MAKE THE SWITCH NOW AND SAVE!
American Professional Agency
Psychologists Professional Liability Insurance Preferred Program
Preferred program for APA-members and TPA-members who receive a 20% premium discount annually

– Introducing Cyber and Security protection*
– Coverage for Telepsychology provided, subject to terms and conditions of the policy
– Prior acts available allowing an easy switch without purchasing tail coverage

*Endorsement available for new policyholders and current policyholders at renewal beginning January 1, 2021 where allowable by law.

MULTIPLE PREMIUM DISCOUNTS**

• 20% discount for APA members every year
• 35% part-time discount for up to 20 client hours a week – employment can be excluded
• 35% new graduate discount for the first year
• 5% risk management discount for three risk management credits
• 10% new policyholder discount (applicable to new American Professional Agency, Inc. accounts only; must be claims-free for the last six months)
• 5% continuing education discount for six CE credits
• 10% practice setting discount

**Discounts and coverage features are subject to individual state approval and underwriting guidelines.

AMERICANPROFESSIONAL.COM/PSYCHOLOGIST-INFO
PSYCHOLOGY@AMERICANPROFESSIONAL.COM
(800) 421-6694 Ext.2304
Dear TPA colleagues/colegas y amigos,

We are devastated to see yet another mass shooting in our nation, this time it happened in Uvalde, Texas killing 19 children and 2 teachers at Robb Elementary School. TPA immediately released a statement urging for evidenced based solutions and the important role psychologists play to support best practices for keeping our children safe at schools. In this Texas Psychologist issue, you will find a detailed report of TPA’s initiatives and continued work in response to the mass shooting in Uvalde.

In a more positive light, I would like to share the hard work TPA is doing to support and advance our profession. I am excited to serve as TPA’s president during our 75th anniversary! We have lots to celebrate and we have much more to do. As we reflect on TPA’s 75-year history, I would like to recognize how far TPA has come on both protecting the standards of our profession and advocating for the people we serve. I have witnessed our TPA colleagues hard work, passion, and leadership throughout the years to do just that. Yes, we have lost some battles along the way, like maintaining our independent licensing board and other Sunset related issues (TPA’s 75th history article in this issue written by Stagner et al. details some of those accounts). TPA did lose some members, but we are gaining more. I credit various committees like Membership, Academic and Higher Education (AHEC), and Public Education Campaign (PEC) and others that are working hard every single day for TPA. And I mean every day y’all! You have people making calls, groups of psychologists meeting weekly to increase student and Early Career Psychologists (ECP) involvement, others are educating the public on what psychologists do, psychologists are meeting routinely to prepare for our legislative agenda, an agenda that will protect our profession and help determine our future in Texas. We also have leaders forming relationships with elected representatives to sponsor and bring bills to the Texas Capitol, we have members providing expert testimony on bills, and leaders working on building and forming stronger relationships with our Local Area Societies (LAS) throughout the state. Most recently, it was rewarding to meet the LAS presidents and presidents-elect in a recent LAS/TPA virtual meeting on a Saturday morning! Yes, we work on the weekends to assure TPA is there and will always be there for the guild and to advocate for the those we serve. TPA also works alongside APA. Every year in the Spring a group of Texas psychologists advocate for psychologists in Washington, D.C. We are at Capitol Hill walking the halls speaking to our Texas senators and representatives to advance our profession and protect it. TPA does all that and more. I thank you for being a member and supporting your profession because membership and convention is where most of our revenues come from. If we had more TPA members we could do more. If you’re colleagues in your practice, department, city, or rural town in Texas are not members of TPA, encourage them to be members and support their state association because we are working hard for them too.

Starting my presidency in January 2022 we had just completed a successful in-person convention in Austin, Texas in November. In February our Executive Director resigned and we have been successfully working with an association management company and completing our ED search. The ED Search Committee and BoT recently selected Mary Beth Kiser, CAE to lead our association. I am confident we made the right decision for the TPA of the future.

As the COVID19 pandemic continues, it is important to reflect how far we have come. Many psychologists are now providing psychological services in person and others have continued telehealth and others a hybrid model. TPA has advocated and continues to advocate for flexible delivery of psychological services and the dissemination of science. In addition to delivery of services, TPA has been advocating for reimbursement for interns and postdocs under Medicare, student loan repayment programs, minority fellowships, and parity for mental health coverage, all amid a global pandemic. My goal is to assure this hard work TPA is doing for its members, our profession, and psychologists in Texas is communicated and disseminated across our state.

Lastly, a very special initiative I have launched as president is TPA’s Citizen Psychologist in support of this year’s presidential theme of Psychology’s Role in Serving the Underserved and Disadvantaged Populations. In this issue, you will find three psychologists that do just that in our Lonestar State. They represent diversity and a passion in their work as psychologists to leverage science and shed light into the communities of Texas that have scarce resources and provide innovative and culturally informed psychological services in different regions of Texas that are underserved. Congratulations to them and the many psychologists devoted to disadvantaged populations. It is rewarding to see the numerous nominations and encourage you to continue to submit nominations to acknowledge our colleague’s important work. To conclude, we have received an overwhelming response of proposal submissions to our 75th anniversary fiesta convention in San Antonio and the convention committee are hard at work to ensure we will have a special and memorable convention. I am also excited to share our keynote speaker line-up which you may read later in this issue.

Thank you for being a TPA member and supporting your association.
As TPA celebrates 75 years of service to the psychological community, your volunteer board has been working to ensure our association’s continued success in the years to come by identifying new staff leadership to provide operational and strategic support and guidance for our association.

The TPA Board of Trustees is pleased to announce that the association has named Mary Beth Kiser, CAE, as the new Executive Director, effective July 1, 2022. With careful consideration for the association’s continued growth, TPA has engaged Mary Beth to serve as our Executive Director through a partnership with Strategic Association Management (SAM).

Mary Beth is a seasoned and accomplished association executive with more than 21 years in association and nonprofit management. She earned her Certified Association Executive (CAE) credential in 2009 and the Texas Association of Nonprofits Certificate in Leadership and Management in 2014. Her professional experience includes executive leadership, fundraising and business development, board and volunteer management, legislative support, and program development through her roles as the President and CEO of Beyond Batten Disease Foundation and the COO of Texas Land Title Association. Mary Beth is a graduate of the University of Texas and has lived in Austin with her family for more than 30 years.

SAM is a well-regarded Austin-based association management company and provides a dedicated team of experienced professionals, including talented association executives, like Mary Beth, who can help us continue to move our mission forward. SAM partners with and manages the operations of more than 18 associations, including other Texas statewide associations of significant size and scope. We are excited to experience the successes of these associations who have found that through long-term partnerships with SAM, organizational sustainability, growth, and, ultimately, transformation have occurred.

TPA would like to thank Angie Guy with Association Management Consultants, who has served as our Interim Executive Director over the last 6 months and will continue with TPA as the Operations and Conventions Manager.

TPA is experiencing an exciting time of growth. Thank you for your commitment to the association and our profession. Mary Beth’s leadership and our partnership with SAM, will support that growth by identifying novel strategies to accommodate the needs of our membership.
A NOTE FROM THE FOUNDATION

KELLY G. ARNEMANN, PHD
TPF President
Staff Psychologist, South Texas Veteran Health Care System
San Antonio, Texas

The Texas Psychological Foundation (TPF) is a 501(c)3 charitable arm of TPA that directly gives monetary awards to students for their research and posters based upon appropriate submission criteria. It was created by TPA for charitable, educational and scientific purposes. A donation of any size is tax deductible.

TPF looks forward to seeing multiple award submissions for this year. The awards for which students can submit are as follows:

- Bo and Sally Family Psychology Research Award will provide an award for research projects related to family psychology for research addressing potential causes and/or prevention of violence against women.
- Roy Scrivner Gay, Lesbian, and Bisexual Issues Award for the best completed research projects (not proposals) related to Gay, Lesbian, and Bisexual research issues.
- Leo Alexander Psychobiology/Psychophysiology Award for research related to psychobiology, psychophysiology, and related areas.
- Manuel Ramirez III Dissertation Award for Ethnic Minority Research done by an ethnic minority graduate student completing their dissertation in psychology.
- Rose Costello Education Fund for furthering education in psychology.
- Student Research Proposal Awards are open to full-time Texas undergraduate and graduate psychology students who are conducting current research in the field of psychology.
  - The Undergraduate Proposal Award is designed to provide funding for an undergraduate’s research proposal related to the broad area of Community/Public Service.
  - The Graduate Proposal Award is designed to provide funding for a graduate student’s research proposal related to the broad area of psychotherapy.

Please encourage any students that you know to submit for these awards in 2022.

TPF is honored to have contributed to the continued support of our current doctoral students and their research. I respectfully request that you join me in supporting the Foundation annually.

We are excited to work with Dr. Mercado and his Presidential Theme of “Psychology’s Role in Serving the Underserved and Disadvantaged Populations”. It is my hope that many of our 2022 research award and poster submissions reflect these underrepresented groups.

Our current Board members are Drs. Kelly Arnemann, Courtney Banks, Glenn Sternes, Jo Vendl, Amanda Venta, and Mr. Patrick Stanford-Galloway. We are always looking for more Board members to join so please consider this opportunity to be a part of TPF. Beginning this year, the Board will meet on a quarterly basis.

As always, we offer our gratitude to our TPF Heroes, Friends and Donors and I again request you to consider being a part of TPF’s legacy and its mission of supporting the future of Psychology. You can quickly and easily donate to TPF by clicking on the box below.

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@hcjpd.hctx.net

DONATE TO TPF
DIRECTOR OF PROFESSIONAL AFFAIRS UPDATE

BRIAN STAGNER, PHD
TPA Director Of Professional Affairs 2022

Is the Pandemic over?

Well, the pandemic may or may not be perpetual. A better question is “When will the Public Health Emergency end?” These PHEs get renewed every 90 days, usually at the very last minute before the end of the prior PHE. The current PHE ends July 15. Best guess from those who track this is that we will have one more last-minute extension (i.e., until Oct 15). Probably. And, depending on “the numbers” and political considerations at that time, that could be the last.

Another good question: What happens when(ever) the PHE finally expires? It’s unclear what’s next, but it is certain that there will be changes. At the very least, there are indications that the reimbursement rates for telehealth may revert to pre-pandemic levels. For example, Medicare may change its fee structure for tele-psychology. Further, some insurance companies may scale back their policies on when or whether they will reimburse tele-psychology. Finally, some states may alter their policies on telehealth services from out-of-state providers. There are few specifics about any of these potential changes. Bottom line, providers need to do what our patients need to do: accept uncertainty and prepare to be resilient.

Update from APA Advocacy

At the Federal level, the regulatory and policy environment for practitioners is quite fluid. Here are some of the projects APA’s Advocacy staff are tackling.

• Integrated care. This is the big focus at legislative and policy levels. APA is working to ensure that the role of psychologists is recognized and that it is codified in law.

• APA continues to partner with Social Workers and Psychiatrists to address the impact of the No Surprises Act.

• APA supports Senators Barrasso and Bennett, who are introducing legislation to allow Medicare reimbursement for trainees.

• APA is lobbying to bring ERISA plans under the jurisdiction of the Department of Labor. Presently, these plans operate with virtually no oversight or accountability.

• APA is pushing bills to ensure telehealth reimbursement parity.

• APAs legal and state advocacy staff (LSA) continue to work to contain the impact of the No Surprises Act. The next round of rules (due out before the end of the year) may require psychologists to furnish insurance companies with Good Faith Estimates, just as we are now required to furnish to patients.

• LSA is also involved in efforts to clarify telehealth regulations as well as network adequacy.

• Mental Health parity continues to be a challenge in many jurisdictions and, to some extent, at the federal level. LSA continues to monitor and to advise state associations on this issue.

