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When was the last time you were moved to a state of awe by a piece of music, a work of art, a scenic vista, or the peaceful face of a sleeping child? For many people, opportunities for such experiences have been rare during the time of COVID. More likely, the experience most of us have shared all too often during COVID is some form of expression of ideological outrage. These come at us through newscasts, talk radio, internet groups, Facebook posts, and Zoom Happy Hours.

Like many other Americans, I am very concerned about the political divisiveness in our country. In the APA 2017 survey of Stress in America, 60% of respondents cited political divisiveness as a significant source of stress. In the February 2021 survey, that number had risen to 70%. 81% of U.S. adults cited the future of the nation as a significant source of stress, 74% cited political unrest around the nation, 72% cited the current political climate. At the same time, 90% of Americans said they hope the United States moves toward unity. Texas is no stranger to political divisiveness as the whole country is now acutely aware. As a microcosm of the country, we can assume that the current political situation in Texas is a significant source of stress for most of its citizens.

I really can’t take any solace in the fact that I am not alone in my concern. We all know someone who we can’t talk to without some sort of rancor erupting. Strained relationships with clients, broken friendships and severed family bonds are beyond sad. They compound the grief associated with the pandemic. From a pragmatic perspective, divisiveness prevents us from getting things done. Since human beings are a problem-solving group, the inability to come together to solve mutual problems is highly frustrating. Divisiveness can easily defeat the goal of having any kind of civic organization or rule-making body.

As TPA president, I can’t ignore the potential for divisiveness to disrupt the effective functioning of our association and strain our relationships with our colleagues. So, I have been reviewing psychological literature, both new and old, to help me understand the current state of divisiveness and identify ways to mitigate the impact on TPA.

One aspect of the current state of divisiveness that is the subject of more recent theory and research is that political partisanship has crept into every aspect of our society. No longer do people just have a difference of opinion regarding health, religion, or flying the U.S. flag on the 4th of July, to take some examples. Now these differences are viewed from a partisan, political perspective. This lack of boundaries between different areas of our lives has been attributed to the perversiveness of the social media and internet communications. Everything has become politically partisan.

Research suggests that appears to be no value attached to, nor social reinforcement for, civil discourse or debate. According to Jonathan Haidt, Ph.D., within the “prestige economy” on social media platforms, the more lethal the verbal dart you throw, the more you are held in esteem by your “tribe” and the greater you are demeaned by those with opposing views (APA/NICD National Conversation on Civility, 2018. http://on.apa.org/Civility). Haidt points out that we can’t underestimate the significance the social aspect of intolerance. We need to add this dimension to our theories regarding the emotional, cognitive, and behavioral aspects of hate and intolerance for the out group.

In an illustration of the social benefits of intolerant discourse, Brown, Keefer, Sacco, and Brown (Emotion, Mar 4, 2021, https://doi.org/10.1037/emo0000955) discuss research on moral outrage as an interpersonal signal and present research findings that actions based on moral outrage are attractive to people seeking long-term relationships.

What I personally have struggled with the most, is that the more different you view your opinions from that of your ideological opponents, the more you perceive your opponents to hold negative feelings toward you. To me it defies logic that if I don’t agree with you, that I also hate you? And if you believe that I hate you, then you will likely distance yourself from me, and eliminate a demonstrated way to reduce intergroup conflict, which is through contact. Social psychology has extensive literature on this phenomenon, and I can understand it intellectually. But I am feeling this personally, and I believe many others are as well.

I found no shortage of explanations about divisiveness related to the pandemic: we have forgotten how to be social; we are acting out our grief and depression through angry behavior; we are anxious about the future and mistrustful of ambiguous or contradictory information emanating from our leaders. I believe all of these exacerbate the situation. At root, though, I believe, is the fundamental attribution error and primitive thinking described by Aaron Beck in “Prisoners of Hate” (NY: HarperCollins, 1999). Under ambiguous circumstances, we will infer dispositional versus situational explanations of behavior from those we perceive as having wronged us. We personalize the negative effects we experience as deliberately inflicted upon us by others. We overgeneralize and interpret any bit of information negatively to bolster our theory about what is going on and how we have been wronged.

I by no means did a thorough review of the research on this topic. But, fortunately, along with the many psychological explanations for our current state of divisiveness come suggestions about how to overcome it. Beck’s work is echoed in the advice of John Gottman, Ph.D., to married couples caught in a cycle of anger, hurt, and mistrust. Each partner must be willing to give the other person “the benefit of the doubt” to allow for the possibility of situational or more benign explanations. In our troubled relationships with friends and family due to political divisiveness, this is wise advice.
Editor’s Remarks

NICOLE DORSEY, PHD
Harris County Juvenile Probation Department
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In our Spring 2021 issue, there was an inadvertent omission from the article, “Conceptualizing Methodological Challenges and Solutions When Working with Refugee Youth Through Self-Determination Theory.” The additional information is: “This work was supported by grants from the Jerry M. Lewis, M.D. Mental Health Research Foundation and the Program for the Development and Evaluation of Model Community Health Initiatives in Dallas.” We apologize for this oversight.

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

You do not need to be a TPA Member to submit. Collaborations with students are encouraged. 1,000-2,000 word count, APA Style.

