works.

Since the first juvenile court was formed in Chicago in 1899, the focus of these courts has been to examine each case to discern what the youth had done, why the behavior occurred, what resources for guidance and supervision existed within the youth’s normal circumstances, and what modifications needed to be introduced for the purpose of rehabilitation. Later, as the focus shifted toward more of a punishment orientation in some courts, attorneys pursued more protection for legal rights of juvenile offenders (cf. Kent; In re Gault), a shift that sometimes supplanted the rehabilitation focus. When the political response of public fear of crime in the 1980s resulted in “tough on crime” approaches, the rehabilitation focus eroded even further (Grisso & Schwartz, 2000; Steinberg & Schwartz, 2000). As a result, approaches for responding to juveniles in trouble for sexual misconduct began to parallel approaches being used with adult sex offenders along with the unsupported belief that the character and behavior of youth were unmalleable (Dodge, 2008).

DEVELOPMENT OF SMITH COUNTY PROGRAM

In early 2005, Smith County (Texas) Juvenile Services began formal planning for an outpatient juvenile sex offender treatment program. Early articulation of goals included emphasis on preventing sexual recidivism, successful completion of probation by focusing on reducing risk factors for general recidivism, and progress toward “good citizenship” and developmentally appropriate goals. An outpatient group was formed for treatment of juveniles who had been adjudicated and placed on probation for their crimes. Another group, based on support and psychoeducation, was created for parents. Both groups relied upon commercially published workbooks and group discussion format.

In the same year our program began, legislation passed in Texas that granted policymaking and regulatory power about treatment of sex offenders (both adult and juvenile) to the Council on Sex Offender Treatment (CSOT), an agency that had previously been tasked with surveillance and restriction of adults who had been adjudicated as sexually violent predators. The legislation also required any mental health professional offering sex offender treatment to adults or juveniles to obtain a second license and to practice under jurisdiction of this agency whose rules took precedence over the rules, regulations, and code of ethics associated with the provider’s primarily license. The CSOT prescribed standardized, group-based treatment that was confrontational in nature. While CSOT rules allowed for some flexibility in working with youth, there was an overall philosophy of “containment” based on an assumption of lifetime pathology and reliance more on restriction and surveillance than on provision of therapy.

It was soon evident to our staff that the peer group treatment was not working. Getting the teens to seriously participate during group meetings was difficult, as anxiety about treatment and fear of consequences for self-revelation increased a natural competitive drive by these young males to create...
an atmosphere of resistance and avoidance rather than a willingness to engage in planned discussions. A critical decision point came when a presumed low-to-moderate risk youth participating in the program attempted to re-offend with a sibling. At that point, treatment staff decided to explore other approaches based on what had been found to work with juvenile offenders.

In looking beyond the containment model, we found professional literature supported more traditional approaches to treating juveniles (Hazelrigg et al., 1987; Liddle & Hogue, 2000; Zankman & Bonomo, 2004; Reitzel & Carbonell, 2006; Friedrich, 2007). Multisystemic Therapy (MST) had shown strong empirical evidence of success with juvenile sex offenders (Borduin et al., 1990; Borduin & Schaeffer, 2001; Curtis et al., 2004), but our program could not afford such an expensive approach. Family-based treatment generally had shown good success with misbehaving youth and also provided the greatest opportunity to structure support and accountability on a daily basis for youth, two elements often integral for change. Self-help and religious groups have long practiced these two elements involving acceptance but also discipline. Interestingly, the Canadian Department of Corrections, faced with release of adult convicted sex offenders when no communities wanted to accept them, highlighted these elements to community safety.