• LSA is working with APAs EDI officer to expand APAs Legislative grants to address EDI issues.
Congratulations to Dr. Ebony Butler for being selected as a TPA Citizen Psychologist! **Dr. Ebony Butler, PhD** is a Licensed Psychologist and Food Relationship Strategist who has made it her mission to help women of color heal and thrive in the areas of trauma, including racial trauma and recovering from food and body trauma experienced through diet culture. Dr. Ebony works alongside women to help them develop skills that increase their relationships with others, themselves, and their bodies. Aligning with her passion to break through barriers that make it difficult for Black people and other people of color to access quality mental health care, Dr. Ebony created My Therapy Cards®, the first-ever self-exploration card deck for Black women and other women of color. Since its launch in May 2020, Dr. Ebony has expanded the card deck to include a Teen Edition and Men’s Edition. The expansion of this resource has made self-insight and discovery work more accessible and affordable! Dr. Butler’s innovative Therapy Cards reaches disadvantaged populations that have access to care barriers and provides a culturally informed self-exploration outlet. In years prior to her current work, Dr. Ebony worked 8 years for Veterans Administration and served Veterans and their families in the areas of trauma, PTSD, and military sexual trauma. Following her service at the VA, Dr. Ebony worked for the City of Austin for 5 years providing psychological and mental health services to first responders within the Austin Fire Dept and Austin Travis County EMS. Dr. Butler embodies the true definition of a TPA Citizen Psychologist. Her clinical work and community engagement for the public good are highly praised!
Congratulations to Dr. Juventino Hernandez Rodriguez for being a recipient of the Texas Citizen Psychologist recognition! Dr. Hernandez Rodriguez is a bilingual (English/Spanish) Licensed Psychologist and an Assistant Professor at the University of Texas Rio Grande Valley (UTRGV). He received his PhD from the University of Arkansas and completed a postdoctoral fellowship at the Medical University of South Carolina. At UTRGV, he is the co-director of the Research Enhancing Access to Culturally-informed Mental Health Services (REACH) lab, which is dedicated to increasing access to evidence-based mental health interventions to underserved populations. His specific research interests focus on understanding how Latinx youth and families are impacted by stressful events (e.g., COVID-19, trauma, bullying, anti-immigration policies) and evaluating novel service delivery models that help increase access to mental health care (e.g., school-based services and primary care behavioral health). His current research projects examine 1) the impact of the COVID-19 pandemic on American youth and families; 2) the prevalence of internalizing problems, trauma, and negative peer interactions among youth in South Texas; and 3) the experiences of LGBTQ+ Latinxs accessing mental health services in the Rio Grande Valley. In addition, Dr. Hernandez Rodriguez leads mentoring efforts to help strengthen and diversify the psychology workforce. At UTRGV, he leads the Reach for Graduate School in Psychology (RGSP) initiative which provides workshops, resources, and mentorship to undergraduate students interested in applying to graduate programs in psychology. Moreover, he is involved in state- and national-level advocacy efforts. Recently Dr. Hernandez Rodriguez was part of the American Psychological Association’s Advocacy Summit, “Advancing Health Equity and Access to Psychological Services,” where he spoke with the offices of Texas Senators and State Representatives to request their support for addressing mental health workforce shortages and reducing health inequities. His research and clinical work in underserved communities in Texas embodies the values of a TPA Citizen Psychologist!
TPA Citizen Psychologist

Congratulations to Dr. Stephanie Robertson for being selected as a TPA Citizen Psychologist! Dr. Stephanie Robertson is an Associate Professor of Psychological Sciences and the founder and director of the Tarleton Center for Child Well-being. She is an active researcher, working to identify needs of underserved communities by utilizing Community Based Participatory Research models, most recently collaborating with Simons Searchlight to assess the needs of families affected by rare genetic conditions. She is passionate about serving the underserved through both research and practice, and established the Tarleton Center for Child Well-being because her community, rural Erath County, is a federally identified health service provider shortage area for behavioral health services.

Dr. Robertson developed the Tarleton Center for Child Well-Being (TCCW) as a multidisciplinary child service center affiliated with Tarleton State University. The TCCW provides psychological, behavioral health, and consultation services to families of school-aged children in the Cross Timbers area. In addition to working directly with families, the TCCW works with agencies, schools, and programs serving children, providing consultation and resources. The Tarleton Center for Child Well-being is dedicated to meeting the needs of the community while training the next generation of practitioners.

In addition to her research and clinic development, Dr. Robertson serves her profession and community as a volunteer. She is a member the Board of Trustees for the Texas Psychological Association. She also chairs the Public Education Committee and serves on both the Academic and Higher Education and the Legislative Committees at TPA. She is the Vice President of the Board of Cross Timbers Family Service, who provide advocacy and education related to domestic violence, sexual assault, and other violent crimes. Dr. Robertson embodies the definition of a TPA Citizen Psychologist. Her research, clinical work, and commitment underserved communities in Texas and her community engagement for the public good are commended!
On May 24, 2022, the world learned about the tragic shooting deaths of 19 children and 2 teachers at Robb Elementary School in Uvalde, Texas. In response to this tragedy, TPA President, Alfonso Mercado, and the TPA Board of Trustees released the following statement:

“Texas Psychologists stand ready, once again, to offer those in distress the comfort, guidance, and support they need to maintain resilience in the midst of shock and profound grief. TPA calls for evidenced based solutions to stop gun violence that has become a public health crisis. These include restricting guns to people who are at risk for violence and working with psychologists and other experts to support best practices for keeping our children safe at schools.”

The TPA Board of Directors (BoT) began working immediately with the TPA Disaster Resource Network (DRN) to address the first need identified in this statement: responding to the psychological trauma of the community of Uvalde. The BoT and DRN organized a list of the many TPA members who had begun volunteering to provide pro bono services to the community of Uvalde impacted by the shootings at Robb Elementary School. TPA reached out to the Department of State Health Services (DSHS) Disaster Behavioral Health Consortium to make known the outpouring of offers of help from TPA members. After being advised by APA that Catholic Charities of San Antonio was seeking contract therapists to respond in person to Uvalde, TPA shared that information with members. TPA also provided lists of resources for supporting children, families and educators impacted by reports of the tragedy.

TPA was subsequently invited to join the Texas Mental Health Rapid Response Team along with seven state governmental entities and 13 professional associations. Through meetings of the Rapid Response Team, TPA learned about the response of state and local disaster responders to the citizens of Uvalde. State officials reported that the immediate needs of the community were being met but that there would be a need for long-term mental health services to facilitate the community’s recovery. TPA members can potentially be part of this long-term recovery. The BoT and DRN will provide details about how members can help as we are advised by the Rapid Response Team.

Through our involvement with the Rapid Response Team TPA is learning more about state disaster response systems. TPA plans to establish a task force with the DRN to identify ways that TPA can potentially interact with existing systems to provide disaster response services.

TPA’s statement also called for evidence-based solutions to the public health menace of gun violence. To address this need, the BoT voted to sign on to the Coalition of National Researchers Violence Prevention Plan. This call for action includes a three-level approach to the prevention of gun violence: 1) universal approaches promoting safety and well-being for everyone; 2) practices for reducing risk and promoting protective factors for persons experiencing difficulties; and 3) interventions for individuals where violence is present or appears imminent.

TPA has shared this document with the Texas House Homeland Security and Public Safety Committee.

TPA’s Legislative Committee will be discussing additional ways that TPA’s members can advocate at the legislative and policy level for evidence-based solutions and make recommendations to the BoT prior to their next meeting in August.

TPA members interested in Disaster Response should consider joining the Disaster Resource Network division of TPA by emailing admin@texaspsyc.org.

Texas Psychologist | Summer 2022 | 9
PREVIEW OF KEYNOTE SPEAKERS

Thursday, November 10th

Keynote Presentation: Mechanisms of Change: Understanding the Personal Processes that Influence the Journey of Change

Breakout Session: Relapse and Recycling: Learning from Failure to Create Success

Carlo C. DiClemente, PhD ABPP
Professor Emeritus
Department of Psychology
University of Maryland, Baltimore County
www.umbc.edu/psych/habits

Dr. DiClemente is co-developer of the Transtheoretical Model of behavior change, and author of numerous scientific publications on motivation and behavior change with a variety of health and addictive behaviors. He has conducted funded research for the past 40 years with funding from NIH Institutes, SAMSHA, and Foundations. He published his most recent book Addiction and Change: How Addictions Develop and Addicted People Recover (second edition) in 2018. He has co-authored several professional books, The Transtheoretical Model, Substance Abuse Treatment and the Stages of Change (second edition), and Group Treatment for Substance Abuse: A Stages of Change Therapy Manual (Second Edition) and a self-help book, Changing for Good.

Thursday, November 10th

Keynote: Latinx Immigrant Health Alliance

The Latinx Immigrant Health Alliance (LIHA) is a group of Latinx scholars with varied expertise in epidemiological, basic, and intervention research with immigrant populations. LIHA scholars collaborate to advance research, policy, and effective interventions to improve immigrant mental health and inform effective policy. LIHA Members: Germán A. Cadenas, PhD; Melanie Domenech Rodriguez, PhD; Thania Galván, PhD; Luz Maria Garcini, PhD, MPH; Alfonso Mercado, PhD; Oswaldo Moreno, PhD; Manuel Paris, PsyD; Oscar F. Rojas Perez; Michelle A. Silva, PsyD; Amanda C. Venta, PhD

https://www.latinximmigranthealthalliance.org/
**Friday, November 11th**

**Thema Bryant, PhD**

Dr. Thema Bryant is the president-elect of the American Psychological Association, the leading scientific and professional organization representing psychology with more than 120,000 members. She is the author of *Homecoming: Overcome Fear and Trauma to Reclaim Your Whole Authentic Self* and co-author of *The Antiracism Handbook.* Dr. Thema Bryant completed her doctorate in Clinical Psychology at Duke University and her post-doctoral training at Harvard Medical Center's Victims of Violence Program. Upon graduating, she became the Coordinator of the Princeton University SHARE Program, which provides intervention and prevention programming to combat sexual assault, sexual harassment, and harassment based on sexual orientation. She is currently a tenured professor of psychology in the Graduate School of Education and Psychology at Pepperdine University, where she directs the Culture and Trauma Research Laboratory. Her clinical and research interests center on interpersonal trauma and the societal trauma of oppression. She is a past president of the Society for the Psychology of Women and a past APA representative to the United Nations. Currently she serves as the elected Vice President and Racial Equity Officer for her neighborhood council in Los Angeles. Dr. Thema also served on the APA Committee on International Relations in Psychology and the Committee on Women in Psychology.

---

**Friday, November 11th**

**Keynote Presentation: How Psychotherapy Works… and How to Make it More Effective**

**Bruce E. Wampold, PhD**

Bruce E. Wampold PhD, ABPP, is Emeritus Professor of Counseling Psychology at the University of Wisconsin—Madison, former Director of the Research Institute at Modum Bad Psychiatric Center in Norway, Chief Scientist, Skillsetter.com. He is a Fellow of the American Psychological Association, is Board Certified in Counseling Psychology by the American Board of Professional Psychology, and is the recipient of the 2007 Distinguished Professional Contributions to Applied Research Award from the American Psychological Association, the 2015 Distinguished Research Career Award from the Society for Psychotherapy Research, and the 2019 Gold Medal Award for Life Achievement in the Application of Psychology from the American Psychological Foundation. His work is summarized in *The Great Psychotherapy Debate: The Evidence for What Makes Psychotherapy Work* which involves understanding psychotherapy from empirical, historical, and anthropological perspectives.

---

**Saturday, November 12th**

**Keynote Presentation: Toward a More Inclusive Psychology: The Ethical Imperative of EDI**

**Maysa Akbar, PhD**

Maysa Akbar, PhD, ABPP is a respected scientist-practitioner and APA's Chief Diversity Officer, charged with infusing equity, diversity and inclusion (EDI) into the fabric of the association's work. As the leading architect of APAs evolving EDI framework, Akbar works with APA staff, leaders and members to refine and build consensus for an overall plan, operationalize its goals and establish metrics to monitor and ensure progress. The CDO also serves as a spokesperson and advocate for EDI in the field of psychology, both within and outside the association.

Before assuming the CDO post, she was the founder and chief executive officer of a clinical practice based in New Haven, Connecticut, that specialized in race-based trauma. She also created a consulting firm and educational network focused on organizational cultural transformation. Her firm delivered cutting-edge programs anchored in EDI to city governments, public schools and court systems, among other entities. Akbar's areas of specialty include racial identity development, racism, urban trauma and allyship, topics on which she has written research articles, books and book chapters. Akbar is an experienced instructor and master trainer in EDI for both the medical and the broader community.
We asked TPA’s past presidents for their recollections of their presidential terms for the past 15 years. What follows is a summary of their recollections, augmented by information from the Texas Psychologist.

The last review of TPA’s history was written by Dr. Robert McPherson in 2007 on the occasion of our 60th anniversary with the title “The Sun Rises Again for Texas Psychology”. It was an optimistic time—in 2008, TPA president Dr. Ron Cohorn stated that TPA was maturing out of its adolescence. Now, TPA is 75. Where have we been this past 15 years? Have we realized the promise we saw then? Where will TPA be headed?

GEARING UP

At the end of his presidential year (2007), Dr. David Rudd had proposed a number of changes to make TPA more nimble and more effective. In order to advocate for “improving access to affordable, high-quality healthcare” in Texas, the association needed to stabilize its finances and take more active ownership of its legislative and regulatory advocacy. The changes included:

• Rethinking our lobbying efforts. In the 1980s TPA was befriended by a retired legislator, Don Cavness. He served as informal lobbyist on a mostly volunteer basis. TPA had invested heavily in professional lobbyists but had virtually no results. The Board of Trustees (BoT) voted to reconfigure the role of the Executive Director. Mr. White's time and effort were redirected to lead lobbying at the Capitol and to mobilize local area societies.

• Dr. Rob Mehl organized our grassroots organization to prepare for the legislative session. We had fared generally well during the sunset hearings in 2007, and we wanted to maintain momentum. The plan was to have at least one TPA member maintaining a relationship with each member of the legislature.