Email submissions to Nicole Dorsey, PhD nicole.dorsey@cac.hctx.net
Tania Israel, Ph.D., in “Beyond Your Bubble, How to Connect Across the Political Divide” provides a flowchart promised to “resolve all political conflict in our country.” Tongue in cheek, Dr. Israel points out the motivations on our part that will prevent this from taking place. These include wanting to vent or generate conflict, wanting to share your perspective without hearing someone else’s, and trying to persuade rather than reach common ground. Connecting across the political divide requires that we set aside these motivations. It also requires the ability to tolerate and manage the unpleasant emotions that may arise during conversations with those holding opposing ideas. Considering how much our ideologies are tied up with our identities, there is considerable risk involved in putting aside strong feelings and listening respectfully without trying to persuade. It is not surprising that so little dialogue takes place. To make use of Israel’s method, ideological opponents need to come together with the intention of finding common ground by agreeing to certain ground rules. Israel is providing space for these dialogues in her work as are other advocates for civil discourse across the country. (APA/NICD National Conversation on Civility, 2018).

The following piece of research resonated with me after the isolation of COVID and prompted the lead-in to this piece. In “Awe, Ideological Conviction, and Perceptions of Ideological Opponents” (Emotion, 2021, Vol 21, No 1, 61-72), Daniel Stancato and Dacher Keltner report some intriguing research on the ability of awe inducing events to lessen polarization and increase cohesion. The experience of awe allows individuals to hold more tolerant views of their ideological opponents. Something about the experience of awe shakes up our cognitive processes and allows for greater possibility in our understanding of those with differing ideologies.

As TPA President, I have looked for opportunities to enhance civility both within our association and for TPA to make some contribution to civil public conversations in the state. We have held a town hall meeting to discuss our legislative agenda and explain how decisions to take positions for and against certain bills were made. We anticipate holding additional townhalls as the need for discussion with members arises.

We have invited Dr. Tania Israel to give a keynote speech at the 2021 Convention in November. We hope that her presentation will be helpful to us as therapists and advocates, by facilitating therapeutic interactions, and promoting civil dialogues with family, friends, colleagues, and our elected officials.

The leadership lessons for me include striving for transparency in all organizational processes and decision making. The research is clear that reducing ambiguity promotes civil dialogue. Opposing views may be the legitimate dissent of an overlooked segment of the group.

Leaders must strive to listen to voices of opposition respectfully and recognize that other people's actions may have situational explanations and are not necessarily motivated by harmful intentions.

Finally, to come full circle from where I started this piece, I think attending a concert, visiting a museum or a trip to the mountains is in order.

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Sixty years ago, President John F. Kennedy at his Inaugural Address uttered what in my opinion are the hallmark words of engagement: “And so, my fellow Americans: ask not what your country can do for you -- ask what you can do for your country. My fellow citizens of the world: ask not what America will do for you, but what together we can do for the freedom of man.” It may seem a bit trite, but I believe these words extend to our profession and to our Association. My companion psychologists, ask what we can do for our profession and TPA. Our strength as a profession is in our working together, by engaging in the many tasks that keep TPA and TPF alive and thriving, by advocating for justice and equality among all licensees, both present and future.

TPF’s presence will be seen at our upcoming convention in Austin. Plans are in preparation for a night of celebration, a reunion of sorts. There will be entertainment along with a silent auction. It looks as though the annual Poster Competition will be both competitive and challenging. This year may be the highest number of submissions to date. The Foundation has added another award this year: Manuel Ramirez, III, Dissertation Award for Ethnic Minority Student (I am using the terminology established by Dr. Ramirez). At the invitation of and sponsorship by the Foundation, Sam Knapp, EdD, ABPP, will return to conduct a three-hour Ethics workshop.

I am urging you to join me in supporting the Foundation. The survey that was conducted last year provided several guidelines for the Foundation’s Board of Director to pursue in successive years. The Texas Psychological Foundation is the 501(c)(3) foundation entity of the Texas Psychological Association organized exclusively for charitable, educational, and scientific purposes. The mission is broad. The Foundation is looking for ways to expand its focus beyond students and early career psychologists.

Any donation to the Foundation, small or large, is tax deductible. The Foundation needs assets to continue funding its awards. If you plan to attend this year’s convention, please consider bringing along a silent auction item. Finally, consider becoming a Board of Directors member of the Foundation. Current members, besides myself, whose term expires this year, include Drs. Kelly Arnemann, President-Elect, Courtney Banks, and Linda Ladd, whose terms also expire this year, Jo Vendl, Glenn Sternes, and Amanda Venta. Patrick Stanford-Galloway is a student member of the Foundation with full voting privileges. We will be appealing for nominations later this year.

The Foundation could not function as well as it does without the assistance of our TPA ED, Jessica Magee, Dena Goldstein, Communications Manager, and Angie Guy, Convention Planner. They are our companions often “behind the scenes.”
PRACTICE

Clover Educational Consulting Group: A Small Non-Profit Doing Big Things for Behavioral Health in Texas

By Alyssa Gilden, PhD

For decades, access to a quality behavioral health workforce has been a demonstrated and persistent challenge nationwide, and especially in Texas. Nationally, 46.4% of adults experience mental illness at least once in their lifetime, and 26.2% of adults experience mental illness annually (TX DSHS, 2014). According to the Substance Abuse and Mental Health Services Administration (SAMSHA), the vast majority of those who need behavioral health care providers. According to the US Department of Health and Human Services, over 125 million Americans live in a designated Mental Health Professional Shortage Area (Mental Health HPSA). This means that over 36% of the US population experiences a shortage in the availability of behavioral health care services (Bureau of Health Workforce, 2021). In Texas, 206 of 254 counties (81.1%) are designated as whole county Mental Health HPSAs, with an additional 4 counties designated as partial county Mental Health HPSAs (TX DSHS, 2021). More than 15 million Texans, or greater than 50% of the population of Texas, reside in a designated Mental Health HPSA, and thus, do not have adequate access to behavioral health services (Bureau of Health Workforce, 2020).