Once we rejected the prescribed containment model, the question arose whether it was even necessary to treat everyone. Research (Zimring, 2004; Reitzel & Carbonell, 2006) has found that only a small minority of juveniles detained for sexual offending are found to re-offend with another sexual offense. Generally, sexual re-offending has been found to occur in only 7–14% of these youth and in an even lower percentage with treatment intervention. Although it could be argued that it makes sense to provide no treatment to youth with low risk since overtreatment creates its own problems (Andrews & Bonta, 2001; Langton & Barbaree, 2006; Andrews, 2012), it matters immensely in two other ways. One, the youth has gotten into trouble presumably due in part to a mismatch between the guidance he needs and what was available or was occurring. Addressing the gap and the needs in a corrective way increases the opportunity for the family to recalibrate in a way that leads to a more healthy development of the youth. Two, the majority of children and adolescents appear to engage in some level of antisocial or criminal behavior although in the vast majority of youth this behavior is time limited (Loeber et al., 1998). But any infraction when a youth is on probation can become the cause of much more serious consequences such as probation revocation with incarceration or registration as a sex offender (a designation having very stringent long-term consequences). This risk for general delinquent behavior must be treated as research findings indicate a juvenile in trouble for sex offending may be six times more likely to reoffend in a non-sexual crime than a sexual offense (Parks & Bard, 2006; Caldwell, 2010; Martinez, 2013). Other research suggests that the same pattern of low recidivism for sexual offending but relatively high rates of non-sexual recidivism (4.3% vs. >50% respectively) continues even into adulthood (Vandiver, 2006). Our approach was to take each youth’s situation seriously and attempt to address the risk for any subsequent delinquent behavior.

**STRUCTURE OF THE SMITH COUNTY PROGRAM**

Outpatient treatment is recommended when there is no pattern of repeated sexual offenses and the family is responsive to working with our treatment team. Outpatient treatment requires commitment by at least one significant adult in the juvenile’s life to participate in treatment and to supervise the youth according to the rules of the juvenile probation officer. Generally, residential treatment as a first option is recommended for juveniles who display major mental health or serious substance abuse problems and/or have a significant dysfunctional family dynamic with little likelihood of change in the near future (e.g., strong intergenerational sexual abuse patterns). Other options the court may consider include treatment in a structured boot camp when there is a strong history of oppositional behavior or unstable family environment leading to inconsistent supervision or ineffective discipline. Incarceration may be imposed by the court if rehabilitation efforts have failed using other methods or when there exists very high risk to community safety.

With a working alliance with at least one parent or parent figure, we then focus on empowering the parent(s) to engage the youth with accountability and support.
We have had few known incidents of general recidivism and only three known incidents of sexual recidivism in our thirteen years of providing a treatment program. These results have been accomplished at a significant cost savings compared to costs of other options.

When the youth is disengaged or seems to lack social skills, the therapist collaborates with the parents to help them develop plans for getting the youth involved. Our assumption is that if pro-social parents take on their hierarchical role, emotionally engage with their sons, and are supported in their efforts, it is likely the family system will move toward health and that normal family tasks of preparing the youth for independent adult functioning will progress beyond the time in therapy.

Graduation from treatment depends on these criteria having been met by the juvenile in addition to completion of therapy assignments and goals: compliance with probation and other court-ordered requirements; compliance with school requirements and adequate academic progress; cooperative behavior with the therapist, family members, and authority figures; adequate stress management and emotional regulation; functioning within the family without significant conflict; behavior and activities consistent with developmental stage; maintenance of alcohol- and drug-free status; and minimized or controlled risk factors for reoffending. We also look for problem-solving skills appropriate for age level; respect for boundaries; positive attachment to significant others; low level of hostility or shame; ability to effectively communicate thoughts and feelings in words; and pro-social attitudes such as cooperation, appreciation for the rights of others, respect for family and community rules, empathy, reciprocity and fairness, and sense of personal responsibility. Several of these factors have been identified as being specifically important in reducing recidivism and need to be targeted for intervention (Hoge & Andrews, 2011).

Generally, families need at least three months to complete our program and usually much longer. The mean treatment involvement time is about nine months with an average of sixteen family therapy sessions. Progress is faster when there is strong parental bonding, stable family structure, healthy attitudes and value system, and family members functioning with a high level of personal and interpersonal skills. Treatment success takes longer when one or more members of the family has serious mental health problems, when family structure is unstable, when members lack good communication and interpersonal skills, or when the youth is detached or extremely oppositional.

