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Editor

Brian H. Stagner, Ph.D.

As I write it is allegedly fall, although drought and heat seem unrelenting. But the summer is over, the kids are back in school, and we’re all getting ready for the TPA Convention in November (register now at www.texaspsyc.org). APA’s convention was held on some island very far away, while TPA will be held in a place where you can really get good Mexican food and decent margaritas. (See Rick McGraw’s report on the many happenings at APA Council in August).

Psychologists are experts at change, but we must also juggle changes in our own work. Catch Munro Cullum’s discussion of applications of telemental health; emerging applications of technology will continue to be a major source of opportunity for psychologists in the future.

In that future, we will need to adapt to the new DSM5, warts and all. Vincent, Stewart, Inman, and Eagle have given us a very informative review of the implications the new taxonomy will have for forensic assessments in civil litigation where claims of trauma are at issue.

Psychologists are extending themselves to help others in both research and in action. Dr. Peterson and his colleagues at the University of Texas Health Science Center at San Antonio are conducting game-changing research to help veterans with PTSD and related problems. Their article summarizes an astonishingly ambitious of research programs already under way and describes the recent awards from the DoD that bring the STRONG STAR research funding to over $100 million.

Psychologists don’t just study trauma. We put boots on the ground. This issue of the Texas Psychologist includes two complementary articles on disaster response. Drs. Hays, Jennings, and Mock describe the things psychologists might do to prepare to be more effective in times of disaster.

Following this, Dr. Hamlin discusses ways that disaster response psychologists are learning to embrace the ways diverse communities may respond to disasters. Both articles offer a number of resources on many aspects of disaster response. Enjoy the issue. Learn about new developments in our science. Think about getting involved in the TPA Disaster Response Network or other groups in your community (it’s good for you, it’s good for your neighbors, it’s good for psychology!). Register for the convention. See you in Houston!
It is my understanding that this will be the last time, within the Texas Psychologist, that I put pen to paper, or fingers to the keyboard, to address the psychologists of Texas in my role as President of the Texas Psychological Association (TPA). That being the case, I would like to begin by expressing to you, the membership of TPA, my sincere appreciation for allowing me to serve in this capacity. Hopefully I have helped, in some small way, to advance the just and noble cause of psychology and the Texas Psychological Association. I said, in accepting this position, that I was both honored and privileged to have this opportunity. As this year winds up, those feelings have lost no intensity and I will always cherish the memories from this opportunity to serve. In my address to TPA members at last year’s convention, I stated with complete sincerity, that I entered this role with no sense of personal ego involvement, but rather the with a great desire to give something back to a profession for which I have always had a strong passion, a profession that has been exceedingly good to me. I still hold those feelings today and I only hope that I have lived that commitment and that, indeed, I have given something back to our profession. As I have experienced in other volunteer experiences in my life, however, I wind this year down with a sense of having received more from you my colleagues, especially from my fellow board members than I have given. The experience has truly been remarkable and the current board members have, with their great differences, varying opinions, and strong personalities, worked hard and in unison for the good of psychology in Texas.

I began the year with what became a redundant message wherein I proclaimed the value of TPA and the need to keep it strong so that we have a voice in Texas legislation and so that we can protect the profession that is experiencing ever-increasing challenges from lesser trained mental health professionals and also from a changing health-care environment. I spent the year pushing for increased membership in TPA, for greater participation by members, and for financial growth, so that we can continue this work and protect our profession, both for the psychologists who are to follow us and for the public sector where we have a voice in Texas legislation and so that we can protect the professional organizations in what I view as a futile and unwise effort to save a few dollars, at the expense of supporting the organization that is in place to protect their profession.

Certainly, this has been true among psychologists and I believe that the long-term cost of such careless abandonment will dramatically override the savings in membership dues. So, once again, I plead with you to maintain your membership; sign up one or more colleagues; give back to TPA in whatever way you can.

Join in the fight to take our profession through the Sunset process that is just a few years away. Our strength comes only through the size of our professional membership. I continued level of proactive involvement and the availability of dollars that we can pour into the preservation and growth of our profession. We met with good success this year legislatively, but we must now build upon this, earn the trust that some of the legislators are showing us, and our goal is to work relentlessly to maintain a position of utmost leadership within the mental health community in our state.

Thank you all once again for allowing me this honor of service to our profession through TPA. May we never take our profession for granted and may we all look, during each of the seasons of our professional careers, for areas of service opportunity so that psychology will both survive and thrive for the benefit of all. See you at the convention in Houston!
Who is TPA?