Data demonstrate that the need for behavioral health care far exceeds the availability of the behavioral health care workforce nationwide, and this is exacerbated statewide by the specific needs of Texas. Texas’ population has increased drastically in the last decade and is projected to grow even more over the next decade. The state’s population is younger, more diverse, and increasing at a faster rate than the United States as a whole. In addition, Texas has unique cultural, ethnic, and linguistic challenges that impact the delivery of behavioral health care. 177 of Texas’ 254 counties (70%) are considered rural (TX HHSC Statewide Behavioral Health Coordinating Council, 2019). While the prevalence of behavioral health disorders is similar between rural and urban populations, the services available are quite different. Rural communities face exacerbated challenges related to both accessibility and availability of behavioral health care services (Rural Health Information Huh, 2018). Texas’ demographics, population density, and diversity of cultures demonstrate the need for a specific approach to building a qualified workforce to provide adequate behavioral health care services to the state and its population.

Texas has consistently identified a need to increase the size, diversity, and distribution of the behavioral health workforce and the need to support innovative models to build a qualified workforce to meet the state’s needs. The state and the nation’s educational institutions are not producing enough new graduates to meet the current or projected demand for services, and this is only expected to worsen as the aging workforce approaches retirement (TX DSHS, 2014). A Statewide Behavioral Health Coordinating Council was established by the Texas Legislature in 2015 to ensure a coordinated statewide approach to treating behavioral health and substance use disorders so that all people have the best chance of a long-term recovery. The Coordinating Council published its Statewide Behavioral Health Strategic Plan in 2016 with an update in 2019. Both reports continued to demonstrate the vast behavioral health workforce shortage in Texas and the immense need to implement innovative strategies to build an adequate workforce and care for the population (TX HHSC Statewide Behavioral Health Coordinating Council, 2016; TX HHSC Statewide Behavioral Health Coordinating Council, 2019). To meet the behavioral health needs of the population of Texas, practitioners and institutions must work together to face the challenges of inequities in care. Workforce development and working with the community are keys to achieving that goal.

Clover Educational Consulting Group implements innovative solutions towards filling the gaps in behavioral health workforce development. Founded in 2015, Clover’s mission is to improve the mental health workforce through advances in policy, workforce, and training. Clover is a 501c3 non-profit corporation based in Mineola, Texas, with a secondary branch in Austin. Clover strives to improve the behavioral health workforce with an emphasis on training program development and accreditation, community outreach and trainings, research and evaluation, and more. Clover aims to fulfill the call of multiple statewide organizations and taskforces to help fill the gaps in the behavioral health workforce and improve the health of the population.
community. Clover’s team of doctoral-level licensed psychologists have specific expertise in research, administration, policy, program development, education, and training, and has dedicated expertise towards psychology training program development to meet the needs of growing the behavioral health workforce.

Developing a robust psychology workforce is both challenging and possible. The path to psychology licensure is long and structured. Students attend a lengthy doctoral program, culminating in a year-long clinical internship, followed in many states, including Texas, by at least one year of postdoctoral residency training. The internship is an essential part of doctoral training in professional psychology; yet, for many years, there was a crisis in the psychology field wherein the number of students ready to embark on internship training far exceeded the number of internship training slots available. In 2012, more than 1 in 4 internship applicants nationwide did not match with an internship site and thus had to delay their progress toward graduation and licensure by at least a year (Dingfelder, 2012). While this imbalance in available positions has decreased since 2012, there remains an imbalance in the number of accredited training positions, thus delaying or possibly hindering the development of a qualified workforce.

Understanding the state of the internship imbalance is key to workforce development overall; understanding its relevance to Texas specifically is crucial. Much has been written about professional “brain drain” wherein highly educated professionals leave the location they were trained for locations with more professional opportunities. In psychology, this looks like students leaving the locations where they receive their doctoral training for places that offer internships, postdoctoral fellowships, and early career opportunities. Data demonstrate that psychologists are most likely to begin their career close to where they complete their training, meaning they tend to work where they complete internship and postdoctoral training. Many students educated in Texas in psychology, social work, counseling, and medicine leave the state to complete their training due an insufficient number of internship and residency slots in Texas (Crocker & Guzman, 2015).

Developing quality training positions in Texas is an innovative and highly effective way to grow the behavioral health workforce within Texas.

Clover provides expert consultancy and technical assistance to training programs. Our staff has extensive experience in all aspects of program development, operations, funding, governance, and accreditation. To date, Clover’s staff has supported more than 250 psychology training programs in more than 41 states and territories in their development and/or accreditation processes. As a Texas-based non-profit, we value and support the creation and development of psychology training positions across the state of Texas.