RESULTS OF OUR PROGRAM

From March 2005 through September 2018, 67 youth were court ordered to and discharged from our treatment program (two other juveniles charged with sexual offenses were certified and tried as adults, and three others who offended while in foster care were sent directly to incarceration after adjudication). In the first six months of the program, boot camp, residential treatment, or individual treatment sessions were the only options as we were developing our outpatient approach based on recommended group treatment. The group work approach lasted for a little over a year before we adopted the family therapy approach in October 2006, after one of the presumed low to moderate risk youth in treatment attempted to re-offend, something which caused us to abruptly rethink our approach. Below is a synopsis of results of thirteen years of our program.

| n = 67 juveniles, mean age=14.13 years, range 10–18, all males |
| months in treatment: mean=8.8 months, range 1–21 (included boot camp for 13 youth) |
| number of family therapy sessions per youth: mean=16.15, range 0–37 |
| 62 youth were involved in family therapy at some point, 42 exclusively |

Successful discharge from program: n=56/63 (88.9%) (4 moved away before discharge)

Unsuccessful discharge from program due to lack of progress (without known recidivism): n=7 (10.4%); one subsequently successfully completed treatment with another provider; six were sentenced to Texas Juvenile Justice Department based on being too high a safety risk to stay in community

Follow-up time at risk for recidivism: mean=78.3 months (6.54 years); range 11–161 months

Known sexual recidivism: n=3 (4.5%) (one low-to-moderate-risk youth at five months into group treatment (age 13), one moderate-to-high-risk youth at four months into family treatment (age 15), and one moderate-risk youth at 16 months post discharge following 15 months of family therapy (age 11))

Known general recidivism: n=5 (7.5%) (one as juvenile with school incident; four as adults, one of whom previously also had juvenile sexual recidivism)

Treatment failure plus any known recidivism: n=13 (some overlap) (19.4%)

LIMITATIONS OF OUR EXPERIENCES

We have discovered some limitations to our approach in working with some types of youth. For instance, we have found that we cannot make progress if a youth’s substance abuse problems remain uncorrected. Even parent substance abuse problems provide a challenging environment for treatment; at least one parent must be free of such problems for progress in our program. We have been unable to make much progress when the youth comes from and remains in a pervasive family and peer culture of sexual abuse and mistreatment. Finally, we...
We think these principles have long proven what makes healthy family environments. Care consistent with our understanding of attack, and support rather than avoidance than harshness, accountability rather than attachment, and support rather than avoidance care consistent with our understanding of what makes healthy family environments. We think these principles have long proven to be useful in the rehabilitation of offending youth and need not be abandoned for “specialized” treatment that dismisses these foundational concepts. We also believe part of the reason for this decreased risk is related to the redemptive difference that restorative justice has over shaming associated with much of the “containment” model.

SUGGESTIONS FOR FURTHER DEVELOPMENT

We strongly suggest further development of programs for treating children (age 10-12) who often will be facing their most risky time for antisocial behavior and influence from deviant peers after treatment and supervised probation has probably ended (around age 14-15; cf. Hein et. al, 2017).

CONCLUSION

The authors of this paper facilitated an outpatient treatment juvenile offender program affiliated with a juvenile probation department in a non-metropolitan setting. Our research indicates that family therapy, an evidence-based treatment for juvenile delinquents, has been effective in our setting and has resulted in enhanced family functioning, pro-social outcomes for teens, and surprisingly low general recidivism rates. Our approach relies upon long recognized tenets that adolescence is often a time of aberrant behavior but that such behavior is malleable with systemic intervention and corrective involvement of the family.

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Psychologists and Their Communities: A Collaborative Approach

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The preamble to the APA’s Code of Ethics (APA, 2002) states that:

Psychologists are committed to increasing scientific and professional knowledge of behavior and people’s understanding of themselves and others and to the use of such knowledge to improve the condition of individuals, organizations, and society. Psychologists respect and protect civil and human rights and the central importance of freedom of inquiry and expression in research, teaching, and publication. They strive to help the public in developing informed judgments and choices concerning human behavior. In doing so, they perform many roles, such as researcher, educator, diagnostician, therapist, supervisor, consultant, administrator, social interventionist, and expert witness.