• Legislative planning was evolving. In a BoT retreat, it was determined that our relationship with both the legislature and the Texas State Board of Examiners of Psychologists (TSBEP) should be more proactive. TPA aspired to have our own legislative agenda (not just react to what other groups were doing), and to adopt a longer time horizon.

• We continued to strengthen our financial footing and we prepared to purchase our own building rather than rent space.

After a hectic legislative year, Dr. Cohorn turned the association’s attention to negotiating better reimbursement rates and more equitable review procedures with managed care companies. This led to the Business of Practice Committee, with Dr. Bonnie Gardner serving as the first chair.

The association continued to professionalize its internal operations. Past president Dr. Paul Burney, worked with Dr. Cohorn to formalize the role of Executive Director. David White had worked for years without a contract, a performance review, or a system of budgetary planning. Mr. White was put under a regular contract; the finance committee was expanded and Dr. Cohorn began to oversee the association’s investments in mutual funds.

Dr. Ollie Seay had a very busy presidential year in 2009. She created a task force to promote an internship consortium given the general shortage of sites for doctoral students. This turned into the Lone Star Internship Consortium geared toward training doctoral interns in underserved areas of the state. It included sites in the Rio Grande Valley, at the Big Spring State Hospital, and at UT Health-Tyler. Eventually, UT-Tyler took over the administration of the internship. The consortium’s work led directly to UTRGV establishing a graduate program in psychology along with internship opportunities. Our current TPA President, Alfonso Mercado, was an intern in the program in 2009.

The convention theme in 2008 was “the Future of Psychology in Texas” with keynotes by Dr. Donald Meichenbaum, and Texas’ own Dr. James Bray and Dr. Melba Vasquez (both later presidents of APA). During the convention we received news of a mass shooting at Ft. Hood. One of the deceased was Major L. Eduardo Caraveo, PhD. Dr. Caraveo worked at the Federal Bureau of Prisons but, as a psychologist with the Army Reserve, he was preparing for his second deployment to Afghanistan when he was murdered. The tragedy shook the attendees but also...
2010 was a year for regrouping and renewing focus. Over the previous three years, TPA had undertaken many disparate projects. The smart and enthusiastic members of the Board of Trustees were very good at generating ideas and projects but the association needed more focused operations in order to succeed. President Brian Stagner, PhD, worked with Mr. White to build up the organizational infrastructure. This included regular, scheduled phone conferences for the finance committee and the legislative committee and for weekly phone conferences with the Executive Committee. TPA’s legislative advocacy thinking continued to move more decisively to a long-term timeline in hopes of being better prepared for the coming legislative session. The procedures for identifying legislative priorities were clarified and Dr. Mehl doubled down on solidifying the grassroots lobbying network.

There had been controversy about whether TPA should pursue prescriptive authority in the legislature. There was a misperception that TPA placed RxP in the first tier of its legislative agenda. Many members felt that TPA resources should not be directed toward this goal. However, the truth was that all the lobbying and funding for RxP advocacy was generated internally by the RxP division, independent of TPA’s legislative agenda and budget. To avoid duplication of effort at the statehouse, the RxP division and the Legislative Committee agreed to combine forces more systematically and transparently.

The convention keynotes were by Peter Nathan, PhD, previewing the DSM-V (still attached to Roman numerals), Jonathan Shedler, PhD, on psychodynamic psychotherapy, and Melba Vasquez, PhD, on “Psychology as a Thriving Profession Despite its Challenges and Complexities.”

Also, President Obama signed the Affordable Care Act in 2010.

PROTECTING THE STANDARD

Dr. Mehl began his presidency committed to tightening decision making at TPA in order to ensure greater accountability. He established that the President, President-Elect, and President-elect-designate would be part of the finance committee creating greater liaison with the BoT.

There were high expectations for the 2011 legislative session. This was a year to remind us that a big part of legislative and regulatory advocacy is vigilance against external threats to the profession. Multiple incursions into the practice of psychology were attempted by master’s level groups.

• For the first time, we faced prospect of Behavior Analyst licensing.
• The psychological associates (LPAs) sued the members of TSBE to grant them independent practice. With opposition from APA and TPA, they lost the lawsuit. The suit may have had the effect of making the board defensive and cautious about change.
• TASP (Texas Association of School Psychologists) petitioned the TSBE to allow them to use the title “Nationally Certified School Psychologist.” They failed. This was one of several strategies by TASP to expand the scope of LSSP practice. Another was the effort to authorize LSSPs to perform neuropsychological testing in the schools. Strenuous objections from TPA and several neuropsychology groups killed this in the Senate at the last minute.

After heroic lobbying by TPA membership, the Authority to Delegate bill was filed in 2011 and HB808 passed in 2013! Psychologists could now bill under their own name for supervised Temporarily Licensed Psychologists and newly licensed psychologists not yet on Managed Care Panels. This is the first expansion of psychologists’ scope of practice.

It was also one of the few times in the history of TPA where one of our bills was passed (other than the Practice Act and its reauthorizations). The association mostly plays defense, blocking or modifying legislation that constrains our scope of practice. Feeling that the association needed more of a proactive vision, president Dr. Mehl held a retreat to organize more long-range legislative strategies and a planning agenda. There was discussion of forming alliances with allied groups (behavioral health providers as well as physicians and other stakeholders) around targeted issues where there are converging interests.

The 2011 convention was a great success with John Gottman, Ph.D. as the keynote. In addition, Convention Chair Dr. Cynthia de las Fuentes arranged for Dr. Gottman to meet with early career psychologists and offer a well-attended open meeting about marital success to which the public was invited. This is the only time TPA has held a public forum.

In 2012, the Texas Psychologist solicited contributions from Texas psychologists on the future of professional psychology. Some declined (“I’m so discouraged by the attacks on our profession and the dwindling reimbursements, I have nothing encouraging to say”). Most contributors shared the view that professional psychology faced multiple challenges from other professions, from the changing demographics of the country, from legal and regulatory challenges, and from scientific breakthroughs. Mergers, cutbacks...
and policy changes in the insurance industry were further threats to the viability of our profession. Bold leadership was called for.

The protection of the doctoral standard was central to meeting these challenges. The 2012 president, Dr. Lane Ogden, focused on reinvigorating the membership, seeking to increase numbers and to promote contributions to TPA, TPF and the PAC. He actively solicited new membership and worked to foster political engagement by all our members.

Beyond building membership engagement, the association was beginning to build momentum in two areas: increased attention to diversity and understanding innovations in service delivery. At the convention, UT Professor Dr. Kevin Cokley spoke on “Multicultural Psychology: A Personal and Professional Journey” and ASPPB sent Alex Siegel, JD, PhD to discuss innovations in service delivery (“Telepsychology: What You Must Know About Using Technology”).

In 2012, a master’s level provider and her husband founded Talkspace.

In 2013, under Dr. Ray Brown’s leadership, TPA prepared several bills to bolster areas of practice, to increase public access to care, and to protect us against the loss of specialty services that we are trained to provide without further licensure/certification (e.g., sex offender treatment). TPA also challenged licensure exemptions in state agencies and worked to protect the term “psychologist” by restricting it to doctoral level, licensed individuals. HB 807 was passed this year that protects the title. There were efforts to expand opportunities within the forensic arenas related to involuntary commitments, competency evaluations, and guardianship.

Also in 2013, the Texas legislature rejected the opportunity to participate in Medicaid expansion. They are still rejecting it.

**PSYCHOLOGY IN THE PUBLIC REALM**

In her 2014 presidency, Marcia Laviage, PhD, faced TPA in turmoil. While several positive gains were made, including the establishment of both the Neuropsychology and Military Divisions, 2014 was one that ultimately found TPA members reflecting on our personal values, our professional ethics, and most importantly, the role of our organization in protecting the public and those we serve. How can I reconcile conflicts between my personal values and the promotion of my profession?

In June, the Texas GOP platform endorsed Reparative Therapy as a “treatment option” for LGBTQ individuals. TPA issued a statement focusing on the lack of empirical evidence toward this kind of treatment. This raised the ire of members whose faith-based beliefs opposed advocacy for LGBTQ+ concerns. Our public statement said, “We also are an organization that embraces diversity – a concept that includes the positions of psychologists on both sides of this issue. Although research continues, the conclusions reached by APA in peer-reviewed studies since 1960 suggest that the ‘value’ of reparative therapy has not been demonstrated empirically.”

In August, TPA endorsed APA’s amicus brief to the Fifth Circuit of Appeals challenging Texas’s law banning same sex civil marriage. After the TPA Board approved this action, our President-Elect and two Past Presidents resigned from the association. Many dissenter had been prominent leaders and supporters of TPA. Their voices were swamped by messages of support, including past presidents, non-members of TPA, the psychologist with the first license in TX, and many others who have demonstrated leadership on both the local, state, and national stage. The debate had been divisive and at times needlessly harsh but the association survived and moved forward. However, the deeper schism remained between those urging advocacy for public interest issues versus those who value TPA for promoting guild issues.

In 2015, Dr. James Bray led efforts in the legislature which have had ongoing impact on the practice of psychology. In 2013 we had passed the post-doc bill that enabled billing for post-doc services. In 2015 this was followed by the passage of bills to:

- enable billing for interns’ services (HB 1924/SB 546).
As changes in the state occurred rapidly and the mental health access crisis was on the horizon, the governor again convened a special committee called the Mental Health Select Committee. TPA was invited to speak in front of the committee, and we were represented by Dr. Simonsen.

**LAWSUITS AND SUNSET**

Psychologists nationwide became alarmed by the outcome of the Seraf ine case. Mary Louise Seraf ine had run for the Texas Legislature, claiming to be a psychologist. Dr. Seraf ine had earned a PhD in psychology but she was never licensed. Her use of the title violated the Practice Act. When the TSBEP asked her to cease and desist, she sued the licensure board. TSBEP lost the case in the appeals court. The definition of the practice of psychology was determined to be unconstitutionally broad and vague. (At one point it was argued that “psychologists just talk to people”, the implication being that there is no real expertise or professionalism involved).

LPAs once again petitioned TSBEP to gain independent practice. Psychologists showed up en masse in Austin to testify as to why LPAs were not trained well enough to practice independently. We effectively defended the doctoral standard yet again.

Sunset of the Practice Act was on the horizon in 2016. Dr. Carol Grothues led the committee writing a report for the senate commission, providing information about the importance of TSBEP’s need for continuation and continued independence as a board. The Sunset Commission had recommended that we drop the oral exam from the licensure process due to high cost and perceived low efficacy (an argument that had failed in the previous sunset cycle). More worrisome, it became evident during that year that the state intended to consolidate behavioral health boards. This was part of a nationwide movement questioning the need for regulatory boards in general. It was also a response to an anti-trust lawsuit against the North Carolina dental board in which it was successfully argued that the professionals on a regulatory board were practicing restraint of trade. (The dentists were trying to prohibit teeth whitening businesses operating without a dentist in charge). The consolidated board would distribute the decision making across all the behavioral professions, presumably voiding the anti-trust objections to the TSBEP. We argued that if TSBEP lost its independence, the psychology license would be the only doctoral level license not to have an independent board. We fought to keep independence and orals.

The 2016 Pulse Nightclub massacre in Florida led Texas Psychologist editor (Dr. Cynthia de las Fuentes) to write an editorial on the dangers of gun violence and advocating for gun control. Some feared this article would tear the association apart. Dr. Simonsen brought it to the BoT, which voted that the editorial be published.

The 2016 convention opened in Austin on the morning after Donald Trump’s 2016 election victory. Peggy McIntosh, the author of White Privilege: Unpacking the Invisible Knapsack presented on her seminal theory. It was also the first TPA convention to have gender neutral bathrooms available in the convention lobby.

Dr. Carol Grothues became president in 2017 and Sunset was the gorilla at dinner. We had a record turnout of psychologists come to Austin that year to oppose proposed Sunset changes. These included: (1) removal of the oral exam requirement for licensure, (2) modifying the post-doctoral year requirement – no longer a calendar year, but total number of hours which could include internship hours; and (3) consolidation of TSBEP with other boards.

We tried to work with the bill’s author to keep TSBEP independent, but it was an uphill battle. APA and NAN supported us and some legislators understood our concerns. However, when the Lieutenant Governor’s bathroom bill blocked all other legislation, our Practice Act was one of many that were deferred for two years.
In the aftermath of the Serafine decision it was necessary to clarify the legal basis of our ability to practice. We had to work with other “stakeholders”, including the Texas Medical Association, Disability Rights, and even life coaches and BAs. It was miserable and difficult – every group being very territorial.

APA legal counsel helped and we passed a new practice definition for psychologists. The one silver lining in this grueling process was that psychologists’ right to diagnose was included in the definition of the practice of psychology for the first time in a bill filed in 2017 by Senator Watson (SB2001) and Rep Garnet Coleman (HB 3266).