Clover provides a wide array of services to benefit community mental health in addition to our training program and development work. Specifically, Clover has established a community outreach initiative to directly serve the rural communities of Northeast Texas. Northeast Texas is a rural, highly underserved area of 35 counties that is severely impacted by poverty, significant unmet need, and significant risk factors. Northeast Texas has been demonstrated to be the unhealthiest region of the state. Over 21% of the region’s full population and 29% of the child population experience food insecurity; nearly 19% of the population has an income below the federal poverty level (Nehme, et al., 2016). The population of Northeast Texas is at greater risk of early death than the statewide average, and the suicide rate is 65% higher than the statewide average (UT Health Science Center Tyler, 2017). An estimated 85,000 people in Northeast Texas are diagnosed with serious mental illness, and approximately 113,000 need substance abuse treatment. According to the Robert Wood Johnson County Health Rankings, every county in Northeast Texas reports a higher number of poor mental health days than the state average. The Northeast Texas region includes a higher percentage of individuals with mental illness than any other region of the state (SAMHSA, 2014). Yet similar to other regions in Texas, there is a critical shortage of behavioral health professionals to serve the population. In fact, every county in the 35-county region of Northeast Texas is designated by HRSA as a Mental Health HPSA.

Innovative strategies are necessary to help underserved regions transition to a health care environment that emphasizes value, quality and efficiency, by allowing overburdened systems to work together and receive support from one another to achieve these outcomes, and by bringing basic behavioral health awareness and prevention directly into high-need communities. In regions like Northeast Texas, there are simply too few behavioral health providers to sustain the traditional model of service delivery. Clover provides innovative approaches to increase access to quality health care services by informing and empowering community members directly, a model which has proven effective via implementation of a number of evidence-based behavioral health prevention programs. Clover’s team of licensed psychologists and public health professionals provides community trainings on a variety of behavioral health related topics to equip businesses, educators, community members, other non-profits, first responders, and others with tools to meet behavioral health challenges within Northeast Texas communities. Clover’s expertise and efforts to expand the behavioral health workforce and to provide quality resources and trainings to rural, Northeast Texas communities, play an important role to meet the growing behavioral health needs across the state.

The economic cost of providing inadequate behavioral health services is clear in hospital admission rates, emergency department visits, criminal and juvenile justice involvement, homelessness, and more (Hogg Foundation for Mental Health, 2016). Providers and agencies across the state can begin to fill in the gaps in the behavioral health workforce by supporting training of the next generation of professionals and by adopting community outreach initiatives like Clover’s. The positive impacts of building training programs and providing community behavioral health trainings is clear. Clover hopes to continue to work with providers and agencies across the state to reduce the gaps in the behavioral health workforce, increase access to services, and thus, improve the mental health of the community.
Beyond the Binary: A Call to Include All Genders in Sexual Assault Prevention Work

Rebekah E. Urban
Texas Woman’s University

INTRODUCTION

April is Sexual Assault Awareness Month in the United States. Each year, we are called to raise awareness and move towards the prevention of sexual assault, and for good reason. Rape has overwhelmingly negative mental, emotional, and physical impacts on survivors (Resick, 1993). Mental health concerns are common following rape, and the lifetime cost of surviving a sexual assault in the United States is estimated to be over $120,000 per survivor (Peterson et al., 2017). The importance of prevention is well understood in the field of psychology, but as is often the case, implementation of a solution to the problem is much more difficult than identifying the problem itself. As a result of the #MeToo movement, rhetoric around the prevention of rape has shifted to no longer focus on rape as “a woman’s issue”; the movement has instead emphasized the dynamics of sex and power, calling attention to the way rape culture impacts all people (Gill & Orgad, 2018). However, unequal representation of all genders exists in many of the conversations around sexual assault prevention and efforts to end rape (e.g. scales used for measuring prevention outcomes focusing solely on cisgender women; see Fay & Medway, 2006; Lonswey et al., 1998).

RAPE AND GENDER

The legal definitions of rape have long only included rape of females by males. For example, in the United States, the Department of Justice’s definition did not change from 1927 until 2012 (United States Department of Justice, 2012). The 2012 change expanded the definition to remove sex-specific language but still only includes penetration without consent; the current legal understanding of rape at a national level does not include those who are forced to penetrate another person. While the legal ramifications of such definitions are immense, the impact of this understanding of rape has on cultural level effectively erases the experiences of many people. In the state of Texas, the legal definition of sexual assault currently includes unwanted penetration (Texas Penal Code §22.011). However, entrenched beliefs about rape result in a focus on cisgender women as the only individuals who experience rape.

Indeed, women are at high risk of rape, with the Centers for Disease Control (2015) reporting approximately 21.3% of women experiencing rape or attempted rape at some point in their life. This number jumps to 43.6% when considering sexual assault in more broad terms (CDC, 2015). The rates of rape of men and trans and gender diverse individuals, however, are also high. While the 2015 National Intimate Partner and Sexual Violence Survey found that approximately 2.6% of men in the United States experience an attempted or completed rape in their lifetimes and 24.8% experience some kind of sexual assault (CDC, 2015), these numbers are likely low. People of all genders underreport their experiences with rape; men are less likely to report rape due to stigma, rape myths, and self-blame (Javaid, 2015). In a study that assessed for victimization in men attending college, a staggering 39% reported sexual victimization by a partner when both penetration and forced penetration of another were included (Prospero & Fawson, 2009). Transgender and nonbinary individuals report even higher levels of rape and sexual assault, with one study finding a startling 47% of trans and gender diverse participants had experienced sexual assault at some point in their life (James et al., 2016). From these numbers alone, it is clear sexual violence impacts everyone, regardless of gender.

