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A NOTE FROM THE PRESIDENT
FRAN DOUGLAS, PSYD
Austin, Texas
TPA President 2021

TPA’S EMERGING LEADERS PROGRAM
If you are in a leadership position, you have probably been told how important it is to think about a succession plan. It is very much like the advice you may receive as a parent or property owner to have a will. During my year as TPA President I have given a lot of thought to what the future holds for TPA. I believe that TPAs future depends on continued strong membership and leaders willing to take on the challenges of our rapidly changing state and nation. So, what exactly is TPA’s succession plan? How does TPA keep new leaders in the pipeline? What preparations are being made to ensure the success of our organization in the future?

Drawing from my own experience prior to moving into TPA leadership, I assumed that becoming a TPA leader depended on “who you know”. But, since starting my time on the Board of Trustees, I have learned that TPA leadership is also “who shows up”, though “who you know” is also very important.

Sunset is what made me “show up” and TPAs membership peaked during those years as psychologists fought for their independent board. Members reaching out to other psychologists helped to increase the numbers who showed up.

But TPA can’t depend on Legislative catastrophes like Sunset to galvanize members into association activities and leadership. In that respect, the “who shows up” strategy has some serious flaws. And the “who you know” strategy is not going to cut it either. TPA, much like the rest of the profession of Psychology, is striving for inclusion and diversity among membership and leadership. This undertaking is vital if we are to remain relevant as the profession evolves and if we are serious about engaging new and younger members. TPA needs to be harnessing the collective energies of our members’ love for psychology to keep the association strong and moving into the future. We need to eliminate any institutional structures and “habits” that limit diversity among TPA leadership.

As I leave my presidential year, I am happy to announce that TPA will be initiating its first Emerging Leaders Program in 2022. I consider this initiative to be a fitting conclusion of my presidential year’s theme of advocacy and engagement. It is my attempt to implement a succession plan for TPA. My hope is that the program will serve to promote inclusion in TPA leadership by de-mystifying TPA and making it easier for anyone who wishes to engage in leadership to have the necessary tools to do so. The Emerging Leaders Program will focus on building the diversity of leadership within TPA. We will strive to include TPA members for the leadership program with a focus on diversity in geographic location, gender, area of expertise, and career status. We will be mindful of the importance of including emerging leaders drawn from groups historically marginalized due to race, ethnicity, sexual orientation, or disability status.

Any psychologist, at any stage of their career, is welcome to participate in this combination of didactic and experiential leadership training. While we don’t have the exact schedule firmed up yet, we will be providing both recorded training sessions and virtual meetings with TPA board and committee leaders to give basic information about how TPA works. We will also provide mentors to those in the program to work on an initiative of their choosing within one of the TPA programs, task forces, or committees. Ideally, we will give participants the nuts and bolts of the association along with an opportunity to create something that is meaningful to each participant as well as to the association.

The call of applicants to the Emerging Leaders Program will go out soon and will close at the end of January 2022. We will begin rolling out the didactic training modules in February. Below is the didactic program topic areas.

Program Schedule
1. TPA Governance, Structure, and Staff
   a. Meet the Executive Committee
2. Ethics in Leadership
3. Leadership Basics and Style
4. Advocacy, Politics, and Grassroots
   a. Meet the Federal Advocacy Coordinator (FAC) and APA Council Rep
5. Diversity, Equity, and Inclusion in Leadership
6. Association Sustainability: Financial and Cultural Considerations

As participants learn more about how TPA works, they will be assigned a mentor from the committee, division, or task force of their choosing. Participants will develop a project within the area they have chosen with the input of their mentor. They can go to work on that project any time between February and June. The program will strive to be as flexible as possible with participants’ needs in mind.

I will continue to chair this project as Past President during 2022. Please direct any inquiries to me or to TPA Executive Director, Jessica Magee.

Thank you for the tremendous support I have been given during my Presidential year. I know that TPA members are smart, kind, and creative. I am excited to see where TPA will go in the future!
A NOTE FROM THE TEXAS PSYCHOLOGICAL FOUNDATION

MICHAEL G. DITSKY, PHD
TPF President
Private Practice, Sugar Land, Texas

Under Dr. Fran Douglas’s direction and superb guidance, we at TPF are concluding a year of Advocacy and Engagement. The following are some highlights at TPF this year.

All meetings were held virtually on the third Wednesday of the month beginning at 5:00 PM. Jessica Magee, Executive Director, was present for all meetings.

Dr. Douglas as president of TPA was a guest of TPF at the April 2021 meeting. Dr. Kipp Pietrantonio, Chair of AHEC (Area Health Education Centers), presented a proposal for a Student Senate and laid out its initial operations. TPF pledged to support this initiative.

After learning that the annual convention would be in-person, the TPF Board of Directors began brainstorming events for a TPF night of entertainment. While some proposals did not come to fruition, Dr. Arnnemann recommended a comedy night with an entertainer, “Chuckles” coming from a local comedy club. Proceeds from the event were placed in the general assets of TPF to continue to provide awards, grants, and convention events for students and general members. The event was well-attended and is likely to be repeated next year.

The Silent Auction appears to have returned as strong as ever. Winners were announced during the Friday night comedy club.

Despite the ongoing adversity accompanying the pandemic, TPF forged ahead with promoting and increasing student access to awards by resurrecting the Manuel Ramirez III Dissertation Award for Ethnic Minority Research for a student completing his or her dissertation. $1,500 is awarded to Nubia Mayorga for her dissertation: Perceived discrimination and hazardous drinking: The role of momentary state-like experiential avoidance on Latinx with anxiety disorder. TPF continues to explore ways of promoting a diverse student body for our profession.

The student Poster Competition took on a new format. Judging occurred during the afternoon from 12:30 to 2:00 PM on Thursday, November 11, and winners were announced at the awards ceremony Thursday evening.

First place was awarded to Rebekah Urban for her poster Development and Preliminary Validation of the Gender Inclusive Rape Myth Acceptance Scale.

Second place was awarded to Raney Sachs for her poster: Familial Dysfunction Influences Suicidal Ideation Through the Interpersonal Theory of Suicide.

Third place was awarded to Rachel E. Dugan for her poster: Identity Distress and PTSD in the Traumatically Bereaved: Effects of Sense of Coherence, Social Support, and Prolonged Grief.