We also were successful in the legislative fight against the independent practice of LPAs in 2017. Sen Hinojosa pushed this bill hard noting the mental health workforce shortage and arguing that there was a possible anti-competitive issue because LPAs were being limited by rule, not by statute (since those on the TSBEPE making the rules were psychologists, this was a clear example of anti-competitiveness).

The bill failed but the tide was turning. Senator Van Taylor berated TSBEPE Director Darrel Spinks in a public hearing, “How can you defend this?” Sen. Hinojosa, after failing to pass his bill, jumped on this bandwagon and urged TSBEPE to change the rule. The fear of an FTC suit eventually led TSBEPE to change the rule and allow immediate grandfathering of all LPAs “in good standing” to become independent practitioners. Fortunately, they also changed the rules to increase the hours of training to be similar to LPC and increased the EPPP test score. However, several LPA licenses were granted to those with very limited training.

We had better outcomes with other bills, including keeping OTs from being listed as mental health professionals. This will continue to be an issue -- they really want this title.

2017 was the first year were successfully had a sponsor for RxP – not only one, but two reps (Burrows and Van Deaver) and a senator (Rodriguez). We did not get a hearing, though. We also obtained a sponsor for our liability protection bill and LSOTP bill.

In 2018, Dr. Cheryl Hall was president and we continued to deal with Sunset issues. The TPA Sunset Committee put in long hours to forestall the consolidation of TSBEPE under an umbrella behavioral health board. The fact that the other MH groups were failing miserably and needed the consolidation, but the biggest issue working against us was the fact that TSBEPE wanted it. TSBEPE also wanted to eliminate the oral exam and change the post-doctoral requirements.

The lawsuit TPA filed against TSBEPE for allowing LPAs to practice independently without any additional or standardization of training was ongoing. After our first counsel abruptly withdrew from our case, we hired new attorneys and began receiving pessimistic input about the likelihood of a win.

We mobilized the membership for Sunset, and 2017 was the best financial year in our entire history. In 2018 (an interim year) we had significant mountains to climb in preparation for the 2019 legislative session. A Save the Profession Fund was created and we amassed more money than in the history of TPA to fight consolidation and to fund the lawsuit against TSBEPE on the LPA issue. A Past Presidents group pledged a total of $8,727.

We were fighting the consolidation of the TSBEPE with other behavioral health boards (social workers, counselors, and marriage & family therapists). We fought alone, as TSBEPE itself was advocating for the consolidation along with all the other professional groups. TPA leaders testified in front of the Sunset Commission in April.

The BoT had become dissatisfied with Mr. White's performance in the previous legislative session and hired three new lobbyists (part time). Two specialized in Sunset issues, Jerry Phillips and Kurt Meachum, and another, Kevin Stewart specialized in scope of practice issues. He handled our legislative issues outside Sunset, which were prescription privileges for specially trained psychologists, protection from civil liability for good faith violations of confidentiality (“duty” to report imminent risk), and exempting psychologists who already have expertise in treating sexual offenders from having to obtain additional training and a certificate.

The lawsuit TPA filed against TSBEPE for allowing LPAs to practice independently without any additional or standardization of training was ongoing. After our first counsel abruptly withdrew from our case, we hired new attorneys and began receiving pessimistic input about the likelihood of a win.
TPA was playing defense, reacting to developments rather than driving its agenda. Dr. Hall appointed a Strategic Planning task force chaired by Dr. Rick McGraw and Dr. Brian Stagner to survey a wide range of individuals inside and outside TPA. to develop. A strategic plan for the next 3-5 years with specific objectives and timelines was approved by the BOT at the November meeting. (A summary can be found on the TPA website under Public Communications or by searching “strategic plan”.)

Our newly developed Social Advocacy policy was published in the Texas Psychologist in 2018 and was immediately invoked. President Trump was promoting inhumane policies on immigration. We made statements to educate the public on the science regarding traumatic effects of separation of children from their parents/guardians. We asserted that we should have a practical and human immigration policy. We also made a statement about the deleterious effects of withholding medical treatment from immigrant families when there was a statement that they would not have the benefit of Medicaid.

In March of 2018, APA Council authorized the development of accreditation criteria for master's degree programs. This was not a retreat from the doctoral standard but rather a recognition that it is in APAs interest to oversee training at the master’s level, just as APA has done for years at the high school, bachelor’s, and doctoral levels. In short, they are playing catch-up.

ROLLING CRISIS

It may be ominous that, in September of 2019, CVS purchased Aetna. Meanwhile, president Alice Ann Holland, PhD, faced a crucial legislative session in which TSBEP was undergoing Sunset review for the second time, carried over as unfinished business from 2017. Unfortunately, when TPA went into the 2019 legislative session we had already lost our efforts to prevent consolidation of TSBEP into the Behavioral Health Executive Council (BHEC). We learned from our outside lobbyists that TPA had not been invited to key meetings involving the TSBEP Sunset process that had been held in 2016, the year prior to the 2017 Sunset session. During those meetings, deals had been made that essentially set BHEC in stone; we had missed our chance to have a voice in the process.

In the wake of this discovery and in the midst of the 2019 legislative session, Executive Director David White and Assistant Executive Director Sherry Reisman resigned. The BoT was suddenly navigating a monumental Sunset session while also trying to keep the TPA ship afloat and hire a new Executive Director. Lobbyist Kevin Stewart, who secured small victories for us during Sunset that had been out of reach in the 2017 session, connected us with an association management company (Evolve Advocacy) to keep things running during our Executive Director search. Mr. Stewart also assisted TPA in making long-overdue updates and revisions to the Bylaws and Policies & Procedures to accurately reflect current TPA practices.

By the end of the year, we had hired a new Executive Director, Jessica Magee, and had completed a substantial overhaul of TPA's bylaws and policies. Our all-female Executive Committee -- a first for TPA -- was a clear sign that TPA was becoming a more progressive, modern organization, and with the hiring of a new Executive Director and a much-needed, comprehensive overhaul of the Bylaws and P&P, with regard to internal operations, TPA ended the year with a very solid procedural foundation to rebuild a stronger organization.

By contrast, the financial picture was not good. Unexpected expenses from the departure of Mr. White and Ms. Reisman plus the enormous costs associated with the abortive lawsuit depleted an unacceptable amount of our reserves. To redress this, some staffing changes were made and the BoT and Finance Committee determined that it was in our best interest to sell the office building we had been purchasing. The equity from this sale restored our financial balance, but funds remained tight.

In November 2019, TPA issued our first public statement in support of gender-affirming care. It’s fair to say that Dr. Megan Mooney’s presidential year (2020) was an earthquake in a cyclone. Her first two months were spent helping Ms. Magee adjust to her new job and developing grand plans for how to increase member engagement with emphasis on inclusion. Then, Covid. When the world shut down in March, TPA pivoted to addressing member challenges with telehealth, insurance, and all the other uncertainties that we all faced professionally and personally at that time. And then, right when things seemed to be settling down, George Floyd was murdered. TPA pivoted to respond to this incident specifically but also to examine broader concerns about racism in society as well as our profession. The Racial Justice Task Force was established and convened regular meetings to consider ways to address concerns within TPA as well as in our communities. TPA’s first Diversity Statement was published on our website. We completed a member survey about experiences of racism and bias within TPA and had a number of presentations at our convention directly addressing the topic.

And don’t forget: that convention was entirely virtual! THANK YOU, Jessica and all the staff, involved!

There were other concerns lingering from 2019 into 2020. We were also watching the beginning implementation of BHEC and following political developments that would have harmful effects on our profession and those we serve. For example, proposed changes to wording for our social work colleagues could have led to discrimination against several marginalized groups of people.

In 2021, Pandemic 2.0, TPA faced big challenges but seemed more productive than the previous few years. In addition to leading TPA through the legislative session, president Fran Douglas, PhD was able to launch several new projects. The Emerging Leaders program was initiated to build the pipeline for future TPA leaders. A Student Senate was established to engage members of the student in TPA activities. The Science Committee developed renewed momentum (Hooray!!) and offered a timely CE webinar on motivational interviewing with the vaccination-hesitant.
Ms. Magee had gotten her arms around the disparate activities of the association and mastered much of the complexity of the operations. Many procedures were upgraded and updated. Our website and other public communications were modernized. It was touch and go whether we would be able to meet in person, but the convention was successfully held at the Arboretum in Austin. President Douglas’ Keynote presentations were chosen to reflect top issues circulating among TPA members. These included Martin LaRoche, Ph.D. speaking on Culturally Competent Therapy and Kevin Cokley, Ph.D. speaking on Black Lives Matter. The President’s invited a panel was comprised of faculty and students from prominent Texas programs speaking on “Texas Training Program Initiatives Combatting Racism in Psychology Training”. Tania Israel, Ph.D., in a keynote co-sponsored by convention and the TPA PAC, presented on Getting Beyond Your Bubble, How to Connect Across the Political Divide.

TPA was very active in the Texas 87th Legislative Session. We passed the liability protection bill and got a new sponsor for RxP (Rep Goodwin). Rep. Van Deaver is still on board. Rep. Rainey continued to sponsor the LSOTP bill and it got a hearing. It was opposed by psychologists on the LSOTP Board – which is problematic. As telehealth continued to prove its efficacy and to be accepted by both providers and consumers, we were successful in arguing for audio-only telehealth under Medicaid.

TPA took strong, science-based stances on several controversial policy issues. In collaboration with other groups, we spoke out to avert the transgender sports ban and the bill criminalizing gender affirming care. At TPA’s urging, Rep. Donna Howard sponsored HR 639 to honor Melba J. T. Vasquez, PhD, for her lifetime of achievement and contributions to psychology. In April of 2021, CVS rolled out a program of mental health services to be offered in its stores. Get your assessment, treatment, and pharmaceuticals in one quick stop. No indication that psychologists will be involved in this plan. .

WHAT NEXT?

Current president, Dr. Alfonso Mercado faces both new and old challenges. Ms. Magee left TPA for a position more suited to her aspirations. She is profoundly missed. The ED Search Committee and BoT recently selected Mary Beth Kiser, CAE to lead TPA.

TPA has been successful by many measures. We’ve sent two presidents to APA in the past 15 years (and perhaps Dr. Cynthia de las Fuentes will be our third!). We’ve done a lot to make the association more inclusive and more welcoming. We made some small gains in the legislature and we are much more actively engaged with TBEP/BHEC. Some of our Divisions and Committees are generating good energy (Forensic, Social Justice, Science). We need to sustain our efforts and our vigilance.

The noise of proximal events (Covid, the grandstanding cruelty of politicians, racial injustice, gun violence, etc.) distracted us from focusing on the many problems that persisted through the past 15 years. Membership numbers and membership engagement need boosting. (Less than ¼ of licensed psychologists are TPA members.) Finances remain problematic if we are to accomplish bold new things. Our grassroots organizing also requires continuous renewal as the members of the legislature turn over.

The tension between TPA-as-guild-guardian and TPA-as-town-crier remains. The need to educate the public about the fruits of our science is greater than ever. Consistent and well-grounded information are needed to counter manipulation and fear mongering. Without an educated public, the dismal and divisive meanness of public discourse will prevail, to the detriment of all. Psychologists should be leading the public.

That said, unless we achieve a solid business and regulatory footing for psychology, our association will wither. Protecting our professional (doctoral) identity is crucial. That’s legislative advocacy and it never ends. In the coming decade the business of psychology will change substantially. To thrive, TPA must adapt to a juggernaut of challenges from other guilds, from the profit-driven healthcare system, and from regulatory and legislative threats to our scope of practice. Our viability is constrained by policies made at many government and industry tables and we must fight for a voice in those decisions.

These problems are familiar but we should hope that, with new leadership and more inclusive participation, our membership will keep TPA in front of the next challenges. If you’ve read this far, you care about TPA’s future. Get involved in the association and bring three colleagues with you! YOU own TPA’s future!

1 We are grateful to all those who contributed to this article: James Bray, Ron Cohorn, Fran Douglas, Carol Grothues, Cheryl Hall, Alice Ann Holland, Marcia Laviage, Rob Mehl, Megan Mooney, Lane Ogden, Ollie Seay, Greg Simonsen, & Brian Stagner.
Depression and Substance Use in Children and Adolescents: Do Risky Behaviors Play a Role?

Summer G. Ijarah and Gabrielle Longo
University of Houston

Child and adolescent substance use is a concerning issue. It can potentially turn more problematic as these populations grow and depend more on substances such as tobacco, alcohol, and marijuana. According to the 2019 National Survey on Drug Use and Health (NSDUH), approximately 2.3 million children/adolescents between the ages of 12 and 17 used alcohol with 414,000 being diagnosed with Alcohol Use Disorder. Additionally, around 1.8 million children/adolescents between the ages of 12 and 17 used marijuana, an almost three percent increase from 2018 (NSDUH, 2019). In 2019, the Centers for Disease Control and Prevention (CDC) also reported that roughly seven of every 100 middle school students and 24 of every 100 high school students used a tobacco product.