This and the remainder of the preamble and general principles suggest that these “aspirational goals to guide psychologists toward the highest ideals of psychology” (APA, 2002) are not enforceable but reflect a value and belief system that we should strive towards as both professionals and contributing members to society. With that in mind, and given our specific understanding and knowledge of human behavior, shouldn’t we strive to help our communities outside of our regular daily jobs as psychologists, researchers, consultants, and/or professors? Yes, we can advance the science with our research, help our clients in our practices, help agencies make crucial decisions, and teach our students to become the best they can be in their chosen field. However, we can do so much more and in giving, we get so much back in return. Please indulge me as I present a personal example.

A Community Collaborative Task Force was initiated in fall 2015 connecting the Victoria County sheriff’s office, county jail staff, police, judiciary, community mental health service providers, hospitals, and related agencies. It became clear that there was a huge need in Victoria and surrounding counties for dedicated mental health services for jail diversion, timely mental health pre-incarceration assessment, and continuity of care (pre- and post-incarceration). Recent estimates are that upwards of 67% of inmates in the county jail have mental health issues. There are no trained mental health service providers employed by the jail, and staff have made it clear that the best they can do is provide required medication and supervision to ensure inmate safety as much as possible.

Thanks to my mentor and now-retired director of our Forensic Psychology MA Program at University of Houston Victoria, Dr. Paul Hamilton, I was invited to join the group with the hope that I could provide them some ideas and consultation. Being new to Victoria, Texas, and the U.S., everything was novel to me, but I met and was welcomed by a group of wonderful, dedicated people with whom I have had the privilege to serve my new community.

To put this in context, Victoria County has no mental health court and has only recently secured limited funding for trained mental health police officers. Until recently, there was no organized mental health service delivery in place, although all available agencies that can help do so when they can. The proposal put forth by the Collaborative Task Force to the state legislature—for funding to establish an integrated response system—was successful, allowing for the hiring of several trained mental health deputies and case workers.

The importance of this initiative is underscored by The Texas Criminal Justice Policy Council (2000), which has provided telling data that between 1988 and 1998, as the incarcerated population grew by 262%, the number of incarcerated offenders receiving outpatient mental health services grew by 429%. One estimate is that upwards of 16% of state and county jail inmates have a history of mental illness, but this is only one definition of mental illness available and many are undiagnosed. A more recent estimate (Kim et al., 2015) suggested that 56% of state prisoners, 45% of federal prisoners, and 64% of those in jail have mental health issues. Similarly, almost one quarter of the correctional population suffers from severe mental illness (Ditton, 1999; Lurigio & Fallon, 2007). Recently, Hill (2016) documented that ten times as many people with serious mental illness are housed in jails and prisons as compared to those in state hospitals.

Most jails have neither mental health resources nor expertise to handle offenders with mental health issues (Steadman & Veysey, 1997). Inmates with mental illness recidivate at higher rates than other inmates (Bureau of Justice Statistics report, 1999), but those who receive treatment for their illness are less likely to recidivate than those receiving no treatment (Solomon et al., 1994; Ventura et al., 1998).
While the Department of Criminal Justice in Texas oversees one of the largest correctional systems in the world, like all agencies, it has had to implement cost-containment measures. Relative to other states, annual increases in per capita healthcare spending have been low by comparison (Raimer, Murray & Pulvino, 2010). Between 2002 and 2009 alone, those within the system with mental health issues rose from 10.4% to 12.9%, with an increase of prescriptions for psychotropic medications increasing by 114% during that time frame.

Mental health courts have been successfully implemented in some Texas counties like Dallas, Tarrant and Travis Counties (Texas Task Force on Indigent Defense Office of Court Administration, 2010) with jail diversion initiatives initiating treatment significantly reducing recidivism such that the more months of treatment, the less likely to recidivate. There are successful examples of community-based mental health treatment services in Dallas (Metrocare) and Tyler (Andrews Center), which cater to special-needs offender populations and provide jail diversion services.

There has been much research in the field linking reduced recidivism to access to treatment. The success of mental health courts is now being documented. There had been no information gathered and summarized for Victoria County with regards to outcomes for incarcerated offenders who have been diagnosed with mental health issues or have received any mental health treatment. I have been tasked with gathering that information for our outcome measures.