RAPE MYTHS

Efforts to prevent sexual assault have long been in practice, and many aim to reduce rape myths, thereby dispelling rape culture. Through a feminist lens, rape myths can be understood to be cultural beliefs about rape that function to preserve society’s heteropatriarchal structure by prioritizing hypermasculinity and protecting traditional gender roles through placing blame on those who violate these norms. By reinforcing traditional gender roles and assuming a male perpetrator and female victim, rape myths also create a culture where the experiences of survivors who are not cisgender women are erased, while also dismissing the experiences of cisgender women or placing blame on them.

The erasure of the experiences of cisgender men and trans and gender diverse individuals is seen in the literature regarding rape myths and rape myth acceptance. Traditional scales to measure rape myths include only myths about cisgender women being raped (i.e. Burt, 1980; Payne et al., 1999). Some scales have been developed to examine myths regarding cisgender men’s experiences of being raped (i.e. Struckman-Johnson & Struckman-Johnson, 1992), but much less research is available on such myths. To date, no published scales measure rape myths about trans and gender diverse individuals.

Current scales are often used to measure rape myth acceptance in a group. Pre-test and post-test measures of rape myth acceptance are often used in primary and secondary prevention programs (i.e. Fay & Medway, 2006; Lonswey et al., 1998). When these measures leave out cisgender men and trans and gender diverse individuals, however, we
cannot fully challenge rape culture in all its forms. When prevention efforts focus solely on cisgender women as those who are raped, a major rape myth, that men and trans and gender diverse individuals do not experience rape, is silently perpetuated. Not having representation of all people may contribute to feelings of alienation in those who have been raped and continue to influence low levels of reporting across genders.

**CALL TO INCLUSIVITY**

What, then, is a solution to this problem? While the existence of statistics on experiences of rape of cisgender men and trans and gender diverse individuals is evidence of progress, there are several steps that need to be taken to address this gap in our efforts.

First, the experiences of people of all genders must be recognized and legitimized. For mental health professionals, this means believing the disclosures of clients no matter their gender. This means examining personal biases regarding sexual assault and the individual scripts one has for sexual assault. Engaging in this kind of self-reflection not only benefits the individual but creates a safer place for all clients with whom one comes into contact. For agencies, this means ensuring resources are available for people of all genders. While a plethora of resources across the state exist for cisgender women who experience rape, it may be harder for cisgender men and trans and gender diverse individuals to access the same kind of support. For agencies where specialized services are not feasible due to funding and/or demand, being prepared to refer clients to appropriate services, face-to-face or virtual, is an ethical imperative.

Second, representation must increase. For those working in prevention, this means examining the curricula used and questioning the way it represents gender. From questions used to prompt participant engagement to the gender of people used in examples, there are many ways prevention efforts may change to include all genders. This often also includes challenging heterosexual assumptions, which may be an added challenge for prevention educators. For those working in re-search, increasing representation means working to diversify research on sexual assault and rape to include experiences of people of all genders. Using appropriate scales that include all genders, being mindful of demographics to include options for people to report all genders, and working to ensure any interventions used in research have equal representation all increase the recognition and legitimization of the experiences of all people.

Third, gender roles and sexual scripts related to gender must be challenged. Teaching abstinence only sex education reinforces the idea it is the individual’s responsibility to remain “pure” and moves the responsibility in a sexual assault from perpetrator to victim (Clonan-Roy et al., 2020). These programs often directly engage in victim blaming and equate choosing to be sexually active with putting oneself at risk for sexual assault (Clonan-Roy et al., 2020). Furthermore, they reinforce heterosexual sexual scripts that posit women as needing protection while depicting men as aggressive. All of these assumptions further hurt people of all genders by assuming a female victim and male perpetrator and must be dispelled in an effort that genuinely aims to prevent sexual assault. Young adults want comprehensive sexuality education as a prevention effort for sexual assault (Hubach et al., 2019), and such a course would be an opportunity to dispel gender roles and introduce healthy, inclusive sexual scripts.

**CONCLUSION**

Each spring, the epidemic of rape is highlighted during Sexual Assault Awareness Month. This month is often used to amplify the experiences of survivors and engage the public in prevention efforts. While current programs are extremely important, there is room for improvement in the movement. Culturally, the experiences of cisgender men and trans and gender diverse individuals are often dismissed or overlooked. Extant research does not accurately represent the experiences of all people, and more voices need to be brought into the conversation. Moving beyond the binary understanding of female victim/male perpetrator to encompass the experiences of all survivors is not only beneficial to all, but the linchpin of creating a world that is safe for people of every gender.

**REFERENCES**


KEYNOTE

Tania Israel, PhD

If You’re Not Listening, You’re Not Paying Attention: Dialogue as a Tool for Social Justice Advocacy

Dr. Israel is a Professor in the Department of Counseling, Clinical, and School Psychology at the University of California, Santa Barbara. She has a PhD in Counseling Psychology, a Masters degree in Human Sexuality Education, and a BA in Psychology and Women's Studies. She is a Fellow of the American Psychological Association (APA) and Past-President of the Society of Counseling Psychology (SCP). Her scholarship on interventions to support the mental health and well-being of LGBTQ individuals and communities has been solicited by the Institute of Medicine, Congress, and the White House. She has received honors for her research and advocacy from the American Psychological Association, the California Asian & Pacific Islander Legislative Caucus, and her local LGBTQ community. Her TED Talk on bisexuality has been viewed by many. She is the Director of Project RISE, a research team at UCSB that develops and studies interventions to support the psychological health of LGBTQ individuals and communities. She tweets at @LGBTRISE (research and professional) and @tania_israel (personal and political).