While there are many factors that can influence children and adolescents to engage in these types of behaviors, depression and suicidality have been a primary focus in previous research (Bell et al., 2011; Conaway, Swendsen, Husky, He, & Merikangas, 2016; Hodgins et al., 2007; Luis et al., 2018). Although many of these studies have limitations regarding sample size and generalizability, the NSDUH has also explored relationships between these issues. For example, from 2015 to 2019, an increasing amount of youths surveyed had a co-occurring Substance Use Disorder (SUD) and Major Depressive Episode (MDE), with some having severe impairment from such comorbidity (see Figure 1; NSDUH, 2019). The experience of an MDE within the past year predicted a significant increase in substance use among children and adolescents compared to those who did not experience an MDE, particularly with opioids, cigarettes, alcohol, marijuana, and other illicit drugs (see Figure 2; NSDUH, 2019).

Another important factor to consider in child/adolescent substance use is non-drug-related risky behaviors. For example, in a study conducted by Mason and colleagues (2017), the risky behaviors of peers impacted the use of marijuana and tobacco use in adolescents, while scoring high in other antisocial behaviors was associated with alcohol use. Additionally, in a study conducted by Wood, Dawe, and Gullo (2013), physical risk-taking activities were a significant predictor of greater alcohol use in adolescent Australian children.

Unfortunately, research studying the role of non-drug-related risky behaviors (e.g., lack of wearing a seat belt while driving, texting and driving, physical fighting, etc.) as a moderating variable in this relationship is lacking. Therefore, the purpose of the present study is to investigate whether risky behaviors, in general, moderate the relationship between depression and child/adolescent substance use. It was hypothesized that risky behaviors would moderate the relation between depression and substance use, such that higher levels of risky behavior would strengthen the relationship between depression and substance use. Results supporting this hypothesis could encourage further research into the impact non-drug-related risky behaviors have on child/adolescent substance use and the development of interventions to potentially reduce or prevent these behaviors from influencing their substance use as adults.

METHOD

PARTICIPANTS
Data from 13,677 students from 136 high schools who completed the 2019 biennial survey conducted by the Youth Risk Behavior Surveillance System (YRBSS) were used in this study. Participants ranged from 12 to 17 years old, with the majority being 16 years old (26.67%). Most of the participants racially identified themselves as White (64.35%), followed by Black or African American (18.33%), Multiracial (6.99%), Asian (5.41%),
American Indian or Alaskan Native (3.10%), and Native Hawaiian or Other Pacific Islander (1.62%).

DESIGN

A secondary multiple regression analysis was used to investigate the interaction between non-drug-related risky behaviors and depression/suicidality on child/adolescent substance use. The data analyzed included five questions (Q25–Q29) about participants’ history of depression; seven questions (Q32, Q35, Q37–Q38, Q41–Q42, and Q47) about participants’ substance use, including alcohol, tobacco, and marijuana; and seven questions (Q8–Q11, Q13–Q14, and Q17) about participants’ non-drug-related risky behaviors.

PROCEDURE

Participants’ data from the 2019 biennial survey conducted by YRBSS was uploaded to SAS OnDemand for Academics to be cleaned and analyzed. Participants who reported being 18 years of age or older were not included in the analysis. Age and race distributions were generated from the corresponding demographic questions. Questions that asked about participants’ history of depression, substance use, and non-drug-related risky behaviors were coded into sums. Finally, multiple linear regressions were calculated to predict substance use based on depression and non-drug-related risky behaviors.

MEASURES

Data from specific questions from the 2019 biennial survey conducted by YRBSS were used in the secondary analysis. These questions are listed below.

Q1: AGE (YRBSS, 2019). To measure the age of the participants, a multiple-choice question was asked in the survey. Choices included A. 12 years old or younger, B. 13 years old, C. 14 years old, D. 15 years old, E. 16 years old, F. 17 years old, and G. 18 years old or older. Participants who chose option G were excluded from the study.

Q5: RACE (YRBSS, 2019). To measure the race of the participants, a multiple-choice question was asked in the survey. Choices included A. American Indian or Alaskan Native, B. Asian, C. Black or African American, D. Native Hawaiian or Other Pacific Islander, and E. White. Participants could choose multiple options. Participants who chose two or more options were categorized as Multiracial in the race distribution.

Q8: SEAT BELT USE (YRBSS, 2019). To measure non-drug-related risky behaviors, a multiple-choice question was asked in the survey. “How often do you wear a seat belt when riding in a car driven by someone else?” Choices included A. Never, B. Rarely, C. Sometimes, D. Most of the Time, and E. Always.

Q9: RIDING WITH A DRINKING DRIVER (YRBSS, 2019). To measure non-drug-related risky behaviors, a multiple-choice question was asked in the survey. “During the past 30 days, how many times did you ride in a car or other vehicle driven by someone who had been drinking alcohol?” Choices included A. 0 times, B. 1 time, C. 2 or 3 times, D. 4 or 5 times, and E. 6 or more times.

Q10: DRINKING AND DRIVING (YRBSS, 2019). To measure non-drug-related risky behaviors, a multiple-choice question was asked in the survey. “During the past 30 days, how many times did you drive a car or other vehicle when you had been drinking alcohol?” Choices included A. 0 times, B. 1 time, C. 2 or 3 times, D. 4 or 5 times, and E. 6 or more times.

Q11: TEXTING AND DRIVING (YRBSS, 2019). To measure non-drug-related risky behaviors, a multiple-choice question was asked in the survey. “During the past 30 days, on how many days did you text or e-mail while driving a car or other vehicle?” Choices included A. I did not drive a car or other vehicle during the past 30 days, B. 0 days, C. 1 or 2 days, D. 3 to 5 days, E. 6 to 9 days, F. 10 to 19 days, G. 20 to 29 days, and H. All 30 days.

Q13: WEAPON CARRYING AT SCHOOL (YRBSS, 2019). To measure non-drug-related risky behaviors, a multiple-choice question was asked in the survey. “During the past 30 days, on how many days did you carry a weapon such as a gun, knife, or club on school property?” Choices included A. 0 days, B. 1 day, C. 2 or 3 days, D. 4 or 5 days, and E. 6 or more days.

Q14: GUN CARRYING PAST 12 MONTHS (YRBSS, 2019). To measure non-drug-related risky behaviors, a multiple-choice question was asked in the survey. “During the past 12 months, on how many days did you carry a gun? (Do not count the days when you carried a gun only for hunting or for a sport, such as target shooting.)” Choices included A. 0 days, B. 1 day, C. 2 or 3 days, D. 4 or 5 days, and E. 6 or more days.

Q17: PHYSICAL FIGHTING (YRBSS, 2019). To measure non-drug-related risky behaviors, a multiple-choice question was asked in the survey. “During the past 12 months, how many times were you in a physical fight?” Choices included A. 0 times, B. 1 time, C. 2 or 3 times, D. 4 or 5 times, E. 6 or 7 times, F. 8 or 9 times, G. 10 or 11 times, and H. 12 or more times.

Q25: SAD OR HOPELESS (YRBSS, 2019). To measure depression, a dichotomous (yes/no) question was asked in the survey. “During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?”

Q26: CONSIDERED SUICIDE (YRBSS, 2019). To measure depression, a dichotomous (yes/no) question was asked in the survey. “During the past 12 months, did you ever seriously consider attempting suicide?”

Q27: MAKE A SUICIDE PLAN (YRBSS, 2019). To measure depression, a dichotomous (yes/no) question was asked in the survey. “During the past 12 months, did you make a plan about how you would attempt suicide?”

Q28: ATTEMPTED SUICIDE (YRBSS, 2019). To measure depression, a multiple-choice question was asked in the survey. “During the past 12 months, how many times did you actually attempt suicide?” Choices included A. 0 times, B. 1 time, C. 2 or 3 times, D. 4 or 5 times, and E. 6 or more times.

Q29: INJURIOUS SUICIDE ATTEMPT (YRBSS, 2019). To measure depression, a multiple-choice question was asked in the survey. “If you attempted suicide during the past 12 months, did any attempt result in an injury, poisoning, or overdose that had to be treated by a doctor or nurse?” Choices included A. I did not attempt suicide during the past 12 months, B. Yes, and C. No.

Q32: CURRENT CIGARETTE USE (YRBSS, 2019). To measure substance use, a multiple-choice question was asked in the survey. “During the past 30 days, on how many days did you smoke cigarettes?” Choices included A. 0 days, B. 1 or 2 days, C. 3 to 5 days, D. 6 to 9 days, E. 10 to 19 days, F. 20 to 29 days, and G. All 30 days.
Q35: CURRENT ELECTRONIC VAPOR USE (YRBSS, 2019). To measure substance use, a multiple-choice question was asked in the survey. “During the past 30 days, on how many days did you use an electronic vapor product?” Choices included A. 0 days, B. 1 or 2 days, C. 3 to 5 days, D. 6 to 9 days, E. 10 to 19 days, F. 20 to 29 days, and G. All 30 days.

Q37: CURRENT SMOKELESS TOBACCO USE (YRBSS, 2019). To measure substance use, a multiple-choice question was asked in the survey. “During the past 30 days, on how many days did you use chewing tobacco, snuff, dip, snus, or dissolvable tobacco products, such as Copenhagen, Grizzly, Skoal, or Camel Snus? (Do not count any electronic vapor products).” Choices included A. 0 days, B. 1 day, C. 2 days, D. 3 to 5 days, E. 6 to 9 days, F. 10 to 19 days, and G. All 30 days.

Q38: CURRENT CIGAR USE (YRBSS, 2019). To measure substance use, a multiple-choice question was asked in the survey. “During the past 30 days, on how many days did you smoke cigars, cigarillos, or little cigars?” Choices included A. 0 days, B. 1 or 2 days, C. 3 to 5 days, D. 6 to 9 days, E. 10 to 19 days, F. 20 to 29 days, and G. All 30 days.

Q41: CURRENT ALCOHOL USE (YRBSS, 2019). To measure substance use, a multiple-choice question was asked in the survey. “During the past 30 days, on how many days did you have at least one drink of alcohol?” Choices included A. 0 days, B. 1 day, C. 2 days, D. 3 to 5 days, E. 6 to 9 days, F. 10 to 19 days, F. 20 to 29 days, and G. All 30 days.

Q42: CURRENT BINGE DRINKING (YRBSS, 2019). To measure substance use, a multiple-choice question was asked in the survey. “During the past 30 days, on how many days did you have 4 or more drinks of alcohol in a row, that is, within a couple of hours (if you are female) or 5 or more drinks of alcohol in a row, that is, within a couple of hours (if you are male)?” Choices included A. 0 days, B. 1 day, C. 2 days, D. 3 to 5 days, E. 6 to 9 days, F. 10 to 19 days, and G. 20 or more days.

Q47: CURRENT MARIJUANA USE (YRBSS, 2019). To measure substance use, a multiple-choice question was asked in the survey. “During the past 30 days, how many times did you use marijuana?” Choices included A. 0 times, B. 1 or 2 times, C. 3 to 9 times, D. 10 to 19 times, E. 20 to 39 times, and F. 40 or more times.

RESULTS

Multiple linear regressions were calculated to predict substance use based on depression and non-drug-related risky behaviors. A significant relationship was found (F(3, 13595) = 396.13, p < .0001), with an $R^2$ of 0.080 meaning approximately eight percent of the amount of variance in child/adolescent substance use was predicted by the model. Participants’ substance use increased 0.113 units for each unit of increase of depression and 0.175 units for each unit of increase of risky behavior. Depression and risky behaviors were significant predictors of substance use at the p < .001 level ($B = .113$, SE = .032; $B = .175$, SE = .025). However, interaction between risky behavior and depression was not significant (p = .595). See Table 1 for further information.

DISCUSSION

The purpose of this study was to investigate whether non-drug-related risky behaviors strengthened associations between depression and child/adolescent substance use. While two significant main effects were found (depression and risky behaviors were independently associated with increased substance use), the analyses did not show a significant interaction between risky behaviors and depression. However, the results from this study support several interventions to reduce potential substance abuse in children/adolescents, such as more accessible clinical services, family involvement, and education about the dangers of substance use (Bell et al., 2011; Conway et al., 2016; Hodgins et al., 2007; Luis et al., 2018; Mason et al., 2017; Wood et al., 2013).

Using a secondary data analysis on previously collected data created several limitations for this study. A lot of information was unavailable to analyze, such as some of the participant variables mentioned in the suggested interventions. Future studies should collect long-term data concerning these variables to examine other factors into child and adolescent substance use and expand this field of research. Additional questions to explore in future studies could include confirming the results found in this study by determining its generalizability to other populations in other countries, examining the causes behind certain participant risk factors, analyzing the long-term behaviors of child/adolescent substance use after one or more interventions are implemented, and examining suicidality (i.e., Q25-Q29) as a specific symptom of depression as these attempts and behaviors could be seen as impulsive and have some overlap with substance use.