Jacob Walla was awarded an Honorable Mention for his poster Explaining Risky Behaviors & Health Outcomes in the LGBT+ Community Through Minority Stress.

At this convention TPF premiered a Peer Reviewed Poster award. The first recipient of the Texas Psychological Foundation Poster Competition Peer Award winner is Summer Ijarah for her poster Depression and Substance Use in Children and Adolescents: Do Risky Behaviors Play a Role?

Because there were funds allocated for Ethics education, the Foundation was able to sponsor at the convention Dr. Sam Knapp’s three-hour workshop Seven Steps to Improve the Evaluation, Management, and Treatment of Suicidal Patients: Turning a Good Intervention into an Excellent One held on Saturday, November 13, 2021 beginning at 8:00 AM.

TPF is in good hands. Dr. Kelly Arnnemann will be taking over as President for 2022-2023. Dr. Linda Ladd is stepping down from the TPF Board of Directors; her contributions have been notable with years of research she conducted to provide ways and means to promote TPF’s mission. Dr. Courtney Banks has agreed to a second three-year term, and the band of regulars will be returning: Drs. Glenn Sternes, Jo Vendl, Amanda Venta, and Mr. Patrick Stanford-Galloway. I encourage students, early career, and seasoned psychologists to fill the four vacancies on this highly engaging and successful venture of TPA.

And so, I bid farewell having served two three-year terms, the last two during the pandemic. I am proud of the work this congenial and collegial group has accomplished. Looking back over the years, I was able to find the original group of founders including that of Dr. Richard McGraw who recently passed away. The names are too many to thank; you know who you are and many of you are still with us. My journey with TPF began when Dr. Angela Cool recruited me at a LAS dinner. I have met and served with a superior group of psychologists. I thank them for allowing me to serve with them. I wish the best for TPF and I will keep my eyes and ears open to its continued success. Finally, I owe a debt of gratitude to Jessica Magee for providing TPF with her insights and constructive abilities for the past two years.

Michael G. Ditsky, PhD
2021 AWARDS AND ACCOMPLISHMENTS

FROM THE TEXAS PSYCHOLOGICAL FOUNDATION

We’re excited to announce the recipients of TPF grants and awards of 2021.

MANUEL RAMIREZ, III, ETHNIC MINORITY GRADUATE STUDENT FOR DISSERTATION AWARD

This grant was awarded to Ms. Angelina Mayorga of the University of Houston for her dissertation in psychology as an ethnic minority student. Her research titled Perceived Discrimination and Hazardous Drinking: The Role of Momentary State-Like Experiential Avoidance on Latinx with Anxiety Disorder was awarded $1,500 toward the costs of conducting her scholarly research to promote the field of psychology.

SECOND PLACE AWARD FOR POSTER PRESENTATION OF RESEARCH

This award was presented to Ms. Raney Sachs for her scholarly research and professional poster presentation of her topic, Familial Dysfunction Influences Suicidal Ideation Through the Interpersonal Theory of Suicide. The award of $200 goes toward supporting future scholarly research in the field of psychology.

THIRD PLACE AWARD FOR POSTER PRESENTATION OF RESEARCH

This award was presented to Ms. Rachel E. Dugan for her scholarly research and professional poster presentation of her topic, Identity Distress and PTSD in the Traumatically Bereaved: Effects of Sense of Coherence, Social Support, and Prolonged Grief. The award of $100 goes toward supporting future scholarly research in the field of psychology.

HONORABLE MENTION FOR POSTER PRESENTATION OF RESEARCH

This award was presented to Mr. Jacob Walla for his scholarly research and professional poster presentation of his topic, Explaining Risky Behaviors & Health Outcomes in the LGBT+ Community Through Minority Stress.

FIRST PLACE AWARD FOR POSTER PRESENTATION OF RESEARCH

This award was presented to Ms. Rebekah Urban for her scholarly research and professional poster presentation of her topic, Development and Preliminary validation of the Gender Inclusive Rape Myth Acceptance Scale. The award of $300 goes toward supporting future scholarly research in the field of psychology.

SECOND PLACE AWARD FOR POSTER PRESENTATION OF RESEARCH

This award was presented to Ms. Raney Sachs for her scholarly research and professional poster presentation of her topic, Familial Dysfunction Influences Suicidal Ideation Through the Interpersonal Theory of Suicide. The award of $200 goes toward supporting future scholarly research in the field of psychology.

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PEER AWARD FOR POSTER PRESENTATION OF RESEARCH

This award was presented to Ms. Summer Ijarah for her scholarly research and professional poster presentation of her topic, Depression and Substance Use in Children and Adolescents: Do Risky Behaviors Play a Role?

Call for submissions

The Texas Psychologist is seeking submissions for upcoming issues.

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

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

Send to nicole.dorsey@cac.hctx.net • rolling deadline.
Each year at TPA’s Annual Convention, awards are presented to psychologists and other individuals who have made significant contributions to professional psychology. This year’s lineup of award recipients is full of outstanding contributors to the profession of psychology and mental health.

**OUTSTANDING CONTRIBUTION TO EDUCATION**

Betsy Kennard, PsyD, ABPP, won the Outstanding Contribution to Education Award. This award recognizes a truly distinguished contribution by a psychologist in the area of education. Dr. Kennard is the Chair of the UT Southwestern Medical Center (UTSW) Clinical Psychology Doctoral Program and is responsible for the training of approximately 40 graduate students a year in two APA-accredited programs: the doctoral program and an affiliated doctoral internship program. She has directed numerous accreditation site visits for the two programs, all of which resulted in receiving full accreditation. On the most recent accreditation visit of the graduate program, site visitors noted: “Dr. Kennard, who has served as the program director since 2009, is extremely qualified on the basis of her skills, credentials, and experience to lead this program.” She has developed and spearheaded training initiatives in developing competency-based training programs in both the doctoral program and the internship.

**OUTSTANDING CONTRIBUTION TO SCIENCE**

Luz Garcini, PhD, received the Outstanding Contribution to Science Award. This award recognizes a psychologist who has made a significant contribution in the discovery and development of new information, empirical or otherwise, to the body of psychological knowledge.