KEYNOTE

Kevin Cokley, PhD

How Psychologists Can Support the Black Lives Matter Movement (working title)

Kevin Cokley, PhD, holds the Oscar and Anne Mauzy Regents Professorship for Educational Research and Development in the College of Education at the University of Texas at Austin. He is a Fellow of both the University of Texas System and University of Texas Academy of Distinguished Teachers, Director of the Institute for Urban Policy Research & Analysis, and Professor of Educational Psychology and African and African Diaspora Studies.

Dr. Cokley’s research and teaching can be broadly categorized in the area of African American psychology, with a focus on racial and ethnic identity and understanding the psychological and environmental factors that impact African American students’ academic achievement. Dr. Cokley studies the psychosocial experiences of students of color and is currently exploring the impostor phenomenon and its relationship to mental health and academic outcomes.

He is author of the 2014 book The Myth of Black Anti-Intellectualism that challenges the notion that African American students are anti-intellectual. He has written several Op-Eds in major media outlets on topics such as Blacks’ rational mistrust of police, the aftermath of Ferguson, police and race relations, racism and White supremacy, the use of school vouchers, and racial disparities in school discipline. His research has been recognized in media outlets including the New York Times, USA Today, and Inside Higher Education.

KEYNOTE

Martin LaRoche, PhD

Cultural Psychotherapy (working title)

Martin J. LaRoche, PhD is a Latino psychologist who received his PhD in clinical psychology from the University of Massachusetts Boston. He is currently an assistant professor in Psychology at Harvard Medical School, Children's Hospital Boston. For the last 16 years, he has served as director of Psychology Training at the Martha Eliot Health Center, where he treats an inner-city, culturally diverse community and trains doctoral-level psychology students. Honored with numerous research and academic awards, Dr. La Roche also served for seven years as co-chair and board member of the Committee on Ethnic
Minority Affairs of the Massachusetts Psychological Association. Having authored numerous articles and chapters on culturally competent psychotherapeutic services with ethnic minority groups, Dr. La Roche has been a private practitioner in the Cambridge, Massachusetts area for the last 16 years, where he treats a culturally diverse clientele.

**KEYNOTE**

Samuel Knapp, EdD, ABPP

Seven Steps to Improve the Evaluation, Management, and Treatment of Suicidal Patients: Turning A Good Intervention into an Excellent One

Samuel Knapp, EdD, ABPP, was the director of professional affairs for the Pennsylvania Psychological Association from 1987-2021 and had worked in rural public mental health clinics in Pennsylvania for several years. He has written several books on ethics as well as suicide prevention: An ethically and scientifically informed approach. Dr. Knapp has written 95 peer reviewed articles and given more than 500 professional presentations on ethics, suicide prevention, and other professional topics.

**INVITED**

Responses to Systemic Racism in Psychological Training and Higher Education

Presidential Panel with Fran Douglas PsyD, 2021 TPA President and invited panelists:

UT Southwestern Medical Center: Kipp Pietrantonio, PhD; Jessica Woodford, MA
Texas Woman’s University: Julie Herbstrith, PhD, LSSP; Juliana Bershell, SSP; LSSP; Alexandra Woodson, MS
Sam Houston State University: Craig Henderson, PhD; Laura Drislane, PhD; Cayla Hari, BA
University of Houston: Lia J. Smith, MA; Amanda Venta, PhD; Jessica G. Hernandez Ortiz, BS

**INVITED**

From the Board to the Bench

Darrel Spinks, JD, Executive Director, Texas Behavioral Health Executive Council; Diane Moore, Board Administrator, Texas State Board of Examiners of Psychologists; Samuel A. Houston, JD, Partner, Scott, Clawater & Houston, LLP

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Psychologists engaging in clinical practice have traditionally been known as psychotherapy providers and assessment administrators, whether in private practice or within institutional settings (e.g., hospitals, community mental health). However, services provided by psychologists have been continually expanding. One shift in behavioral medicine is the incorporation of interdisciplinary treatment teams. An interdisciplinary treatment team refers to multiple disciplines bringing their individual knowledge and expertise together to collaboratively provide patient care (McLoughlin & Geller, 2010). Treatment team members commonly include disciplines such as: physicians (e.g., psychiatrists, surgeons), psychologists, nurses, social workers, occupational therapists, and dieticians. Psychology has been well represented on interdisciplinary teams within specialties such as primary care, oncology, cardiology, palliative care, inpatient psychiatry, and pediatric medicine. Effective interdiscplinary collaboration requires that each discipline have clearly defined and respected roles (Nancarrow et al, 2013). Defining these roles, in particular as an early career psychologist, can be challenging. However, this serves as an opportunity for psychologists to showcase their diverse skill sets that bring value to the team and to patient care. The current discussion will focus on two unique areas of contribution psychologists provide on interdisciplinary teams: education and consultation.

Psychologists working as part of an interdisciplinary treatment team have various roles, including the role of educator. Although education is often thought of as being geared toward supervising and training practicum students, interns, residents, and fellows, it also includes providing education to patients, families, colleagues, and staff members. Patients benefit from receiving psychoeducation about their symptoms, diagnosis, and treatment planning. For patients new to mental health care, education about what to expect in interactions with psychology providers can be useful (e.g., reviewing the potential benefits of psychotherapy or discussing what may occur in the first few psychotherapy sessions or meetings with the treatment team). Psychoeducation about diagnosis, progress in treatment, prognosis, and follow up care is helpful for patients’ family members and caretakers. Often, family members will have specific questions about the course and expected outcome of treatment for their loved one and psychologists can provide this information, as well as address other concerns specific to patient care.