In short, this study attempted to determine the moderating effect non-drug-related risky behaviors had on the relationship between depression and child/adolescent substance use. The study’s hypothesis predicted that the presence of risky behaviors would strengthen this relationship, which was not supported by the data. Using a secondary data analysis on previously collected data created limitations for this study, which should be expanded on in future research with further questions.

Table 1

Results of multiple regression analyses predicting substance use based on depression and non-drug-related risky behaviors

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Estimate</th>
<th>Standard Error</th>
<th>T-Value</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercept</td>
<td>9.157</td>
<td>0.242</td>
<td>37.84</td>
<td>&lt;.001*</td>
</tr>
<tr>
<td>Depression</td>
<td>0.113</td>
<td>0.032</td>
<td>3.57</td>
<td>&lt;.001*</td>
</tr>
<tr>
<td>Risky Behaviors</td>
<td>0.175</td>
<td>0.035</td>
<td>6.88</td>
<td>&lt;.001*</td>
</tr>
<tr>
<td>Depression*Risky Behaviors</td>
<td>0.002</td>
<td>0.003</td>
<td>0.53</td>
<td>0.5953</td>
</tr>
</tbody>
</table>

Note: * = p<.05
## Substance Use among Youths Aged 12 to 17, by Past Year Major Depressive Episode (MDE) Status: 2019

<table>
<thead>
<tr>
<th>Substance</th>
<th>Had MDE</th>
<th>Did Not Have MDE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illicit Drugs, Past Year</td>
<td>31.9+</td>
<td>14.4</td>
</tr>
<tr>
<td>Marijuana, Past Year</td>
<td>24.6+</td>
<td>11.1</td>
</tr>
<tr>
<td>Opioids, Past Year</td>
<td>4.2+</td>
<td>1.8</td>
</tr>
<tr>
<td>Binge Alcohol, Past Month</td>
<td>8.9+</td>
<td>4.1</td>
</tr>
<tr>
<td>Cigarettes, Past Month</td>
<td>4.4+</td>
<td>1.8</td>
</tr>
</tbody>
</table>

+ Difference between this estimate and the estimate for youths without MDE is statistically significant at the .05 level.

Note: Youth respondents with unknown MDE data were excluded.

---

### REFERENCES


Trauma-Informed Care Training for Medical Students

Tanisha R. Clark  
(Department of Clinical Psychology, University of Texas Southwestern Medical Center)

Jill McLeigh, PhD  
(Rees-Jones Center for Foster Care Excellence, Children’s Health)

Hilda Loria, MD, MPH  
(Department of Pediatrics, University of Texas Southwestern Medical Center)

Laura Lamminen, PhD  
(Rees-Jones Center for Foster Care Excellence, Children’s Health)

INTRODUCTION

The Substance Abuse and Mental Health Administration (SAMHSA, 2014a) defines trauma as “a single event, multiple events, or a set of circumstances that is experienced by an individual as physically and emotionally harmful or threatening and that has lasting adverse effects on the individual’s physical, social, emotional, or spiritual well-being” (p. 7). Further, vicarious or secondary trauma can be experienced through exposure to another individual’s traumatic experiences rather than direct exposure to a traumatic event (SAMHSA, 2014b). Estimates suggest that about two-thirds of children experience a trauma before the age of 16, and more than 30% experience multiple traumas (Gopeland et al., 2007; McLaughlin et al., 2013). Studies have also found that about 70% of adults have experienced at least one trauma in their lifetime (Benjet et al., 2016). Vicarious trauma estimates are also high, with one study suggesting that 70% of social workers exhibited at least one symptom of secondary traumatic stress (Bride, 2007) and another suggesting that 50% of victim services workers experienced severe traumatic stress symptoms (Conrad & Kellar-Guenther, 2006).

The ramifications of trauma exposure and vicarious trauma on health across the lifespan have been well-documented. Immediate outcomes range from exhaustion, confusion, sadness, and anxiety to severe dissociation symptoms and intense intrusive recollections (SAMHSA, 2014). Responses to traumatic experiences can also include high-risk or self-injurious behaviors, disordered eating, and somatic complaints (e.g., Oral, et al., 2016; Felitti et al., 1998; Shonkoff et al., 2012). If left unaddressed, trauma can significantly increase risk for mental and substance use disorders and chronic physical diseases (e.g., Dube et al., 2003; Felitti et al., 1998; Pierce et al., 2020). Other literature suggests that symptoms may be exacerbated in providers with a history of unresolved personal trauma (Michalopoulos & Aparicio, 2012). Furthermore, Sanglang and Vang (2017) found that severe trauma experienced by one generation can lead to increased trauma responses in the subsequent generation. This adds yet another layer to an already complex cyclical phenomenon.

Due to the high prevalence of trauma and secondary trauma and the associated potential adverse health outcomes for both patients and providers, it is imperative that medical and allied professionals receive training in trauma as a constitutive element of their professional development (Cook et al., 2005). Trauma-informed care (TIC) is an approach designed to address the needs of individuals who have experienced trauma by promoting safety and empowerment and by avoiding re-traumatization (SAMHSA, 2014). TIC promotes early recognition of trauma-related symptoms for both patients and providers and has been identified as an important component in enhancing physical and mental health outcomes for patients and the workforce (e.g., National Child Traumatic Stress Network [NCTSN], 2019; Reeves, 2015). Increasing the number of professionals trained in TIC helps to ensure that individuals whose symptom presentation and treatment adherence are impacted by trauma get necessary supports to enhance outcomes. Further, practitioners
who are unaware of their client's trauma history can inadvertently cause iatrogenic harm through re-traumatization (Oral, et al., 2016).

Despite the growing recognition of the importance of TIC, Ditcher and colleagues (2018) found in a survey of 263 family medicine residency programs that only 27.0% had TIC in the curriculum. For those programs with TIC training, only 4.6% of the program directors reported the training met patient needs “a great deal,” and only 48.5% reported the TIC training “somewhat” met patient needs. This is of concern as medical and allied health service professionals are more likely to have initial contact with individuals who have experienced trauma. Additionally, studies have shown that providers training TIC have more patient centered interactions and increased patient satisfaction (Green et. al., 2015 via Oral et. al., 2016). Such research suggests a need to explore routes for delivering efficacious TIC training to healthcare trainees.

A review of the literature identified seven studies that evaluated TIC trainings for students in medicine and allied health fields. The results are compiled in Table 1. Each study had limitations that need to be addressed in future research. Specifically, training length and format were found to be barriers to participation for graduate students in select studies. Additionally, most trainings were specific to medical students, which excludes allied health trainees engaged in significant contact with patients in healthcare settings. Lastly, there is a need for collection of more data to determine if and how students are impacted by TIC training and which students are more likely to be impacted by TIC training.

### Table 1

<table>
<thead>
<tr>
<th>Authors</th>
<th>Article</th>
<th>Year</th>
<th>N</th>
<th>Population</th>
<th>Summary</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chokshi, B., Chen, K.-L. D., &amp; Beers, L.</td>
<td>Interactive Case-Based Childhood Adversity and Trauma-Informed Care Electronic Modules for Pediatric Primary Care</td>
<td>2020</td>
<td>35</td>
<td>Pediatric residents, attending physicians, medical students, and a fellow</td>
<td>Four self-paced e-modules were used to provide training on childhood adversity and trauma-informed care. Pre- and post-surveys indicated increased participant knowledge, attitudes, practice, and confidence</td>
<td>Delivered later in trainee development, lacked a follow-up survey.</td>
</tr>
<tr>
<td>Dueweke, A. R., Hanson, R. F., Wallis, E., Fanguy, E., &amp; Newman, C.</td>
<td>Training Pediatric Primary Care Residents in Trauma-Informed Care: A Feasibility Trial</td>
<td>2020</td>
<td>33</td>
<td>Pediatric primary care residents</td>
<td>An in-person training included information about trauma, introduction of a screening tool for trauma. Pre- and post-surveys indicated increased favorable attitude and perceived competence. Pre-and post-chart reviews indicated a significant increase in trauma screening.</td>
<td>Training was delivered in-person which increases barriers. Survey was delivered at two time points, 4 months apart.</td>
</tr>
<tr>
<td>Elisseou, S., Puranam, S., &amp; Nandi, M.</td>
<td>A Novel, Trauma-Informed Physical Examination Curriculum for First-Year Medical Students</td>
<td>2019</td>
<td>188</td>
<td>First-year medical students &amp; faculty</td>
<td>Training was delivered in a lecture format, and researchers used a 5-point Likert scales to measure increases in participant knowledge and satisfaction.</td>
<td>In-person format, efficacy not measured, limited to medical students</td>
</tr>
<tr>
<td>Goldstein, E. et al.</td>
<td>Medical Students' Perspectives on Trauma-Informed Care Training</td>
<td>2018</td>
<td>20</td>
<td>Medical students</td>
<td>6-hour, in-person training was delivered over the course of 3 days via lecture, discussion, and practice to students at the University of California Davis medical students attending a summer institute. Qualitative data collected post-training revealed that students increased their ability to recognize signs and symptoms of ACEs and to respond to patient disclosure of ACEs.</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>Pletcher, B., O'Connor, M., Swift-Taylor, M., &amp; Dallapiazza, M.</td>
<td>Adverse Childhood Experiences: A Case-Based Workshop Introducing Medical Students to Trauma-Informed Care</td>
<td>2019</td>
<td>535</td>
<td>Medical students</td>
<td>Small group lectures on addressing ACEs through TIC along with case study discussions were delivered over the course of 3 academic years. Students completed a quiz testing knowledge post training and grades were applied to courses. Post-training quiz scores indicated that student proficiency in TIC knowledge increased.</td>
<td></td>
</tr>
<tr>
<td>Schmitz, A., Barry, C., &amp; Hodges, K.</td>
<td>Adverse Childhood Experiences and Trauma-Informed Care: An Online Module for Pediatricians</td>
<td>2019</td>
<td>91</td>
<td>2nd year pediatric residents</td>
<td>A 25-minute online training module specific to pediatricians was presented as an optional training. Data from this module suggested participant knowledge and efficacy increased following completion of the training.</td>
<td></td>
</tr>
<tr>
<td>Siegel, M., Gonzalez, E. C., Wijesekera, O., Finkelstein, K., Petricone, R., Glass, L., Lewis-O'Connor, A., Duffy, C., Quijije, N., March, G., &amp; Bell, S.</td>
<td>On-the-Go Training: Downloadable Modules to Train Medical Students to Care for Adult Female Sexual Assault Providers</td>
<td>2017</td>
<td>32</td>
<td>Medical student volunteers</td>
<td>Students opted-in to complete three online modules addressing medical management of sexual assault (SA), simulated patient interview, and suggestions for practice. Students completed pre- and post-training knowledge assessment. Scores improved 20%.</td>
<td></td>
</tr>
</tbody>
</table>
STUDY PURPOSE
Following a review of the literature and discussions with healthcare providers offering TIC in an integrated pediatric primary care setting, a brief, 45-minute online TIC training adapted for medical and allied healthcare students was developed. The current study tested the effectiveness of this training, which sought to expose students and trainees in healthcare fields to the concept of trauma and its effects on patients and providers. The training was also designed to offer practical guidance on providing TIC. Researchers hypothesized that study participants would experience gains in knowledge and perceived efficacy, as evidenced by pre- and post-training survey responses. Additionally, researchers posited that gains would be maintained over time, as demonstrated by scores on a 3-month follow-up survey.

METHODS
PARTICIPANTS AND PROCEDURES
Fifty-six medical and allied health students and trainees participated in this pilot study. Fifteen participants only completed the pre-training survey and so were excluded from pre- and post-training survey comparisons. Of the remaining 41 participants, 25 completed the 3-month follow-up survey and so were included in analysis of the pre-, post-, and 3-month follow-up surveys.

All study procedures were approved by the Institutional Review Board. Academic deans submitted letters of approval for the recruitment of student participants. Medical and allied health students were recruited through an integrated pediatric primary care clinic and affiliated medical and allied health training institutions. Researchers collaborated with professors and clinical supervisors from affiliated universities and hospitals. To meet inclusion criteria for the study, participants had to be currently enrolled in an accredited program as a medical or allied health graduate student or trainee. Potential participants received an email from professors and clinical supervisors with an invitation to participate in the study. The email provided details regarding the study, including IRB contact information and a clause regarding voluntary participation. Participants consented to the study by clicking on a secure link to complete the pre-training survey in a web-based, HIPAA-compliant software platform designed to support data capture for research studies called Research Electronic Data Capture (REDCap; Harris et al., 2009). Participants were then given access to the training, and a unique personalized link to their post-training survey was sent via email within 48 hours of completing the initial survey. An automated email containing a link to the 3-month, follow-up survey was sent via REDCap to each participant three months after their completion of the post-training survey. Participation was optional, and no incentives were provided.