Dr. Garcini is the co-founder of the Latinx Immigrant Health Alliance and an Assistant Professor at the Department of Medicine and Psychiatry University of Texas Health Science Center at San Antonio. She has more than 15 years of research experience in health disparities research and more than 55 peer-reviewed publications in high impact journals. Her research with underserved immigrant communities has been presented at more than 125 national and international conferences and has been recognized by numerous awards and prestigious fellowships, including three Ford Foundation Fellowships; the American Psychological Foundation Barlow Award; and a National Heart, Lung, and Blood Institute Supplement to Promote Diversity in Health-Related Research.

Most recently, Dr. Garcini was interviewed by Oprah for her research on health and immigration. In 2019, she completed the National Institute of Health Future Research Leaders Conference and the Leadership Development Institute with the Council of National Psychological Associations for the Advancement of Ethnic Minority Interests.

**OUTSTANDING LEGISLATIVE CONTRIBUTION**

State Representative Vikki Goodwin received the Outstanding Legislative Contribution Award. This award is given to a legislator, legislative employee, or other individual who has had a major role in initiating advocacy in favor of passing legislation that has a major impact on psychology in Texas.

Rep. Goodwin is serving her second term representing Texas House District 47 in Western and far South Travis County. Representative Goodwin’s priorities include education, child welfare, human rights, and health care. She earned the TPA Outstanding Legislative Contribution Award for sponsoring TPA’s Prescription Authority Bill during the 87th Regular Session and for supporting legislative efforts to expand telehealth.

During the 86th Legislative Session, Rep. Goodwin voted to adopt the TPA-supported amendment to its Sunset Bill that would have allowed the Texas State Board of Examiners of Psychologists (TSBEP) to remain a stand-alone board. Rep. Goodwin is a passionate advocate for mental health access and human rights and has proven herself to be a strong advocate for psychology in Texas.

**OUTSTANDING MEDIA COVERAGE**

Bonnie Petrie with Texas Public Radio received the Outstanding Media Coverage Award. This award is presented to an individual who has had a major role in initiating advocacy in favor of passing legislation that has a major impact on psychology in Texas.
individual or organization that has benefited psychology through a media event. Ms. Petrie covers bioscience and medicine for Texas Public Radio and is the host of the Petrie Dish podcast, which explores science, medicine, and life during the COVID-19 pandemic. Bonnie grew up on the Canadian border in northern New York but has happily called Texas home for nearly 20 years. She is a 2017 Texas Radio Hall of Fame nominee in recognition of her work in Houston and Dallas before moving to San Antonio, and she has received several Edward R. Murrow, Associated Press, and other journalism awards throughout her career.

ROBERT MCPHERSON, PHD, LEGISLATIVE ACTION AWARD

Robin Burks, PhD, received the Robert McPherson, Ph.D., Legislative Action Award. Dr. Burks has been a TPA member for 34 years. Through her work on political campaigns and grassroots advocacy, Dr. Burks models how to best build relationships with legislators.

Dr. Burks served on the TPA Grassroots Committee for four years before becoming co-chair. In this capacity, she also served on TPA’s Legislative Committee for the 2021 Legislative Session. Dr. Burks has consistently attended TPA Legislative Days and responds to TPA calls for actions during session and for federal advocacy.

In the past, Dr. Burks was a tireless member of the PSY-PAC Board. “She exemplifies the legislative involvement we need at TPA and is a deserving recipient of this award,” said Dr. Douglas.

STATE ADVOCACY AWARD

Ronald Palomares, PhD, received the State Advocacy Award. This award is given to a TPA member who passionately and tirelessly demonstrates commitment to the advancement of the profession of psychology at the state regulatory level.

Dr. Palomares was appointed to TSBEP, where he served for the past six years. He most recently served as vice-chair, a critically important role given that the present chair is a public member. Dr. Palomares helps others understand the tenets of psychologists’ training, the importance of being a scientist-practitioner, and the need to maintain appropriate competency measures for licensure. His history of work with APA, National Association of School Psychologists, and the Association of State and Provincial Psychology Boards has enabled him to ensure that Texas maintains the national standards of the profession. Throughout his tenure on the Board, Dr. Palomares has worked tirelessly to defend the standards of the profession and to bolster the ability of TSBEP to honor the expertise of its licensees and fulfill its mission to protect the public.

AMERICAN PSYCHOLOGICAL ASSOCIATION 2020 AWARD FOR OUTSTANDING LIFETIME CONTRIBUTIONS TO PSYCHOLOGY

In 2020, Melba J. T. Vasquez, PhD, received the APA Award for Outstanding Lifetime Contributions to Psychology. This year, TPA honored her with House Resolution 639 from State Representative Donna Howard. APA and the broader field of psychology have benefited significantly from the leadership and vision of Dr. Vasquez as she has worked toward advancing equity and opportunity. Dr. Vasquez became the first Latina president of APA in 2011. During her time, she addressed issues like immigration and educational disparities and focused on eliminating discrimination and promoting diversity. She also served on the APA Board of Directors and the APA Council of Representatives and held several roles on APA governance boards, committees, and task forces. Her other leadership experience includes serving as president of TPA and APA Divisions 17 and 35.

Dr. Vasquez is a cofounder of both APA Division 45: the Society for the Psychological Study of Culture, Ethnicity and Race and the National Multicultural Conference and Summit through which she has worked to elevate and highlight the achievements of other psychologists of color and spent her career mentoring and supporting psychologists from marginalized communities to take on leadership roles in associations.

She has published significantly on professional ethics, social justice, ethnic minority psychology, women’s psychology, among other topics; she is coauthor of Ethics in Psychotherapy and Counseling and How to Survive and Thrive as a Therapist and has written more than 100 journal articles and book chapters. In addition, she has served on the editorial boards of 10 journals and has been invited to be the keynote speaker at many events.
INTRODUCTION

There is a growing need for Shared Decision Making (SDM; Rotar et al., 2018). SDM according to Elwyn et al. (2012), is an approach that provides patients with evidence for effective treatment options. Through this information sharing, providers support patients to make an informed choice about their care as well as facilitate the stepped care process in primary care. Currently, SDM is utilized in many areas of medicine including primary care where team-based care is common (Legare et al., 2011). Patients often benefit from an SDM approach as it affords patients the potential for positive outcomes, including a greater sense of control and engagement in their treatment (Adams & Drake, 2006). There are many benefits to patient care when SDM is utilized and an example of this was noted in a recent study that found a reduction in unnecessary antibiotic prescriptions (van Esch et al., 2018). However, multiple barriers exist regarding the practical utilization of SDM in primary care. Current barriers include provider limitations, performance-based metrics, and time (Friedberg et al., 2013; Legare et al., 2011; Legare & Witteman, 2013).