The foundation of TPA are members just like you who have volunteered their time and energy to make TPA a successful organization. The definition of volunteering is defined as persons who freely offer to take part in an enterprise or undertake a task. Have you ever thought about volunteering at TPA?

I did some internal research and found out that if I add up all the members who serve on TPA’s committee and task forces that only 42 members or 4.9 % of membership, volunteers for TPA. This was alarming for me so I began looking into if our numbers were representative of the society at large.

According to the 2012 US Bureau of Labor and statistics report…

- Women volunteer more than men (23.2 and 29.5 percent, respectively)
- Most volunteers were involved with either one or two organizations--70.5 and 19.1 percent.
- Individuals with higher educational attainment were more likely to volunteer for multiple organizations than those with less education
- By age, 35- to 44-year-olds were most likely to volunteer (31.6 percent) compared to the lowest among 20- to 24-year-olds (18.9 percent).
- Among the major race and ethnicity groups, white continued to volunteer at a higher rate (27.8 percent) than did blacks (21.1 percent), Asians (19.6 percent), and Hispanics (15.2 percent).
- Married persons volunteered at a higher rate (31.9 percent) than did those who had never married (20.7 percent and those with other marital statuses (21.3 percent).
- Individuals with higher levels of education engaged in volunteer activities at higher rates than did those with less education. Among persons age 25 and over, 42.2 percent of college graduates volunteered, compared with 17.3 percent of high school graduates and 8.8 percent of those with less than high school diploma.

Here are the top ten reasons people volunteer:

- Give Something Back
- Unique Opportunities
- View a Culture from the Inside
- Personal Growth
- Personal Benefit
- A Sense of Accomplishment
- Recognition and Feedback
- Learn New Things
- Friendship and Belonging
- Skills and Experience

So who is TPA...

Are you a volunteer for TPA? A past president once stated that TPA is ‘whoever shows up at the meeting or conference’. An interesting thought and if you really think about it has a lot of truth in it. TPA is shaped by whoever gets involved!

I have been asked many times; how would I characterize some of TPA’s best volunteers? The answer is simple, the best leaders are the ones that ‘give time to the organization’. You can be the best clinician in the state or be the most successful psychologist in Texas but if you don’t give of your time and energy to the association it cannot grow.

Volunteers drive this association. If you don’t believe me ask your colleagues on the Board of Trustees. These folks volunteer hundreds of hours each year. I know each of you have a very busy practice but we need some members are want to get involved and make a difference. I am looking for my 43rd volunteer. Can I count on you?

I ask you to become TPA. Call me at 512-528-8400 and let me find a place for you to be part of the BEST State Psychological Associations in the country.

Plan on attending the DSM - 5 Workshop on Saturday November 16, 2013 9:00 AM - 12:00 PM at TPA’s Annual Convention It is worth 3 CE/PD Hours To review more information about DSM - 5 (See page 5.)
APA Council Meeting Report
Rick McGraw, Ph.D.
APA Council Representative

Travel to this summer’s meeting of Council (and the 2013 APA Convention) turned out to be both a challenge and an adventure for some. The tropical storm Flossie caused cancellations and delays for many Council members and convention attendees traveling early in the week. Fortunately, it lost most of its intensity before reaching Hawaii and both the convention and meeting of the APA Council schedules remained relatively intact. Unfortunately, due to travel delays, Texas was not represented at some of the pre-Council caucus meetings, although your representative was elected to chair the Caucus of State, Provincial and Territorial Representatives without being present. Absence can be risky.

Much of the Council meeting was directed toward finalizing APA governance and organizational reform. The approved motions regarding this include:

- Directing the APA President to appoint an Implementation Work Group (IWG) made up of 15-20 individuals who are a broadly representative group of leaders from diverse backgrounds and organizational perspectives and who shall include members of Council, the Board of Directors and other members who have relevant expertise and will submit recommendations to Council beginning in February 2014 for consideration as an executable plan for the following governance-specific motions approved by Council.

- Enhanced use of technology to support governance and its advisory bodies’ effectiveness, efficiency and nimbleness in addressing the future of psychology and APA. Four elements to the plan will include expanding opportunities for communication with and learning by members of governance; adding general APA members’ viewpoints into deliberations; increasing the opportunity for governance activity between face to face meetings; increasing communication and awareness about the activities of governance.

- The Implementation Work Group providing recommendations to Council for increasing opportunities for leadership participation and leadership development for governance service as well as for leadership in the general APA community.

- Creating an APA governance-wide triage system that ensures appropriate, timely and comprehensive governance response to new business items and emergent situations without duplicative efforts.

- Developing mechanisms to facilitate the focus of Council on directing and informing APA policies that are aligned with APA’s mission and strategic plan.