Victoria is one of the first counties to implement such an integrated initiative of service providers and as such, provides an excellent opportunity for comparison between the previous system with no specialized services for offenders with mental health issues and the new, integrated approach. It was suspected that with such an intervention/potential jail diversion program in place, incarceration and recidivism would be greatly reduced, and our data support that hope and hypothesis. In fact, the Criminal Justice/Mental Health Consensus Project (Council of State Governments, 2002, p. 188) suggests just that: “People with mental illness who have become involved (or are at risk of becoming involved) with the criminal justice system frequently have multiple needs that can be addressed only through the collaborative efforts of several agencies working within the constraints of diverse systems.” Similarly, Lurigio and Swartz (2000, p. 46) suggested “building enduring connections between the mental health and justice systems.” Our collaborative is doing just that.

Working with Gulf Bend (our community mental health center) and the Community Collaborative, I was tasked (along with my graduate student, Chris Alas), to develop forms and outcome measures for their initiative. The intent was to document and collate police/sheriff’s and emergency providers’ ongoing encounters with calls that involve mental health issues that are attended to by Mental Health Officers. It involved immediate and retrospective data gathering as to the outcomes for those with mental health issues who come under the umbrella of the new initiative. The intent was for a more targeted approach, providing demographic data, information about where the individuals are diverted from, as well as their trajectory. It will also hopefully help to secure further funding for the Community Collaborative’s initiative.

Some data had already been collected, only in a cumulative capacity, but the individual data collection form we developed was implemented late last fall. When a call comes into the Crisis Response Team or to the Mental Health Officers, they attend the person and complete the form for each, as well as a summary form at the end of the day. The data then goes to Gulf Bend, where it is encoded and entered into their system. I then provide comparative analyses of the cumulative results and examine individual (encoded) data for trends, specific variables (like gender, initial referral, race/ethnicity, etc.), as well as trajectory versus what it could have been before this mental health initiative.

My point with all of this is that we have skill sets and knowledge that can be useful to our communities for the betterment of all. Contrary to the concern about the public’s suspiciousness of the mental health professions, I have only been met with appreciation for my expertise. In the process of helping, we have all developed a mutual respect for our areas of knowledge and skill sets. I have done my best (and will continue) to help my community and have not only worked with the collaborative at every juncture, but made important inroads bridging the divide between academia and the real world while connecting with colleagues in multiple professions and making lifelong friends. In giving, we receive back many times over, both professionally and personally. This is not new to me, as when I lived in Calgary, Alberta, Canada, I was involved in community initiatives as well, but this experience has cemented my belief that no matter where we live, we can give back to our communities.

REFERENCES
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The Gatekeeper’s Dilemma: An Imposter’s Commentary on Supervision

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“I do not belong. “I am not good enough at this.” “Why did they let me into graduate school?” Questions like these are commonplace among student trainees, even after launching into their professional careers (McCormick & Barnes, 2008). Plagued with self-doubt and uncertainty, students have found the greatest challenge in providing psychological services to be ourselves.

To make matters worse, we must quickly learn to perform feats of assessment and intervention to the satisfaction of our supervisors. The stratification of the supervisory relationship creates a power imbalance that does not always promote growth and progress (Wilson, Davies, & Weatherhead, 2016). This dynamic is made without fault of the supervisor or supervisee, but rather is the product of our rapidly evolving field. New mandates for measuring and recording psychological trainee progress provide additional layers of protection against the licensure of less-than-competent practitioners. Yet, these same policies have added pressure to the supervisory relationship. Students learn to be cautiously vulnerable, sharing just enough to get feedback but not enough to get a low mark on your evaluation.

After ascending into internship, I recognized the irrationality of my fears. Supervisors must act as gatekeepers to protect our field and our patients, and they also serve to support, teach, and build us into outstanding clinicians. My graduate training was filled with excellent supervision and, much like the child who launches from the nest only to realize she misses home-cooked meals, I write this article to share some of those experiences with readers. Each example examines the supervisory intervention through the task-analysis frame of the Marker, or issue, that needs addressing, Task Environment, or process of intervention, and Resolution, or result (Ledany, Freidlander, and Nelson, 2016).