The Primary Care Behavioral Health (PCBH) model (Robinson & Reiter, 2016) adds behavioral health providers who function as Behavioral Health Consultants to the primary care team to enhance the team’s ability to treat and manage its patient population. Bryan, Morrow, & Kanzler Appolonio, 2009; Corso et al., 2012; Robinson & Reiter, 2016). The “GATHER” acronym, described by Reiter et al., (2018), describes the role of the BHC, which is: Generalist, Accessible, Team-Based, High-productivity, Educator, and Routine. BHCs are well-positioned to utilize SDM during patient encounters to facilitate the stepped care process, increasing quality and access to evidenced-based behavioral interventions when a higher level of care is warranted.

Bower & Gilbody (2005) define stepped care as a healthcare delivery model that engages patients in a systematic way to assist in the improvement of functioning. Through this delivery system patients are engaged in treatment starting with low intensity interventions and are monitored to ensure improvement in functioning. If functioning does not improve or low intensity interventions are not successful, the patient is stepped up to a higher level of intervention. Stepped care has been used within the primary care setting to assist with multiple health conditions (Unützer et al., 2001; Drummond et al., 2009; Goorden et al., 2014). Should a higher level of intervention be needed, SDM can assist patients as they move between steps. SDM can create a discussion between a patient and provider focused on past interventions, currently functional status, their outcomes, and possible next steps. This focused discussion allows the patient to make an informed choice on their care and gives the patient ownership in their care and may result in better health outcomes for the patient and health system.

A recent study demonstrated a one visit, 30-minute model for SDM with Veterans seeking specialized care for PTSD (Mott et al., 2014). In this pilot study, the authors demonstrated how a one visit SDM approach could reduce care transfer loss, increased adherence to intervention post transfer, and improve evidence-based choice for treatment. This study and its time frame are well suited to the time constraints of primary care and help to illustrate how a model of SDM could fit within a PCBH approach through BHCs.

This paper builds on this brief illustration by providing a demonstration of a modified SDM dialogue as well as an example of SDM within the 5As model (Hunter et al., 2017). With origins in the 4As model for promoting tobacco cessation during medical visits, the modified 5As model has demonstrated effectiveness for other health behaviors and conditions (Glynn & Manley, 1995; Goldstein et al., 2004). The 5As model provides an organized approach to behavior change.
within the PCBH model which focuses on developing a patient-centered behavior change plan (Hunter et al., 2017; Whitlock et al., 2002).

**SHARED DECISION-MAKING MODEL**

The SDM model developed by Elwyn et al. (2012) consists of three main components: Choice talk, Option talk, and Decision talk. These components have subsequent minor sub-components to help providers move from one component to another, ultimately arriving at a decision that is well informed and geared toward patient preference (Elwyn et al., 2012). SDM is a well-informed model of patient-centered care; however, this model does not fit all patient care situations or preferences, as Murray et al. (2006) note.

The model presented by Elwyn et al. (2012) does not provide guidance on the length of time a clinician should utilize each SDM components. This allows clinicians to choose the different sub-components that match each patient interaction. For SDM to be successful, a clinician will need to select the sub-components that match their patient's situation. A mock selection of these sub-components for a BHC are in Figure 1.

*Figure 1*

**Shared Decision-Making Model**

- **Choice Talk**
  - Stepping back: Reflecting on previous interventions
  - Offer choices: Higher level of care options

- **Option Talk**
  - Check Knowledge: What does the patient understand about offered options?
  - Discuss: What are the positives and negatives of each choice?
  - Summarize: What did the patient choose and how might that help them?

- **Decision Talk**
  - Focus on preferences: What preferences do they have for treatment? (e.g., brief, long, evidence-based, process-focused, etc.)
  - Move toward a decision: Set up a plan for the decision to be followed. Possibly utilize Motivational Interviewing/Brief Motivational Interviewing
  - Offer review: Review and reflect the SDM visit to ensure all questions are answered and motivation is present for the patient to access a higher level of care
Outside of these sub-components, a brief demonstration of how SDM may fit in the 5As model listed in Table 1. This demonstration centers around a patient with depression who is presenting to their PCP office, after multiple previous visits with his PCP and BHC for depression management.

**Table 1**

**Demonstration of SDM with 5As Visit Structure within PCBH**

<table>
<thead>
<tr>
<th>5As</th>
<th>SDM</th>
<th>Description</th>
</tr>
</thead>
</table>
| **Assess** | Choice Talk/Option Talk | • BHC reviews previous interventions attempted by the patient.  
• BHC reviews the patient’s knowledge of previous interventions and their intended goal. This will help in later treatment recommendation conversations based on previous intervention attempts. |
| **Advise** | Choice Talk/Option Talk | • BHC discusses and checks the patient’s knowledge of treatment.  
• Discussion about higher level of care options and evidence-based treatments for depression. |
| **Agree** | Option Talk | • Summarization of the two previous phases of the visit.  
• Facilitates mutual understanding between BHC and patient, focused on working towards the same goal. |
| **Assist** | Option Talk/Decision Talk | • Visit content is focused on decision talk and option talk.  
• BHC investigates preferences for continued care such as evidenced-based traditional psychotherapies for depression (e.g., interpersonal psychotherapy, problem solving therapy) and/or psychiatric consultation (e.g., psychopharmacology).  
• Option talk used to briefly discuss the positives and negatives of the patient’s treatment choices. |
| **Arrange** | Decision Talk | • BHC utilizes decision talk and works toward a supported decision with patient.  
• Consider use of Brief Motivational Interviewing to ensure that intrinsic motivation is in place and that barriers are minimized for a successful transition to a higher level of care.  
• Consider the use of a brief visit summary to reflect the content of the visit and reiterate the developed plan. |