Psychologists are also often tasked with providing education to colleagues and staff members about general psychological topics or specific patient needs, such as educating nurses, patient safety assistants (PSAs) or mental health technicians (MHTs) about a patient’s treatment goals. Nurses, PSAs, and MHTs are integral members of the treatment team who can encourage and aid patients in meeting their goals. Providing education to staff and other treatment team members may also be more formalized, such as didactic lectures or workshops. An example of this is presenting a didactic lecture for nursing staff and MHTs about effective methods of de-escalation and managing burn out related to treatment of acute severe mental illness and working with patients with aggressive behavior. Treatment staff and providers would be given psychoeducation about de-escalation techniques and encouraged to discuss effective methods that have helped with managing agitation and aggressive behavior in their work with patients. Additionally, the role of burn out would be addressed and staff provided with the space to discuss their experiences with burn out and ways to combat it while still finding joy in their work with patients.

In sum, opportunities for providing education go beyond the traditional model of psychologists training supervisees or students and extend to multi-level education for patients, their families, and the people who provide treatment to the patients on a day-to-day basis.

In addition to providing educational opportunities, psychologists in the role of a consultant can offer a much-needed perspective towards developing effective and efficacious programming in an interdisciplinary setting. Consultation offered by psychologists in these settings has traditionally been conceptualized as offering team members a psychological perspective in developing general treatment goals, monitoring and enhancing patient’s progress toward those goals, implementing behavioral interventions, and conducting assessment and conceptualization of patients. The incorporation of research, such as in analyzing trends in patient demographics, clinical history, risk and protective factors, and promotive factors towards treatment outcomes, allows psychologists to evolve the traditional role of assessing individual patients to identifying overarching themes across the patient population. In doing so, psychologists can provide consultation to
team members on ways to modify current programming and procedures to ultimately augment patient outcomes. Beyond analyzing patient variables, psychologists can offer a more expansive assessment of a setting’s culture to subsequently identify target areas for change efforts. In addition to traditional elements of workplace diversity (e.g., race/ethnicity, gender, age), an interdisciplinary team presents an added layer of diversity (i.e., discipline, specialty) that may affect group dynamics. Conducting observations of organizational procedures and climate (e.g., workflow, interpersonal dynamics), and meeting with respective disciplines to solicit feedback on ideas and concerns can reveal what needs to be addressed for more effective functioning. In gathering such information, psychologists can gain team members’ buy-in, identify the best disciplines or team members to carry out specific roles, and coach team members to be more effective in their role. By conducting both informal and formal needs-assessments, operationalizing what defines improvements in these areas, and establishing data collection procedures, psychologists can aid in determining how to enhance best practices in clinical programming.

The scope of the consulting psychologist in an interdisciplinary team can be further highlighted in an example of work conducted by a psychologist on an inpatient psychiatry unit. Through holding meetings with each discipline, the psychologist learned of team members experiencing workplace stress as a result of issues related to communication, organization, and differing perspectives on ways to improve patient care. Additionally, MHTs expressed feeling ineffective in their role and were seeking more opportunities to be involved in patient care. This workplace stress was further exacerbated by the reality of treating an increasingly acute population. Specifically, in analyzing data collected on patients at intake and discharge along with reviewing holds and seclusion data, it was shown that patients were presenting with higher levels of emotion dysregulation, suicidality, and history of traumatic events. In presenting this data to the team and connecting it to concerns that team members had raised, informal work groups collaboratively engaged team members in program development. In redesigning the general treatment framework, curriculum for nurses, MHTs, and licensed mental health professionals were developed to be more involved in delivering evidence-based content. In doing so, staff expressed feeling more effective in their role, which helped to improve the general climate on the unit. Additionally, following the implementation of these changes, patients were more engaged in treatment, exhibited fewer behavioral issues requiring crisis intervention, and, in reviewing the data, showed better outcomes in symptom reduction during their inpatient stay. By utilizing multi-level data (e.g., patients, team members, workplace climate), early career psychologists have the unique capacity to carve out their role as educators and consultants to then provide valuable information that can be directed towards improving general patient care, team member engagement, and overall workplace culture.

**Take Home Points**

- Psychologists are dynamic and a vital part of interdisciplinary teams.

- Early career providers often have opportunities to develop psychology services that go beyond traditional roles, including education and consultation.

- Know your skill set and the needs of your team when considering how to define your role and contribution.

- Ensure your team is aware of how you can contribute so they can best incorporate your skills into the team.

- Be creative and think outside the box when determining how to add value to the needs of your team.

**REFERENCES**


We do not know if Floyd was a polymath, but if he wasn’t, he certainly came close, having met the requirements for and practiced three different professions, along with being an accomplished pianist and a gifted writer. There must be something he could not do, and if we could ask him, I’m sure he would give us a long list. It is hard to do justice to such an exceptional person, but we will try.

Floyd was raised in Wyoming and went to college at McMurray University in Abilene, Texas. He then pursued a degree in pastoral care and later ordination at SMU’s Perkins School of Theology. Almost immediately, he pursued a degree in Clinical Psychology from UT Southwestern, graduating in 1972, but he was not done. Not only did he obtain law degree from the University of Houston in 1996, but then became board certified in Clinical Psychology in 2006.