EXAMPLE 1: LEARNING TO SKI

Supervisor: “So, you have your first week under your belt! How are things settling in?”
Me: “Great! I don’t think I have any questions or anything.” [I said this despite feeling overwhelmed and confused by the details of the job]
Supervisor: [Smiles warmly and nods]
“IT sounds like you are adjusting well.”
Me: “Yes, everything is great.” [Nervously picking at my thumbnail, smiling painfully]
Supervisor: “At first, I was totally embarrassed. I wanted to impress my friends, but I had to start from square one. I needed the basics. No skier has ever been successful on their first try, and I don’t expect you to either. Consider this a safe space for rookie questions and self-doubt.”

THE MARKER. My anxiety about revealing insecurities and lack of knowledge prevented me from opening up to my supervisor. My supervisor, being a wise and observant psychologist, read between the lines and decided to provide an intervention.

THE TASK ENVIRONMENT. My supervisor operated from a developmental and systems-based style of supervision. As a new trainee who was eager to please, this method was a better fit than a confrontational approach. For example, if my supervisor would have questioned my confidence, I may have dug in my heels and continued to deny any issues. Or, my supervisor could have taken my word at face value and moved on in the session without providing a safe space, thereby reinforcing my avoidance of vulnerability.

THE RESOLUTION. As my anxiety dissipated and I was given permission to be a learner, I was finally able to open up. I did
My graduate training was filled with excellent supervision and, much like the child who launches from the nest only to realize she misses home-cooked meals, I write this article to share some of those experiences with readers.

EXAMPLE 2: YOU ARE A MAN

Me: “I don’t know what I am doing wrong here. Most of my clients are doing really well, but these three are struggling.”

Supervisor: “They have been struggling?”

Me: [Notices my words] “I am struggling with these three. All of them are women who come in for anxiety. I don’t think it’s a gender thing. I am meeting with other women for therapy who seem to be doing well so far.”

Supervisor: “Hmm, not a gender thing. Do these three have anything else in common?”

Me: “I’m not sure. Maybe it’s something in their history?”

Supervisor: “Any issues with relationships? Parents or siblings, maybe?”

Me: “Come to think of it, yeah. I think each of them has mentioned difficult or abusive relationships in the past.”

Supervisor: "Heterosexual relationships?"

Me: “Yes, I believe so. Maybe I need to try to find out if those connect to their current issues.”

Supervisor: “I wonder if those might be playing into your therapy dynamic.”

Me: “What do you mean?”

Supervisor: “History of bad relationships with men.”

Me: “Are you thinking more of a PTSD approach?”

Supervisor: “Kyler, you are a man!”

[Supervisor and I share a good laugh.]

Supervisor: “You represent something or someone to the people you meet with. It’s easy to forget that, especially when our identity carries privilege. Let me ask you this: how was that for you when I pointed out an identity marker?”

Me: "It caught me off guard, but I really appreciate it. In the future, please feel free to call those out if I have my blinders on."

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THE MARKER. My lack of insight regarding gender roles and representation may have been interfering with the therapeutic process. As a man with other identity markers that come with privilege, I was able to easily brush those cultural factors aside and focus on what I perceived to be the problem. Ladany et al. (2016) describe this marker as a significant issue related to diversity and cultural sensitivity, and therefore, I needed some insight to provide adequate care.

THE TASK ENVIRONMENT. The safety and support of the supervisory relationship provided space for my supervisor to intervene in my ignorance. After noticing my blind spot, my supervisor used Socratic reflections and questions to guide me there (Carey & Mullan, 2004). Ample opportunity was provided before my supervisor provided clarity using professional humor.

THE RESOLUTION. This insight provided me with incredibly helpful awareness for future sessions. Additionally, this provided me with encouragement to reflect and consider how other markers of my identity may come into play with my work. As we continued to meet for supervision, I was reminded of this insight and made greater efforts to attend to cultural blind spots.

EXAMPLE 3: THE RUPTURE

[Context: Suicidal client on phone. Called supervisor for guidance on how to respond. They walked me through the steps, and we were able to help secure the patient. After this encounter, I sensed some anger from my supervisor. I successfully avoided conversation with them until supervision.]

Supervisor: “How are you holding up?”

Me: “I’m alright. Sorry about what happened with Patient X, I just didn’t know what to do. We should talk about my other patients.”

Supervisor: “You did the best you could, and you contacted me, which was smart. What makes you say that you are sorry?”

Me: “I don’t know. I’ll try to be more prepared next time, I promise.”