The above example allows a BHC to explore past attempts by the patient, examine future options, and then focus on providing the patient with quality information to help them make an informed choice. As Ogbeide et al. (2018) noted, some individuals seen in primary care may not want to seek assistance from traditional mental health services. Because of this, it is important that referrals to specialty mental health use an SDM model rather than a traditional referral (Ogbeide et al., 2018). Gonzalez et al., (2005) found that only 71% of patients who received a traditional referral to specialty mental health attended their appointments. However, it was noted if patients had a positive attitude regarding mental health treatment, reported readiness for change, and perceived benefits from mental health treatment, they were more likely to follow through with their original referral. Beyond SDM, Brief Motivational Interviewing (BMI) can assist providers in their understanding about perceived patient barriers and current goals for care (Elwyn et al., 2014). With these goals in mind, SDM as administered by a BHC may help to discern patient preference and potentially increase motivation and follow-through.
CLINICAL IMPLICATIONS

The proposed conceptual model provides an approach for BHCs to utilize SDM within a PCBH framework to facilitate stepped care. This framework helps BHCs develop an improved plan of action for their visits that require higher levels of care. SDM models of care have shown to be beneficial when compared to those who did not receive SDM when seeking higher levels of care (Mott et al., 2014). The usage of an SDM model with patients may provide BHCs greater intervention effectiveness and improve the likelihood of patient’s adherence. The PCBH model and the utilization of the 5As may compliment an SDM approach (Whitlock et al., 2002). Additionally, the usage of BMI with the SDM model, as described by Elwyn et al. (2014), may further increase patient’s attunement to intervention choices and reduce apathy and non-adherence in patients seeking assistance.

There are many considerations to consider with the illustrated model of SDM (on page 8) within a PCBH framework. The PCBH model is well suited to support the usage of SDM with BHCs being skilled providers in efficiently developing rapport with patients in a potentially time-limited context. Training is another consideration as BHCs may not have sufficient training or experience in SDM to utilize in a precise way. Finally, the lack of increased reimbursement for an added value service such as SDM may discourage health systems from adopt this model compared to referral as usual care. A future direction in research would be to test the proposed SDM approach within the PCBH model for feasibility and acceptability. SDM is ideal for patient-centered interactions, but it is not appropriate in all situations such as emergency situations or when patients prefer other decision-making styles (Murray et al., 2006). The use of SDM to facilitate stepped care in primary care is promising in order to not only promote patient-centered care, but to also equip providers with clinical tools to enhance their effectiveness in clinical practice.

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INTRODUCTION AND BACKGROUND

A history of child abuse and neglect is associated 30-90% of individuals with a Borderline Personality Disorder (BPD) diagnosis, which is greater than any other personality disorder (Cattane et al., 2017). Individuals with BPD often report childhood trauma in the form of neglect (92%), sexual abuse (40-70%), and physical abuse (23-73%) (Zanarini et al., 2002). Adverse childhood experiences also correlate to BPD symptom severity (Zanarini & Frankenburg, 2007). Although childhood adverse events are not sine qua non for developing BPD, they are the most significant environmental risk factor (Gunderson et al., 2018).

The causal relationship between trauma and BPD (Ball & Links, 2009) suggests that BPD may be considered a trauma-related disorder (Gunderson & Sabo, 1993). Yet, the existence of a traumatic incidence is not necessary or sufficient to explain the etiology of BPD (Ford & Courtois, 2014). Genetics (e.g., temperament) and formative developmental experiences (e.g., maltreatment, disruptions in formative relationships) likely interact in complex ways to contribute to the etiology of BPD (Zanarini et al., 2013). Many perspectives exist regarding developmental etiological factors, but one perspective is that while BPD may stem from childhood abandonment and unreliable caregiver attachments, BPD may also stem from traumatic victimization throughout development in childhood and early adulthood (Zanarini & Frankenburg, 2007). Given elements of etiological convergence between BPD and PTSD, there remains an open question as to whether BPD may be conceptualized as a trauma-related disorder.

Prevalence of BPD and PTSD in the general population is approximately 0.5–5.9% and 3-8%, respectively (Bisson et al., 2015; Grant et al., 2008; Lenzenweger et al., 2007; Goldstein, et al., 2016; Kessler, et al., 2005, Kessler, et al., 1995). In individuals with BPD, the most common co-occurring disorder is PTSD with a prevalence 25-58% (Grant et al., 2008; Zanarini et al., 1998). BPD co-occurs in approximately 10-76% of individuals with PTSD (Scheiderer et al., 2015). Although BPD and PTSD share common underlying risk factors, the extent to which the etiology of BPD and PTSD overlap or diverge is yet unclear. While BPD are PTSD are currently established as two independent disorders, it has been postulated that they may be variants along a spectrum of a single trauma-related syndrome (Scheiderer et al., 2015).

BPD has been nosologically classified by some as complex PTSD (cPTSD), suggesting that these disorders should be viewed through the same lens as trauma-related disorders (Gunderson & Sabo, 1993; Lewis & Grenyer, 2009). Both BPD and PTSD share numerous clinical features, particularly disturbances in...
emotional regulation, impulse control, reality testing, interpersonal relationships, and self-identity (Gunderson & Sabo, 1993; Lewis and Grenyer, 2009). BPD and PTSD are both also associated with high mortality and morbidity, suicidal behaviors, frequent hospitalization, substance use, psychiatric comorbidity, poor quality in interpersonal relationships, and economic burden (Bisson et al., 2015; Skodol et al., 2005). The considerable overlap of clinical features between PTSD and BPD – or complex PTSD (cPTSD) –, calls into question if these two disorders are more related than the current paradigm of diagnostic classification would suggest.

**PSYCHOTHERAPEUTIC TREATMENTS FOR BORDERLINE PERSONALITY DISORDER**

An extensive body of literature has established five evidence-based psychotherapeutic approaches are used for treatment of BPD: cognitive behavioral therapy (CBT), mentalization-based therapy, schema focused therapy, transference-focused psychotherapy (TFP), and dialectical behavior therapy (DBT) (Choi-Kain et al., 2017). Generally, treatment modalities include weekly meetings with an individual therapist, one or more weekly group sessions, and meetings of therapists for consultation or supervision. Although it is not established that one approach is better than the other, of the five approaches, DBT has been studied the most extensively. Both DBT and TFP have been shown in randomized controlled trials to have efficacy (American Psychiatric Association Practice Guidelines, 2001) yet, almost half of BPD individuals never fully recover over their lifetime (Videler, 2019). Treatment-seeking BPD individuals do show an initial 8% remission rate in one to three years (Skodol et al, 2005), with resolution of impulsivity, self-harm, and suicidality (Biskin, 2015). Domains that tend to remain unchanged despite treatment are the underlying, “temperamental” symptoms of sadness, unstable interpersonal relationships, lack of self-identity, emptiness, and fear of abandonment which causes 10% of BPD individuals to relapse into suicidal behavior over their lifetime (Videler, 2019). There also currently are no effective medications for BPD (Gunderson & Choi-Kain, 2018). Thus, better treatments are still desperately needed for individuals with BPD.