Floyd was in private practice off and on for most of his career, and had he remained there, he certainly would have developed a thriving and lucrative practice, but that is not something he would have done. A brief examination of his CV reveals that he lived his faith by routinely working for the public good. For example, since 2008 he had been working for Harris County first in the office of Court Management and then in the public defender’s office.

As if he was not busy enough, he found time to write over sixty articles. His presentations at TPA were always Standing Room Only since he could explain the complex intersection of law and psychology in a way that everyone could understand.

Floyd loved teaching and supporting students in their professional growth. While in the public defender’s office he went out of his way to offer students research opportunities using his data, freely offering consultation to students and colleagues alike. If you emailed him a question on Sunday afternoon, it is likely you would have a detailed response by Sunday evening. No matter how often you did so, his response was always helpful and gracious. There was never a question of compensation—except for the joy he got from being able to give you something.

Floyd learned that he had a bad heart after returning from a trip to Machu Pichu over twenty years ago. Where others might have retired or cut back, he continued working and did so, long after his care providers didn’t think he could. In fact, he enjoyed hearing things such as, “I’ve never seen anyone with your condition still working.”

The interesting thing about Floyd was that, while he entertained us with these stories, we do not think he was working as long as he could to defy the odds or rebel against authority. Those of us who knew him believed that he was simply doing what he had always done, which was to give as much as he could to others to live his faith.

Now he is gone, and we deeply miss him, but he has left us with something bigger than himself.

He was an example for us all to do our best work, benefit others, and to do so unselfishly.

“Is there a calling in your life? Listen for it.”

-Floyd Jennings
What more can anyone ask? His memory will be a blessing for all of us.

MEMORIES

One special memory comes from a time when the scheduled presenter did not appear for a crowded CE workshop on a forensic topic. Rather than disappoint the audience Floyd stood up, pulled four of his forensic colleagues up front with him, and orchestrated an hour-long question and answer session. Reviews from the audience were highly appreciative, and they even got CE credit for the unscheduled event.

Over the years, we called each other from time to time to talk about things or to bounce ideas off each other, and I am so sad that we will never have another conversation in this life. Floyd was as smart and erudite as he was wise and droll. The first time he referred a client to me, I felt like I had been knighted. I called him to thank him for the referral and jokingly referred to him as “Obi-Wan.”

He shot right back with, “Are you Luke or Leia?” And then we laughed and laughed.

One of my first contacts with Floyd came after I got my bar card at a TPA conference. I had misquoted the Texas insanity rule in a seminar that neither of us was teaching. Floyd corrected me immediately, and of course, accurately. If you got something wrong, he did not mind correcting you; he was always polite and kind but, he was never a pushover.

A few years ago, Floyd was given the Distinguished Psychologist award at the TPA Annual Meeting. I vividly recall him receiving it and went up to congratulate him afterwards. He turned to me and said, “this means so much to me I am going to cry.” He then threw his arms around me and did just that.

* Numerous people made suggestions and wrote recollections for this memorial, but as a group we decided that we would not list our names. We agreed that the signature should be, “Those who admired and loved him.”
The legislative session is officially over! TPA had a fantastic session, despite the numerous difficulties with passing bills this time around. Passage rates were extremely low, due largely to the pandemic, the storm, and disagreements between the chambers on how to move forward. Nevertheless, this was certainly one of TPA’s best sessions at the legislature.

HB 549 (Thompson; Zaffirini), which protects providers from liability when they report someone who they believe is a danger to themselves or others, made it all the way through the legislature and will become effective on September 1 of this year. We had great testimony from TPA members, as well as strong support from other stakeholders. Another bill that TPA worked on directly was HB 4 (Price; Buckingham), which instructed Texas Medicaid to expand its telemedicine and telehealth coverage. We fought hard to ensure that audio-only behavioral health was expressly included in the bill, and the bill ultimately passed with that language intact.

TPA was also regularly at the capitol advocating on items that were not on our agenda, but nevertheless had important implications for mental health services in Texas. TPA members testified multiple times against bills that would have negatively impacted the rights of providers who treat LGBTQ+ patients, and we’re happy to report that none of those bills passed. We also registered our position publicly on tons of other mental health bills, including those that intersect with criminal justice, commercial insurance parity, public education, and veteran care.

All told, this was a fantastic session, certainly for our advocacy on specific bills, but also for building relationships with legislators and other stakeholders. With a special session right around the corner, legislators will be busy for the next few months, but we’re looking forward to continuing to build off the successes of this session during the interim. Stay tuned for future updates!
Case Management Referrals

When your clients with special needs have Medicaid, refer them to case management for help finding services.

Our case managers are licensed social workers or RNs. They understand your clients’ complex needs and can help access medical, behavioral health, educational and other services.

Children enrolled in Medicaid (Traditional Fee-for-Service and STAR) may be eligible. Clients enrolled in STAR Kids and STAR Health should first be referred to their health plan.

To refer your client, call Texas Health Steps at 1-877-THSteps (1-877-847-8377) or visit https://hhs.texas.gov/case-management-provider.

Case Management for Children and Pregnant Women is a Texas Medicaid benefit for eligible clients. It serves children birth through age 20 with a health condition or health risk and women of any age who have a high-risk pregnancy.