Supervisor: “I completely understand how that would catch someone off guard, especially for a trainee. It seems you are worried about what I’m thinking, though, and I am curious about that.”

Me: “I just try to always do my best, and I know I help represent our department, and that I am working under your license.”

Supervisor: [Does not respond, but gives me a knowing look]

Me: [Exhales] “I felt like you were angry about what happened. And I really am sorry! I should’ve been a better therapist; there’s a dozen things I should have tried.”

Supervisor: [Shakes their head] “No, you did good work. I was angry at myself. The whole situation made me question my supervision and oversight, and so that might have been what you picked up on. And actually, I thought you were angry at me for not preparing you well enough. I’ve been having anxiety about that all week. I’m hoping we could spend some time today talking it through so that in the future there is more understanding between us. What are your thoughts?”

** **

THE MARKER. The supervisory relationship experienced a rupture that was effectively disrupting our ability to work together, thus inhibiting my capacity to learn and provide supervised care. As a trainee, this sort of rupture felt incredibly threaten-
ing. The power differential added additional stakes to the situation, such as student evaluations and future recommendations.

THE TASK ENVIRONMENT. My supervisor employed a relational approach that used professional self-disclosure and affirmation of my experience to allow space for repair of the supervisory alliance (Friedlander & Hilsenroth, 2015). My supervisor could have just as easily dismissed my anxiety to focus instead on discussing current patients, thereby reinforcing my concerns. By focusing on the supervisory alliance instead of discussing the patient, we were able to address the relational issue in a way that felt respectful and put our team back together. This approach also modeled how to handle similar relational ruptures in the future.

THE RESOLUTION. For any relational break to occur, there must first be a bond. The openness and willingness to work through the rupture signified our dedication to the supervisory alliance. As we were able to work through this issue together, I experienced deeper feelings of security and trust in our relationship. Ultimately, this allowed me to risk greater levels of vulnerability and, in turn, receive essential guidance from my supervisor.

CONCLUSION
The added pressure of regular evaluations and competencies can complicate relational dynamics in the supervisory alliance, and some supervisees may feel uncomfortable being fully forthright and vulnerable with their supervisors. This presents a risk for inadequate training experiences and incompetent patient care. However, relational styles of supervision can dramatically improve the experience for supervisees and promote a sense of safe attachment despite these stressors. By focusing on the supervisory alliance, supervisors can help the next generation of highly scrutinized trainees to receive the training and support they need to become professionals.

REFERENCES


Let me begin by reassuring you that your forms are probably “all right.” This article is not intended to scare anyone into a hurried or wholesale modification of their office forms. Probably, your forms are at least “good enough” to keep you out of trouble. Psychologists are rarely found at fault because their forms have unwarranted language or because a form lacks some magic word or phrase that should have been there. When there is trouble over a psychologist’s forms it is usually because they did not have the form, not because the form they had was somehow “wrong.” Psychologists generally borrow forms and language from one another and psychologists are smart, well-informed, and careful; most psychologists’ forms are good enough.

On the other hand, you should not be satisfied with “good enough.” Your office forms serve a handful of functions, and the better your forms fulfill their functions, the better your office will operate. Generally, poorly crafted forms display good intentions harmlessly, while they lack language sufficient to establish legal and enforceable agreements with the client. Some words and phrases have more power than others.

**SOME IMPORTANT WORDS AND WHEN TO USE THEM**

There are legal differences between the language that we are inclined to use as psychologists and the language that lawyers use. The important legal models tell us to use language that is specific, unambiguous, and enforceable in our documents. Is the language in your forms specific? Does it clearly instruct your clients as to your expectations? Consider the admonition, often seen in one form or another in many psychologists’ informed consent: “If you miss a regularly scheduled appointment you will be charged for the appointment.” What about unusual appointments that are not “regularly scheduled”? How much notice is necessary? How much will the client be charged? When must the payment be made? What happens if the client does not pay the charge?