**MDMA-ASSISTED THERAPY**

MDMA (3,4-methylenedioxymethamphetamine), otherwise known in recreational settings as “Ecstasy,” is currently being studied to enhance psychotherapy for the treatment of PTSD. Six phase 2 trials and a phase 3 trial of MDMA-Assisted Therapy (MDMA-AT) for PTSD have shown it to be safe and efficacious, with approximately two-thirds of individuals with treatment-resistant PTSD no longer being diagnosable after a course of treatment (Jerome et al., 2020; Mitchell et al., 2021; Michael C. Mithoefer et al., 2019). Improvements continue to be durable at one and four years (Jerome et al., 2020; Michael C. Mithoefer et al., 2013). MDMA-AT for individuals with PTSD may also improve symptoms of depression and insomnia, while also enhancing posttraumatic growth (Gorman et al., 2020). MDMA-AT may also reduce alcohol use in those with PTSD (Jerome et al., 2020) and in those with alcohol use disorder (Sessa, Sakal, O’Brien, & Nutt, 2019). Given the current body of evidence, it is estimated MDMA-AT will be FDA-approved for PTSD in approximately 2023.

**BPD EXCLUSION FROM PSYCHEDELIC RESEARCH**

No MDMA-AT studies yet exist of individuals with BPD and with the high comorbidity of BPD and PTSD, the question remains as to what extent MDMA-AT is appropriate for individuals with BPD. It is possible that MDMA-AT may be useful in treating individuals with BPD (Pagura et al., 2010). However, all the studies of MDMA-AT for PTSD thus far had excluded individuals with BPD to mitigate the risk of potential of high-risk behaviors as individuals with BPD often engage in self-harm and have suicidal ideation (Aviram et al., 2006).

Clinical research in individuals with BPD has been limited not only in studies of MDMA-AT but also in studies of other psychedelic-assisted therapies as well. Studies of psychedelics where confirmed BPD diagnosed participants were included was identified in only nine studies (Zeifman & Wagner, 2020). Psychedelic researcher, Peter Gasser (1994), noted “from 1988 to 1993, a significant number of patients with narcissistic personality disorders sought therapy with psychedelic drugs. BPD was also diagnosed rather often, as were depressed mood disorders and adjustment disorders. We can presume that the treatment is well suited for these disorders” (Gasser, 1994, p. 7). Nonetheless, current psychedelic research has excluded BPD individuals from clinical trials (Mithoefer et al., 2011). Psilocybin researcher, Carhart-Harris and colleagues (2018) has excluded individuals with BPD due to “psychiatric condition judged to be incompatible with establishing rapport with therapy team and/or safe exposure to psilocybin, e.g. suspected borderline personality disorder” (Carhart-Harris et al., 2018, p. 399). Additional psychedelic research trials also excluded individuals with suicide risk or substance abuse (Palhano-Fontes et al., 2019), which are found in over 70% of individuals with BPD (Gunderson, 2001; Kienatz et al., 2014).

While early anecdotal evidence supports the treatment of BPD with psychedelic-assisted therapies, the current body of psychedelic research has systematically limited the advancement of evidence for BPD. Thus, evidence of MDMA-AT for BPD is currently lacking, and more studies are needed.

**CONCLUSION**

Individuals with BPD are a population with high clinical risk and a great need for better treatment options. Yet, their high clinical risk has paradoxically precluded individuals with BPD from being studied with state-of-the-art treatments such as MDMA-AT. Given the elevated clinical risks of this population and the relative infancy of MDMA-AT research which is not yet FDA-approved, clinical trials of this high-risk population may be too risky at this time.

However, if provisions can be implemented to sufficiently mitigate the risks associated with BPD treatment, the weight of their unmet needs and inadequate treatment options may outweigh any remaining unmitigated risk. Thus, the threshold at which to consider conducting clinical trials of MDMA-AT for BPD hinges upon adequate risk mitigation. If risks can be adequately mitigated, the wide gap between this patient population’s unmet needs and the inadequacy of current...
treatment options to meet those needs may in fact necessitate that clinical trials of MDMA-AT be supported.

REFERENCES


Using Pre-surgical Psychological Evaluation for Bariatric Surgery to Understand Patient Perspectives and Postsurgical Health

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INTRODUCTION

Year after year, obesity rates in the United States continue to rise. According to the National Center for Health Statistics from the Centers for Disease Control and Prevention (CDC), in 2015-2016 nearly 40% of U.S. adults were obese (Ogden et al., 2015). Compared to 15% in 1990, this represents an increase of approximately 1% per year (Siegel et al., 1991). Obesity is defined by a body mass index (BMI) >30 and is recognized by the World Health Organization (WHO) as a chronic and progressive disease (World Health Organization, 2018) linked to several chronic health issues, such as cancer, diabetes, and cognitive dysfunction (Mitchell et al., 2011). Additionally, obesity poses a substantial economic burden at the individual, societal, national, and global levels (Tremmel et al., 2017). To combat the rising rates of obesity-related health conditions, bariatric surgery has become an acceptable and popular form of treatment, contributing to reduced mortality from heart disease, cancer, and diabetes, by 56%, 60%, and 92%, respectively (van Hout et al., 2005). They posited these improvements were related to taking an active role in changing their lives, resulting in a feeling of having a “new lease” on life, increased optimism, and future-oriented behavior.