TRAINING DEVELOPMENT
Development of the training involved reviewing existing studies and assessing available TIC trainings, such as those used by the Texas Department of Family and Protective Services (TDFPS; 2019) and NCTSN (2019). The training also underwent a rigorous, tiered review process involving medical and behavioral health providers in a trauma-informed, integrated pediatric primary care clinic. Multiple iterations of the training were piloted with social work and medical students completing training at partner institutions.

The specific objectives of the training were for students to be able to differentiate among trauma, toxic stress, and ACEs; understand how trauma impacts the brain, child development, and health outcomes; discuss practical strategies for applying trauma-informed knowledge and care; and understand the importance of advocating for trauma-sensitive practices in medicine and behavioral health.

Training learning objectives include: 1). Differentiating among trauma, toxic stress, and ACEs; 2). Understanding how trauma impacts the brain, child development, and health outcomes; 3). Discussing practical strategies for applying trauma-informed knowledge and care; and 4). Understanding the importance of advocating for trauma-sensitive practices in medicine and behavioral health. The final training was divided into four sections: A). Essential Knowledge: Statistics on trauma and adverse childhood experiences (ACEs), SAMHSA’s TIC principles, and multidisciplinary (e.g., neuroscience, medical, and behavioral health) knowledge on the impact of trauma; B). Clinical Skills: Pediatric case study is used to demonstrate practical skills; C). Trauma and the Provider: Information on the prevention and intervention for vicarious traumatization and potential steps for trainees with a personal history of trauma; and D). Practice: A vignette of an adult patient presenting for a medical visit with potential symptoms of trauma exposure and ungraded multiple-choice questions regarding the vignette. Allows participants to self-assess their knowledge. The final video was intentionally kept at 45 minutes to address concerns raised in the literature about length of time posing a barrier to participation for medical and allied health students.

MEASURES
A survey was developed to measure participant knowledge and perceived efficacy regarding TIC. Surveys from previous TIC training were reviewed for strengths and limitations. Specifically, surveys from the TDFPS TIC training (2019) for child welfare professionals and a study conducted by Elisseou, Paraman, and Nandi (2019) were used to inform the format, content, and length of the surveys. Survey questions relevant to the target participant population were created and reviewed by licensed medical and behavioral health professionals with knowledge of TIC. Initial survey items collected demographic data including participants’ graduate programs, current years in the programs, previous hours of TIC training, and previous service in a trauma-informed organization. Next, five survey questions measured participants’ perceived confidence in delivering TIC with a 4-point Likert scale ranging from 1 = Not Confident to 4 = Extremely Confident, and one question measured participants’ perceived importance of providing TIC with a 4-point Likert scale ranging from 1 = Not at All Important to 4 = Extremely Important.

PARTICIPANTS’ knowledge was measured using six multiple choice questions (e.g., Which strategies below are examples of trauma-informed care [select all that apply]?). The survey was administered at three time points: pre-training, immediately post-training, and 3-months following the training. Training feedback questions were also incorporated into the post- and 3-month follow-up surveys but were not calculated as a part of the survey scores. The surveys were designed to take about 10 minutes to complete.

DATA ANALYSIS
All data were analyzed in SPSS (IBM Corp., 2017). A paired samples t-test was conducted on participant survey scores from T1 and T2. A one-way repeated measures ANOVA was then conducted on participant scores from T1, T2, and T3. To determine if the training differentially impacted knowledge and perceived efficacy, two additional one-way repeated measures ANOVAs were conducted. Due to repeated statistical tests on the same date, a corrected p-value of .01 was used to decrease the possibility of a type 1 error.

RESULTS
As shown in Table 2, a significant number of participants reported studying in physician's
### Table 2

**Participant Data**

<table>
<thead>
<tr>
<th></th>
<th>Pre-/Post- (T1, T2) Sample</th>
<th>3-Month Sample (T1, T2, &amp; T3)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td><strong>Program</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counseling</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>Medical</td>
<td>14</td>
<td>34.1</td>
</tr>
<tr>
<td>Public Health</td>
<td>2</td>
<td>4.9</td>
</tr>
<tr>
<td>Physician Assistant</td>
<td>21</td>
<td>51.2</td>
</tr>
<tr>
<td>Social Work</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>Psychology</td>
<td>2</td>
<td>4.9</td>
</tr>
<tr>
<td><strong>Years in Program</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>8</td>
<td>19.5</td>
</tr>
<tr>
<td>2</td>
<td>14</td>
<td>34.1</td>
</tr>
<tr>
<td>3</td>
<td>17</td>
<td>41.5</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td><strong>Hours of Previous TIC Training</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-2 hours</td>
<td>10</td>
<td>24.4</td>
</tr>
<tr>
<td>3-5 hours</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>6-8 hours</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>None</td>
<td>29</td>
<td>70.7</td>
</tr>
<tr>
<td><strong>Previous TIC work or volunteer experience</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>5</td>
<td>12.2</td>
</tr>
<tr>
<td>No</td>
<td>20</td>
<td>48.8</td>
</tr>
<tr>
<td>Unsure</td>
<td>16</td>
<td>39.0</td>
</tr>
<tr>
<td><strong>Pre-Training level of TIC Confidence</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extremely Confident</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Very Confident</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Somewhat Confident</td>
<td>8</td>
<td>19.5</td>
</tr>
<tr>
<td>Not Confident</td>
<td>33</td>
<td>80.5</td>
</tr>
</tbody>
</table>

*One participant did not report years in program*
assistant 51.2% (n = 21) or medical programs 34.1% (n = 12). Most trainees 80.5% (n = 33), reported a lack of confidence in delivering TIC prior to the training and a large majority 70.7% (n = 29) had no prior TIC training. Furthermore, 87.8% of trainees (n = 36) reported either no previous TIC work or volunteer experience or being uncertain about whether they had worked or volunteered in an organization that delivered TIC.

A paired-samples t-test was conducted to determine whether there was a statistically significant mean difference between the pre-training and post-training total scores. Participants (n=41) scored higher on the post-training survey (M = 10.46, SD = 2.11) than on the pre-training survey (M = 7.12, SD = 1.27). The increase of 3.34 was statistically significant, 95% CI [2.61, 4.07], t (40) = 9.22, p < .001, d = 1.44.

A one-way repeated measures ANOVA was conducted to determine if there were significant differences among participant (n= 25) scores for the pre-training, post-training, and 3-month follow-up surveys. There were no significant outliers, and the data was normally distributed, according to box plots and the Shapiro Wilkes Test (p > .05). The assumptions of sphericity were not violated according to Mauchly’s Test of Sphericity X² (2) = 1.18, p = .555. The test scores did elicit significant main effect differences, F (2, 48) = 35.14, p < .001, partial h² = .59 with the following pre-training scores (M = 7.12, SD = 1.09), post training scores (M = 10.48, SD = 2.02), and 3-month follow-up scores (M= 8.40, SD= 1.56) (See Figure 1). Post hoc analysis with a Sadik adjustment revealed statistically significant differences across all three surveys.

Two additional one-way repeated measures ANOVAs were also conducted to determine if there were significant differences among perceived efficacy and knowledge scores from pre-training, post-training, and 3-month follow-up survey scores. There was a significant main effect difference in perceived efficacy scores F (2, 42) = 41.44, p < .001. There was also a significant main effect difference in knowledge F (2, 48) = 15.93, p < .001.

Participants completing all three surveys provided feedback on training quality and content. Of the 25 participants, 92.0% (n=23) reported they would recommend the training to others, 84.0% (n= 21) found the training engaging, and 76.0% (n= 19) stated the training increased their comfort with delivering TIC to patients. Additionally, 52.0% (n= 13) of trainees noted discussing TIC with colleagues following the training. However, only 8.0% (n = 2) sought additional TIC training. When asked how the training could be improved, 40.0% (n=10) suggested increased engagement, 8.0% (n=2) recommended enhanced content, and 40.0% (n=10) reported that no changes were needed.

DISCUSSION

This study sought to test the effectiveness of a brief, online 45-minute TIC training. A paired sample t-test demonstrated a mean increase of 3.34 points for 41 trainees in pre- to post- surveys. Findings are similar to previous studies shown in Table 1 (Chokshi, Chen, & Beers, 2020; Dueweke et. al. 2020; Elisseou, Puranam, & Nandi, 2019; Goldstein, et. al. 2018; Pletcher et. al., 2019; Schmitz, Barry, & Hodges, 2019; Siegel et. al., 2017). Additionally, scores from pre-, post-, and 3-month follow-up surveys suggest that the training resulted in increased TIC knowledge and perceived efficacy among medical and allied health trainees. Previous studies have included pre- and post-training surveys, but only one study followed up with trainees over an extended period. Dueweke et. al. (2020) increased the period between pre- and post-survey, allowing four months between administrations. Despite the length of time, gains were still evident. However, there is no way to know if knowledge loss occurred over time due to the absence of an additional survey administered immediately post-training. Of note, researchers in the study provided participants with an index card containing a mnemonic device to help with recall of training material. It is likely that this allowed participants to retain information and demonstrate gains four months post-training. This information, along with the present set of findings, highlights the importance of continued education in TIC throughout trainees’ professional advancement. Furthermore, frequency tables demonstrated that trainees with lower baseline TIC confidence and knowledge were more likely to respond at three-month follow-up. This may indicate that trainees who require more support could benefit from ongoing engagement.

Of note is the finding that 3-month follow-up survey scores were significantly higher than the pre-training scores and lower than post-training scores. This could be potentially explained by learning loss, given competing professional demands and milestones that trainees must simultaneously achieve while improving direct patient care. The finding that only 8.0% (n=2) of participants sought out additional trauma-informed care training three months following the initial training but over half, 52.0% (n=13) discussed trauma-informed care with their colleagues, due to the training, indicates an ongoing interest in TIC. Also relevant to this point is that 100% of participants reported increased confidence in delivering TIC three months following the training, and nine of the 12 participants who answered a question about whether they had advocated for TIC since completing the training responded in the affirmative. These results imply that TIC may be a gap in existing training structures. Brief, easily accessible, online content may be a viable pathway to fill this gap.

LIMITATIONS

This study is not without limitations. First, the small convenience sample from one geographic location limits generalizability. Future studies should aim to duplicate findings with a larger sample. One possible explanation for the relatively small sample size may have to do with the fact that no incentives were offered for participating. The initial e-mail containing consent information and the link to the pre-training survey was sent to over 100 medical and allied health students, and 56 individuals responded to the pre-training survey, 41 of them participated in the post-training survey, and 25 completed the 3-month follow-up survey. Competing tasks may have limited the number of students who were able to participate. Future studies should consider offering incentives to students to encourage their participation, particularly for longer-term follow-up.

Additionally, not all relevant fields of study were represented in our sample. A brief, online TIC training with other clinical students in allied health programs may yield increased data for comparison of results.
CONCLUSION

Despite these limitations, this study can be seen as a first step toward integration of a brief, online TIC training in the early phases of trainee development. The prevalence of potential patient and provider trauma creates a clear impetus for the continuation of this crucial work. Early receipt of this training would also inculcate trainees to operate from a lens of trauma-sensitive practice in any setting in which they embark. Within non-healthcare settings, these tools are valuable in understanding staff and client populations.

Ethical codes across disciplines advocate for an increasing focus on multiculturalism and intersectionality. TIC highlights the pluralistic experiences within our society and demands empathic providers and leaders to serve our communities. Although the generalities of results warrants further study, current data and literature indicate trauma is a pervasive phenomenon, and this study has shown the potential for efficacious and cost-effective methods to take early action to ensure that trainees are prepared to meet this demand.

The findings also highlight the need for ongoing education and training to ensure retention of key concepts and practices and comfort among providers in implementing TIC.

REFERENCES


The Moderating Role of Anti-Black Racial Identity and Coping on the Association between Perceived Racism and Health Behaviors

Jasmine Phillips, M.A., Shayon Tayebi, B.S, Craig Henderson, PhD, Courtney Banks, PhD
Sam Houston State University

Research shows that Black Americans are more likely than any other racial/ethnic group to experience racism (Anderson & Stevenson, 2019; Odafe et al., 2017). Black Americans who experience racism are more likely to have more chronic symptoms of depression, anxiety, and substance use (Britt- Spells et al., 2018; Gibbons et al., 2004; Hill & Hoggard, 2018; McNeil et al., 2014; Pieterse et al., 2012; Sosoo et al., 2019) as well as hypertension, cardiovascular disease, and early mortality rates (Bell et al., 2019; Cruz & Palmer, 2015; Drolet & Lucas, 2020; Lucas et al., 2016; Volpe et al., 2019). Although research has documented the relationship between mental and physical health outcomes of racism, limited research has examined the relationship of perceived racism and eating pathology. Increasing attention to this relationship is important, as Black Americans have the highest rate of obesity and are more likely to engage in poor eating patterns when stressed (Talleyrand et al., 2017). Research has shown that perceived racism was positively associated with loss of control eating and poor diet. Studies have indicated that binge eating when experiencing racism can serve as a means of alleviating stress, regaining control, and an alternative to coping (Salami et al., 2019). Thus, coping responses are important to consider when investigating eating patterns, as the presence of active and effective coping may mitigate the risk of eating pathology.