Specific language tells the client exactly what act or omission will trigger the consequence. It tells the client precisely when the consequence will occur and what the consequence will be. It is not enough to tell clients they will be charged for missed appointments. Clients need to know how much a missed appointment costs, how much advance notice is required, and when they are expected to pay the cost. Language becomes enforceable when the language is specific and unambiguous, and when the language clearly spells out the consequence and the time of the consequence. Consider the common phrase, “Payment is due when services are rendered.” With that simple phrase, the client knows when the payment is due. Absent similar language, enforcing payment can become complicated by the old “I’ll gladly pay you later” problem.

**THE DIFFERENCE BETWEEN NOTICE AND COMMITMENT**

A common theme in many informed consent forms establishes fees that will be charged for court appearances or for litigation-related services. Does your form set a fee, or does it establish an enforceable agreement? It is fine for your informed consent to assert that your fee for depositions or court appearances is, for example, $300 per hour. The form must do more than simply notify the client of the fee. The form’s language must establish the client’s agreement to pay the fee. “By your signature, below, you agree to pay your psychologist” is much more powerful language than a simple notice of the fee structure. By the latter phrase, an agreement is established that is more specific, less ambiguous, and more enforceable.

Better still is language by which the client “agrees” to pay a specific retainer amount at a specific time: *By your signature below, you agree to deposit a retainer of $2,500 with [your provider] before our office will schedule a deposition or court appearance. In the event that a subpoena is served on [your psychologist], you agree to pay a retainer of $2,500 at least 48 hours in advance of any appearance for a deposition or hearing.*

While no language will guarantee payment by a reluctant client, enforceable agreement language gives you a better prospect of payment than vague, uncertain, and unenforceable language. Simply telling clients what you expect may not be enough. Use specific language to assure that your clients have agreed to comply with your expectations.

There are times when notice alone is sufficient. Sometimes you do not seek or need permission. If you take two weeks each year to vacation or to attend an annual conference in the Netherlands, notice is sufficient.
For example: Our office will be closed from August 1 to August 15 each year. Dr. Smith will not be available to see you during those weeks. She will provide professional, clinical coverage in her absence.

In this case the psychologist is not seeking permission or the client’s agreement. This is clearly an appropriate use of notice language. If your office does not return phone calls on weekends or after a certain daily hour, notice language is both sufficient and wise.

Authorization language is another area where specificity is critical. At times you need a client to consent to an action from you or from your office. Consider two possible ways of phrasing this: If you miss a scheduled appointment our office will call the phone number in your file to reschedule your appointment. That is notice. Necessarily better is, By your signature below, you authorize our office to contact you at the following phone number __________________ to reschedule the missed appointment. In the latter sentence there is both explicit and implicit authorization for the psychologist to act.

Further, in the latter case, the client has provided a limited authorization to release protected health information. If your office uses advance telephone appointment reminders, authorization is essential. Notice is not sufficient. Be sure that your forms distinguish between notice and authorization.

A problem that has received recent attention is the question of what will be done with client records in the event of a psychologist’s death or disability. TSBEP is poised to require psychologists to have a plan ready in the event of the psychologist’s death or disability. We will be required to provide proof to the board that we have a plan and that we have our clients’ permission to implement the plan. At the heart of the problem is the need to provide an advance authorization for the disposition of protected health information in response to an event surrounded by uncertainty. Without digressing into the many complications in the question, the following language allows the client to make a limited, yet effective consent: By your signature, below, you authorize our office to appoint a qualified professional to serve as custodian of your treatment record in the event of your psychologist’s death or disability. Notice regarding how you may obtain your record in such an event will be posted on [your psychologist’s] website.

That language combines notice to the client as well as establishing the client’s consent for the psychologist to make a proper disposition plan. The additional step, of course, will require a psychologist to enter an agreement with another mental health professional—and to make sure that the colleague can access the record as needed, knows where the record may be found, and knows what username and password will allow entry.

Finally, you should wonder whether your clients have actually consented to treatment with you. The common form may carry the style “Informed Consent,” but has the client actually signed language to assert that he or she “consents” to treatment? It is easy to spend four or more pages explaining your office policies and expectations, side effects, and treatment plans and goals, and then to neglect, on the last page and in the last paragraph, to include language by which the client acknowledges receipt of the document, understands and accepts its terms, and finally, and most important that your client consents to your treatment.

Specificity, clarity, and enforceability. Make your intentions clear, and make sure your clients have agreed to abide.
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