OBESITY AND MENTAL HEALTH

Individuals with obesity also exhibit elevated rates of psychiatric symptomology (Abiles et al., 2010; Herpertz et al., 2003; Kubik et al., 2013; Sjostrom et al., 2013) and are five times more likely to experience a major depressive episode (Sarwer et al., 2005). An estimated 25-30% of bariatric patients report significant preoperative mood symptoms, and up to 50% report lifetime depression. While psychiatric difficulties are prevalent amongst this population, post-surgical improvement in psychological outcomes is well documented. This has been well documented in the Swedish Obese Subjects (SOS) study, the largest longitudinal bariatric study conducted to date, examining 4047 individuals with matched controls (Sjostrom et al., 2007). Results documenting improvement in psychological outcomes across several domains, such as depression, quality of life, self-control, eating, social and sexual functioning, and economic status, have been corroborated by other studies (Castellini et al., 2014; Herpertz et al., 2003). Kubik et al. identified over 40 studies from 1983-2002 supplying evidence of improved psychiatric functioning post-bariatric surgery (Kubik et al., 2013). Interestingly, some researchers determined that functional improvements are not necessarily related to weight loss but to the surgical process itself. Van Hout, Verschure, and van Heck found improved psychological functioning in individuals who lost only a small amount of weight or even experienced weight regain (van Hout et al., 2005). They posited these improvements were related to taking an active role in changing their lives, resulting in a feeling of having a “new lease” on life, increased optimism, and future-oriented behavior.

...post-surgical outcomes are shown to be highly correlated with premorbid functioning

Still, many other studies reflect improvements in psychiatric functioning as being limited to the first couple of years following surgery, with scant research on long-term impact (Canetti et al., 2009; Herpertz et al., 2003). Some longitudinal studies have observed psychological deterioration several years after surgery with prevalent themes such as recurrent loss of control, disinhibition of compulsive eating, resorting to food as a form of coping, and a positive correlation between depression and weight regain (Burgmer et al., 2014; Burgmer et al., 2007; Canetti et al., 2009; van Hout et al., 2005).

PRE-SURGICAL PSYCHOLOGICAL EVALUATION

Based on this review, post-surgical outcomes are shown to be highly correlated with premorbid functioning. Consequently, a number of psychological and behavioral risk factors may adversely affect surgical outcomes, including substance use, financial instability, untreated depression, or lack of understanding about post-operative risks and procedures (Walfish et al., 2007). History of eating disorders or behaviors (e.g., grazing, night-time eating) and unsuccessful weight-loss attempts (“yo-yo” dieting) have also predicted decreased post-surgical weight loss (Brandao et al., 2015). Therefore, to
determine whether a patient will benefit from bariatric surgery, a thorough medical and psychological evaluation is warranted.

As the use of bariatric surgery as a treatment for obesity continues to evolve, the development of practice guidelines for pre-surgical evaluation has been an area of focus for several major health organizations. These guidelines provide empirical support for using a comprehensive and integrated approach to assessment and treatment (Mechanick et al., 2020). Similarly, the National Institute of Health Consensus Panel recommends careful selection of surgical candidates using a multidisciplinary team that includes mental/behavioral health (Marcus et al., 2009).

While a pre-surgical psychiatric evaluation is not required for all candidates, it is highly recommended and often required by many health insurances and over 80% of bariatric surgery programs in the U.S. (Marcus et al., 2009; Sogg et al., 2016). At minimum, pre-surgical psychological assessment should be performed by a qualified mental health professional and include assessment of: environmental, familial, and behavioral factors, suicide risk, psychiatric illness, substance abuse, and history of physical and mental health treatment compliance. Other vital components include weight history, presence of an eating disorder, compensatory behaviors, developmental and family history, cognitive functioning, current stressors, social support, health-related behaviors, motivation, and knowledge of surgical procedures, risks, and benefits (Sogg et al., 2016).

While this guideline is helpful in identifying the necessary components of the evaluation, a uniform “gold standard” for pre-bariatric psychological assessment has yet to be recognized. Methodology and instrumentation vary significantly depending on clinician and/or site. However, most evaluations include a semi-structured interview and psychometric testing resulting in one of three outcomes: approval (minimal risk), delay/conditional approval (some risk factors apparent), or denial (several risk factors apparent). Most candidates (65%-70%) pass the evaluation with minimal red flags; another 15% are delayed or denied approval based on their risk profile (Wallfish et al., 2007). Following initial assessment, recommendations are made to the patient and surgical team aimed at improving surgical candidacy.

**INTERVIEWS WITH BARIATRIC PATIENTS**

This study included interviews with 68 patients who underwent open/laparoscopic roux-en-Y gastric bypass (RYGB) or laparoscopic sleeve during 2011-2016 at Baylor Scott & White Health in Temple, Texas. All participants had bariatric surgery with the past five years, psychological evaluation within one year of surgery, a pre-surgical metabolic panel, and lab results within +/-3 months of surgery anniversary. Patients were contacted via telephone and interviewed about their bariatric surgery experience.

Medical data was collected retrospectively from medical chart reviews.

Based on qualitative interview data, post-surgical dietary changes/restrictions were reported by 47%; primarily new-onset lactose intolerance followed by intolerance for meat, high-fiber foods, sugar, salt, acidic foods, spices, oils, gluten, and carbonated beverages. One-third (34%) reported post-surgical changes in taste (65%) and/or smell (30%), with loss of flavor detection and hypersensitivity to strong food odors among the complaints. Participants reported high adherence (41%), 34% medium, or 25% low/minimal adherence to the recommended post-bariatric diet.

On average, pain scores decreased by nearly 3 points. Patients with conditional approval had marginally higher pain scores at follow-up: 4.1 (SD: 2.9) vs 2.4 (SD: 2.7; p=.07). Two out of five respondents (43%) attended a bariatric support group; of those that did, 97% found it helpful. Two-thirds of the sample reported ongoing exercise after surgery.

Compared with pre-surgical scores, post-surgical anxiety and depression increased over time. Before surgery, those with conditional approval were more likely than expected by chance to be anxious (chi-square=6.715; p=.0096) or depressed (chi-square=4.768; p=.0290). At follow-up, no difference in probable depression (chi-square=1.207; p=.2719) or anxiety (chi-square=0.976; p=.3232) was found.

Most patients reported being satisfied or very satisfied with their quality of life and bariatric surgery. A majority (91%) stated they would “still have had the surgery” even knowing what they know now about potential complications/difficulties because the benefits of losing weight and improved health and quality of life were so important. One respondent said,

“Yes, even with everything that happened; I had complications, but had tried everything else.”

Other respondents mirrored that statement: “Yes, it was a tool to help me lose weight” and “yes, I can do things now without feeling anxious.” Another said, “Yes, but I wish I was better prepared.” Among those that said “no,” reasons included postoperative complications, lifestyle limitations, and difficult recovery.