- Three year trial delegation of financial/budget matters; hiring, evaluation, and support of the Chief Executive Officer; assuring alignment of the APA budget with the Council approved APA strategic plan, and internal organization focused policy development.

- Change in the composition of the Board of Directors to include 6 members-at-large elected by and drawn from the general membership; 4 members elected by Council including the Secretary, the Treasurer, and two members of the new Council Leadership Team; one member elected by and drawn from APAGS membership (APAGS Past-Chair); 3 members in the presidential cycle; one member from the public appointed by the Board; and the CEO in an ex-officio capacity (and a commitment to include at least one Early Career Psychologist on the BOD).

- Restructuring of council as a constituency based model that includes disciplinary/mission based elements to support the strategic plan.
Implications for forensic assessment of psychological trauma in civil litigation

John P. Vincent Ph.D., ABPP, Ashley K. Stewart, Ph.D., Tonya Inman Ph.D., and Mary-Madison Eagle M.A.

The DSM-5:

Any and all IWG recommendations deriving from these motions must be approved by Council before implementation. Some recommendations may require APA general membership approval. In other business, Council approved new specialty designations for sleep psychology and for police and public safety psychology as well as renewed specialty designations for counseling psychology, biofeedback, school psychology, and clinical psychology. Council also approved new guidelines for the undergraduate psychology major; revised guidelines for psychological practice with older adults and revised standards for educational and psychological testing.

A resolution was approved on accreditation of programs that prepare psychologists to provide health care services that affirms that health service psychologists must be trained in American Psychological Association/Canadian Psychological Association accredited doctoral training and internship programs or programs accredited by an accrediting body recognized by the U.S. Secretary of Education for the accreditation of professional psychology education and training in preparation for entry to practice as a prerequisite for licensure for independent practice as health service psychologist. Another resolution was approved that requires psychology as a discipline to increase its efforts to advocate actively for accessible and quality HIV test counseling for all persons being tested and to encourage publication of research into the health impact and outcomes of HIV testing where test counseling is and is not available.

Telepsychology guidelines moved through the governance pipeline at a remarkable pace to receive approval at the meeting and give us the structure needed to take our place at this technology table.

Finally Council approved a consolidated policy developed by an APA member task force relating to psychologists’ work in national security settings that reaffirms the APA position against torture and other cruel, inhuman, or degrading treatment or punishment.

Please continue to support the efforts of APA, APAPO, and TPA to promote and protect the profession and practice of psychology. If anyone would like additional information regarding any of the actions or developments reported, please feel free to contact me at rmcgraw@wcc.net.

University of Houston Center for Forensic Psychology

In May, 2013 the Diagnostic and Statistical Manual-5 of the American Psychiatric Association was launched (American Psychiatric Association, 2013). In addition to changing the diagnostic landscape for practicing psychologists, the changes to many diagnostic categories will have important implications for psychologists who practice forensic psychology in civil and criminal law contexts. In this article we address cautionary concerns that generally pertain to the use of the DSM-5 in forensic matters and specific implications of changes to the trauma-related diagnoses.

Cautionary statement for forensic use of the DSM-5

As with previous versions of the DSM, the DSM-5 includes a cautionary statement regarding its use in forensic settings. While noting that the DSM-5 diagnostic criteria are intended for use in clinical contexts involving assessment, case formulation, and treatment planning, it is acknowledged that attorneys and courts rely on the DSM-5 in legal matters that pertain to the forensic consequences of psychological disorders. Given its intended use by clinicians, researchers and public health professionals, the authors of the DSM-5 included a disclaimer that it may not meet “all of the needs of the courts and legal professionals” nor provide treatment guidelines for any particular disorder.

However, it is noted that the DSM-5 may be useful in establishing the presence of a mental disorder for use in determinations like involuntary civil commitment as well as in providing a research base to assist in making legal decisions regarding the relevant characteristics of mental disorders. Furthermore, the DSM-5 may prove useful in providing a check against “ungrounded speculation about mental disorders”, a useful heuristic regarding an individual’s psychological functioning, and a framework for understanding the longitudinal course of a person’s mental functioning along a temporal course involving past or future functioning. These potential benefits for use of the DSM-5 in forensic settings are offset by concerns about potential misuse or misunderstanding of diagnostic information and cautions “awareness of the risks and limitations” of its application in forensic arenas. Forensic psychologists are well aware of fundamental differences between legal and psychological perspectives, differing definitions concerning the nature of relevant data (e.g. witness reports vs. psychological test results), and clashing epistemologies regarding matters of causation.
Consequently, the mere presence of a psychological diagnosis may not necessarily meet legal criteria for a similar construct, and information in addition to a DSM-5 diagnosis is most often required before making determinations such as level of impairment. When employed as experts, psychologists should be prepared to help the trier of fact understand these issues, and in the process help guard against untrained individuals making unfounded and inappropriate inferences from diagnostic information that is presented in judicial proceedings.