The way in which individuals perceive and respond to stress can vary, particularly in heterogeneous racial/ethnic groups. Using the Lazarus model of stress, the appraisal and coping styles used by an individual impacts psychological and physical health outcomes. Research depicts a positive relationship between ineffective coping styles and poor health outcomes (Mwendwa et al., 2011). Thus, individuals who appraise a situation as stressful but possess adequate coping strategies may experience decreased stress over time, compared to an individual without effective coping strategies who experiences the same stressors (Greer, 2021). In the Black community, there is mixed results based on the use of active coping and health outcomes (Clark & Adams, 2004; Jones et al., 2020; Lewis-Coles & Constantine, 2006; Volpe et al., 2021). Research indicates Black culture-specific coping, involving social support, spirituality, religion, and community has been shown to buffer against the deleterious effects of racism (Greer, 2021; Jones et al., 2020). More research is needed to understand the role that identifying with a particular group could influence these individual differences.

Racial identity is described as the way an individual conceptualizes their self-concept and place meaning on themselves based on the endorsement of group membership (Forsythe & Carter, 2012; Lee & Ahn, 2013). Often, William Cross’ Nigrescence model (1971, 1991) is cited as a way to conceptualize racial identity for Black Americans. In this model Black identity is then divided into four stages: Pre-Encounter, Encounter, Immersion-Emersion, and Internalization (Cross, 1971, 1991, 1994; Vandiver et al., 2001). For the purposes of this paper, the Pre-Encounter (Anti-Black) and Immersion-Emersion (Pro-Black) stages are of interest. The Pre-Encounter identities represent rebuking qualities that are considered Black (e.g., Assimilation, Miseducation, Self-hate; Vandiver et al., 2001, 2002). The Immersion-Emersion stage is where an individual applies all aspects of their life to their sense of group membership (e.g., Anti-White or Intense Black Involvement). Research indicates that stronger racial identity can buffer against the deleterious effects of perceived racism due to its association with greater psychological well-being (Forsythe & Carter, 2012; Hughes et al., 2015; Lee & Ahn, 2013; Thomas et al., 2010). However, few studies have examined the role that racial identity can play in the development of physical health outcomes (Capodilupo & Kim, 2013; Flowers et al., 2012; Shuttleworth & Zotter, 2011).

The purpose of the current study was to examine the association between perceived racism and eating pathology, and the moderating effect of coping style and racial identity on this association.

The purpose of the current study was to examine the association between perceived racism and eating pathology, and the moderating effect of coping style and racial identity on this association. We hypothesized that individuals who experience more perceived racism will have more eating pathology. Next, we hypothesized that individuals who engage in active coping strategies and endorse a “Pro-Black” identity
will have less eating pathology; while individuals who endorsed "Anti-Black" identities would have more eating pathology.

**METHODS**

**Participants**
Participants included 399 Black college students, ranging in age between 18-49 years (M = 20.50, SD = 3.93). Most participants were female (75.6%), 23.6% male, 32.2% first-generation college students, 97.2% single, and 1.8% married.

**Procedure**
Participants were recruited from three universities in Texas. Participants completed a demographics questionnaire and self-report measures of racism, coping, racial identity, and eating pathology.

**Measures**

Perceived Racism Scale. The Perceived Racism Scale (PRS; McNeilly et al., 1996) is a 51-item scale used to assess an individual's perception of racism. The items were split into three separate sections. Section I asked participants to rate how often they experience instances of racism at the job, in an academic setting, in public, in the past year, and in their lifetime. Items were rated on a 6-point Likert scale, ranging from 0 (never) to 5 (several times a day). Section II items asked participants how they feel about racism (e.g., "powerless") using a 5-point Likert scale, ranging from 1 (not at all) to 5 (extremely). Lastly, Section III asked participants to indicate coping with racism (e.g., "speaking up").

Brief COPE. The Coping Orientation to Problems Experienced Inventory scale (Brief-COPE; Carver, 1997) is a 28-item scale that gives participants statements on ways to cope with stress (e.g., "I've been trying to come up with a strategy about what to do") and asks them how often they have been doing these actions. Each statement was then rated on a 4-point Likert scale, ranging from 1 (I haven’t been doing this at all) to 4 (I’ve been doing this a lot).

Cross Racial Identity Scale. The Cross Racial Identity Scale (CRIS; Cross & Vandiver, 2001) is a 40-item scale that gives participants statements evaluating racial identity. These 40 items are split into 6 subscales, including Assimilation (e.g., "I am not so much a member of a racial group, as I am an American."). Miseducation (e.g., "Blacks place more emphasis on having a good time than on hard work"). Self-Hatred (e.g., "I sometimes struggle with negative feelings about being Black."). Anti-White (e.g., "White people should be destroyed"). Afrocentricity (e.g., "I respect the ideas that other Black people hold, but I believe that the best way to solve our problems is to think Afrocentrically."). and Multiculturalist Inclusive (e.g., "As a multiculturalist, I am connected to many groups..."). Each statement was rated on a 7-point Likert scale ranging from 1 (strongly disagree) to 7 (strongly agree).

Three Factor Eating Questionnaire. The Three Factor Eating Questionnaire (TFEQ-R18; Karlsson et al., 2000) is an 18-item scale that assesses eating patterns based on three factors: cognitive restraint, uncontrolled eating, and emotional eating. The first 17 items (e.g., "I am always hungry enough to eat at any time.") were rated on a 4-point Likert scale. For item 18, participants were asked to rate themselves on an 8-point Likert scale ranging from 1 (no restraint in eating e.g., eating whatever you want, whenever you want it) to 8 (total restraint e.g., constantly limiting food intake and never "giving in").

**RESULTS**
Study hypotheses were examined using multiple regression, specifically testing the impact of interaction effects between racism, coping, and ethnic identity. We used the PROCESS macro (Hayes, 2022) with its focus on statistical moderation—another conceptualization of interaction effects—to test these interactions. We used procedures outlined by Aiken and West (1999) to create the interactions. Specifically, we first centered the three variables and created the interaction terms by multiplying the centered variables. All interaction effects with p < .10 were probed to examine simple effects. Results of the interaction effects indicated that a three-way interaction between the experience of academic racism, miseducation, and distraction coping approached statistical significance, b = -.07, (SE = .04), t = -1.91, p = .058. Simple effects revealed that for participants who reported high levels of miseducation and high levels of distraction along with experiencing higher levels of academic racism also reported less uncontrolled eating, b = -.35, (SE = .11), t = -3.35, p = .001. Conversely, those with low levels of miseducation and low levels of distraction but also experiencing more academic racism reported more uncontrolled eating patterns.

![Figure 1. Three-way interaction depicting relations between academic racism and uncontrolled eating as a function of miseducation.](image-url)
eating, $b = .17, (SE = .08), t = 2.18, p = .031$. These relationships are displayed in Figure 1. There were no statistically significant relationships for other levels of these variables nor were any statistically significant relationships observed for other racial identities, coping styles, or other types of racism.

**DISCUSSION**

The current study is one of the first within the literature to examine how coping strategies moderate the relationship between racial identity and uncontrolled eating among Black participants who also report experiencing racism. Results indicated that when Black undergraduate students have negative views about being Black and engage in coping strategies to distract, they are less likely to present uncontrolled eating behaviors. Conversely, when Black undergraduate students have positive racial identity and do not endorse adoption of distraction coping strategies, they are more likely to engage in uncontrolled eating behaviors.

Previous research has indicated that positive racial identity is a predictor of adaptive outcomes in Black young adults such as academic achievement, psychological adjustment, and a lower risk for alcoholism (see Livingston et al., 2020). Conversely, the results of this study present that the adoption of a positive racial identity begins a trajectory towards maladaptive behavior and an Anti-Black attitude is a protective factor against adverse eating behaviors when experiencing racism. However, important considerations emerge from the results that should not go unnoticed - regard and salience of racial identity. In their Multidimensional Model of Racial Identity (MMRI), Sellers et al. (1998) suggests that the level of internalization and impact of racial identity is derived from perceptions of public and private regard, salience, centrality, and ideology of being Black. Since adoption of negative Black stereotypes is considered a pre-encounter stage (Cross et al., 2001), it is possible that the participants in this study that adopted miseducated Anti-Black messages have not internalized being Black as positive, important, and central to their lives. Thus, experiences of racism may not be a stressor that one needs to attend to (distraction coping), weakening the likelihood of engaging in uncontrolled eating. On the contrary, Black students that endorse a positive racial identity may perceive being Black as important personally and publicly in their lives and experiences of racism only exacerbate stress. To this end, results from the current study suggest that Black identity development and coping strategies are components to be emphasized when developing interventions for psychological distress particularly among Black individuals.

These results reinforce the value of culturally responsive practices in applied settings. Specifically, psychologists can facilitate positive outcomes and well-being of clients through explicit application of coping strategies and drawing upon client's adaptive socialization messages as sources of grounding, support, and cultural assets.

**REFERENCES**


The primary election took place recently, and despite some last-minute efforts to shake things up, most of the votes went about as expected. There were a few runoffs, but there were not too many surprises there, either. On the statewide ticket, Governor Greg Abbott beat the field with 66% of the vote, securing the Republican nomination. He will face Beto O’Rourke in the general election. Attorney General Ken Paxton received the most votes in the Attorney General race, and then defeated George P. Bush in the runoff.

In the district races, the most important outcome was in House District 91, where incumbent Stephanie Klick faced off against multiple challengers. Klick is the current Chair of the House Public Health Committee, so many in the healthcare world have been monitoring the race closely. She ended up with 49% of the vote, just shy of what she needed to avoid a runoff. She ultimately defeated runner up David Lowe in the runoff in late May.

Physician Suleman Lalani finished first in the Democratic primary for House District 76, but he had to face social worker Vanesia Johnson in the runoff for the Democratic-leaning district. Lelani ultimately won. In House District 23, freestanding ER physician Abel Longoria failed to make a runoff for the open seat.

In addition to the primaries, TPA has been closely monitoring interim charges. Interim charges are instructions from the leadership of each legislative chamber to each legislative committee on items that should be studied or discussed before the start of the session. Interim charges have been released for the Senate and the House, and they contained numerous references to mental health. There is a charge on the overall delivery system, student mental health, veteran mental health, and mental health services in jail facilities. TPA will be engaging in those discussions as needed.

Last but certainly not least, the Speaker of the House established a new House committee, the Select Committee on Healthcare Reform. This is a strong indication that there will be long discussions about the healthcare system and likely a significant number of bills proposed to address perceived issues. The committee is charged with looking at market competition, access to care, and affordability of care, among other things. Both the House and Senate also created committees in response to the tragedy in Uvalde, both of which focus at least partially on access to mental health care. TPA of course will be monitoring these committees as well.

While there will certainly be some new faces and new issues to tackle, this upcoming session is shaping up to be a return to normalcy after COVID and the winter storm complicated last session, although there will likely be a renewed focus on mental health services and school safety. We will be sure to keep you updated as interim discussions progress and the general election results.
Professional Liability Insurance
Peace of Mind Protection for Your Career

We’ve got you covered
Trust Sponsored Professional Liability Insurance* for psychologists is spot on — with essential coverages that protect you whenever and wherever you provide psychology services, plus a host of features you may not find in other malpractice policies.

We focus on Psychologists
At The Trust, you’re not just another insurance policy among so many professional classes. Our malpractice coverage and supporting programs are designed by psychologists and insurance experts to focus on the profession of psychology — especially as it explores and adapts to new and dynamic service delivery models.

Complete Career Financial Protection
- Telehealth Professional Services - included at no additional charge
- Risk Management Consultations - free, unlimited and confidential
- Affordable Coverage Options - choice of claims-made or occurrence
- Multiple Premium Discounts - some of which can be combined
- Free ERP or ‘Tail’ - unrestricted, upon retirement, death or disability
- Prior Acts Included - when switching from a claims-made policy
- Free CE & Discounts - on a variety of live and on-demand courses
- Free TrustPARMA Membership - the new home for practice

The only insurance provider that’s truly for psychologists, by psychologists!

* Insurance provided by ACE American Insurance Company, Philadelphia, PA and its U.S.-based Chubb underwriting company affiliates. Program administered by Trust Risk Management Services, Inc. The product information above is a summary only. The insurance policy actually issued contains the terms and conditions of the contract. All products may not be available in all states. Chubb is the marketing name used to refer to subsidiaries of Chubb Limited providing insurance and related services. For a list of these subsidiaries, please visit new.chubb.com. Chubb Limited, the parent company of Chubb, is listed on the New York Stock Exchange (NYSE: CB) and is a component of the S&P 500 Index.