The most challenging aspects of the bariatric surgery process cited were: adhering to diet and daily activity/exercise recommendations, limiting food, controlling urges to eat “junk” food, stopping when feeling full, staying adequately hydrated, avoiding old habits (grazing, binging), cost, excess skin, mood/irritability, body image, and the approval process. Responses reflecting these challenges include:

“Taste and flavor of food is different”

“It was hard to change my relationship with food”

“I have difficulty eating in general; it’s hard to get adequate nutrition”

The most rewarding aspects were weight loss, improved physical and mental health, reduced pain, decreased medications, saving money on eating out, increased mobility and socialization, appearance, independence, self-esteem, and feeling “happier.” Responses reflecting the benefits of surgery include:

“I’m feeling 100% better – more energy and better appearance”

“I can bend over and see my toes, and tie my shoes!”

“Before surgery I was on 15 medications, now I am only on 5”
THOUGHTS ABOUT THE PRE-SURGICAL APPROVAL PROCESS

Of the 51 respondents providing qualitative answers, about half stated that the psychological evaluation process and information received were helpful, some found the process to be unhelpful, and others felt neutral about the evaluation process. Several intriguing themes were revealed. Individuals who were initially approved found the evaluation informative, supportive, helpful with adjustment and coping strategies; they felt the process increased self-awareness and helped them to mentally prepare for lifestyle changes. One participant stated, “It [the psychological evaluation] was helpful and supportive and not biased or judgmental, and got me into therapy.” Individuals who were conditionally approved found the additional psychotherapy prior to surgery helpful. One commented, “The psychological aspect should have been more of an emphasis,” and another said, “The mental aspect [of bariatric surgery] is the biggest part.” Among those that found the process unhelpful, several reported frustration with the test lengths or lack of clarity of questions, disagreed with the outcome, felt unsupported, or had difficulty “opening up about things that I had shut off.”

DISCUSSION

Overall, significant reductions in BMI and improvements in health outcomes were observed. Most individuals were satisfied or very satisfied with the results, even those who experienced surgical complications or other serious side effects. One unique aspect of this study was the insight gained into the patients’ experience by their response to: “knowing what you know now, would you still have had the surgery?” Consistent with perceived benefit from surgery, over 90% stated they would do it again.

PRE-AND POST-SURGICAL SUPPORT

Factors such as diet and lifestyle also play a major role in the weight loss/management experience and are pivotal in preventing weight regain. In this sample, almost all patients stated that adhering to the diet and coping with cravings were the most challenging aspects of their weight-loss journey. Additionally, several participants explained that although they were happy with their results, they continued to feel distressed about body image, societal pressure to maintain weight loss, and ongoing struggles with diet resulting in curtailed social engagement. Improving coping mechanisms for these potential pitfalls can better prepare patients and improve weight-loss success.

One way to do that is through pre- and post-surgical support groups, which can be a highly effective way of providing

Among those that found the process unhelpful, several reported frustration with the test lengths or lack of clarity of questions, disagreed with the outcome, felt unsupported, or had difficulty “opening up about things that I had shut off.”

patients with psycho-education, support, and encouragement. Postoperative psychotherapeutic interventions, such as cognitive-behavioral therapy, psychodynamic, and emotional regulation, are also highly effective (Beck et al., 2012). Further exploration of the effect of pre-surgical support/interventions on post-surgical success is needed and should be considered for inclusion in practice guidelines.

Metabolic changes related to weight loss and calorie restriction may also impact mood. Considering biopsychosocial interventions that bring together behavioral, cognitive, and metabolic factors, and education on the bidirectional relationships between mood, lifestyle, and health offer a key point of intervention to help individuals prepare for affective and lifestyle changes.

To further this point, recommendations made to individuals who were initially conditionally approved for surgery to have individual pre-operative psychotherapy appears to have ‘evened the playing field’ with respect to decreasing rates of post-surgical depression/anxiety. Therefore, the psychological evaluation served as a gateway to treatment that aided individuals in improving their mental health allowing them to move closer to surgery and their health and weight goals.

Uniquely, the present study captured patients’ perceptions of the pre-surgical psychological evaluation process. Qualitative interviews revealed that pre-surgical psychological evaluations can shed light on the role of counseling to prepare patients for bariatric surgery while identifying riskier candidates. They also point to the importance of using a multidisciplinary approach to support patients through the bariatric process and thereafter.

Future research on this topic should take into consideration the unique experiences of the patient, including their perceptions about the process and ongoing struggles with behavioral, cognitive, and metabolic changes after surgery. Additional research on the effectiveness of specific strategies for pre- and post-care to support physical and affective wellness is warranted, as well as development of a standardized process with consistency in structured interview, diagnostic instruments, and guidelines for approval would be desirable from a programmatic and healthcare policy standpoint.

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We are officially in the interim! After three nearly consecutive special sessions, legislators are finally able to return to their districts. In this article, I’ll provide a quick recap of the special sessions, an update on what we’ve learned since the interim began, and what it all means for us moving forward.

As you may already know from all the media attention, the special sessions were a bit hectic. The first special session was focused almost entirely on partisan issues. Shortly after the first special session began, Democrats in the House of Representatives fled the state, using a tactic called “quorum breaking.” Essentially, because the House did not have enough members present to act, the first special session ended without any of the leadership’s agenda items passing.

The second special session began almost immediately after the first ended. Democrats had still not returned, but they eventually did, leading to most of the leadership’s agenda items making it across the line. The third special session was primarily about redistricting and the allocation of federal funds, and things seemed to move relatively smoothly.

Now that we’re in the interim, members are refocusing on elections. There have been a significant number of retirement announcements, as well as one member changing parties. Most of the retirements are coming from left-leaning republicans and right-leaning democrats. I won’t list out all the names here, but you should certainly lookup the name of your Representative and Senator to see if they are running in the next election.

Given the turnover at the legislature, this will be an important election cycle for outreach and advocacy. First-time candidates are typically extremely responsive to constituents, so for those of you without an incumbent in your district, this would be a great time to build a new relationship. Of course, if you are planning to meet with candidates, don’t hesitate to reach out to TPA—we’re always happy to assist.
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- Defended licensing standards against a TSBEP rule change to allow for exceptions on a case-by-case basis

- Addressed concerns with TSBEP’s proposed changes to the multiple relationships rule

- Made permanent audio-only Medicaid reimbursement

- Protected providers from causes of action in cases where injury to a client or others is imminent and disclosure is required