Perhaps one of the most familiar forensic psychological evaluations, the evaluation of a defendant’s competency to proceed with trial, illustrates this concept well. Although most state and federal statutes require the presence of a “mental disorder,” “mental disease,” or “mental defect,” these terms are not synonymous with mental illness or cognitive impairment as typically conceptualized by clinicians. Indeed, not even diagnoses of severe and persistent psychiatric conditions such as schizophrenia, bipolar disorder, or mental retardation will consistently meet legal standards. As such, a diagnosis based upon the DSM-5 is generally considered a necessary but insufficient condition for establishing a defendant’s lack of competency.

In order to demonstrate that a defendant lacks competency, a clinician will generally be required to highlight how the diagnosed mental illness is a substantial disorder of thought, mood, perception, orientation, or memory as well as how that diagnosed condition impairs the defendant’s judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life. Within competency evaluations, the evaluator must then describe how the impairment directly impinges on the defendant’s competency-related abilities.

Simply stating that an individual is psychotic, delusional, manic, or cognitively impaired does not establish impairment in the legal sense. As such, the evaluator’s behavioral observations and detailed description of the defendant’s functional abilities or impairment are far more relevant than the specific diagnosis of a mental health disorder. The courts may not recognize the variants of psychiatric symptomatology and resulting impairment that may be present across the same or similar diagnoses. As such, it is incumbent upon the clinician to communicate this to the courts and to provide ample information on which the courts may base their mental health-related decisions. The principles discussed in this example are also relevant to forensic evaluations occurring in other criminal domains (e.g. criminal responsibility) as well as in civil litigation (e.g. personal injury, child custody). For instance, it is not uncommon for courts to refer parents with previously diagnosed or suspected psychological disorders for parental fitness evaluations. The mere presence of a psychological diagnosis does not in and of itself tell us about the level or quality of impairment to functioning that an individual is experiencing and if such impairment even impacts the individual’s ability to parent a child. It is the responsibility of the mental health professional to assess, evaluate and communicate such complexities to the trier of fact ensuring that the diagnostic labels themselves do not become a primary consideration in legal...

### Conceptualization of trauma under the DSM-5

The changes inherent in the DSM-5 diagnostic criteria have implications for many of the diagnostic classes that are commonly observed in legal settings. One area where we are likely to see the most profound impact is in cases involving psychological trauma. Psychological trauma is a common complaint in various types of civil litigation, such as employment law (e.g. unwanted sexual advances), personal injury (e.g. a life threatening motor vehicle accident or refinery explosion), premises liability (e.g. a sexual assault at an apartment complex), or medical malpractice (e.g. a medical error resulting in permanent disability or death). Of the various psychological disorders that may be claimed in a civil suit, alleged trauma is especially appealing to attorneys since it requires a discrete event(s) as the trigger, (presumably a defendant’s conduct), and subsequent psychological symptoms that may represent compensable emotional damages if causation can be established. While many of the diagnostic criteria of the DSM-5 map on to the diagnostic guidelines of the DSM-IV-TR (American Psychiatric Association, 2000), with slightly different groupings and diagnostic clusters, the trauma- and stress-related diagnoses have significantly changed. The trauma- and stress-related diagnoses are no longer grouped among the anxiety disorders, but now constitute their own separate grouping. This change stems from that fact that, while many trauma reactions involve elements of anxiety and fear-based symptoms, individuals who are exposed to trauma more typically present with anhedonia and dysphoria, symptoms reflective of anger and aggression as well as dissociative symptoms.

A separate grouping was warranted to capture this uniqueness and variability in symptom expression. The DSM-5 also more fully elaborates on the manifestations of stress and trauma in children, both in terms of reactive attachment disorder and disinhibited social engagement disorder that are linked to early neglect as well as further explication of the children’s symptom presentation associated with Posttraumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD), specifically with children 6 years of age and younger. The adjustment disorders are also grouped under the new trauma- and stress-related disorders, since by definition they involve emotional symptoms that are the direct result of an identifiable stressor (single event, recurrent or continuous; e.g. divorce, seasonal business fluctuation, persistent painful illness or living in a high-crime neighborhood).

The next important change, and the one that has the potential for the most impact to forensic practice, concerns Criterion A – or what constitutes “trauma” for diagnostic purposes. Criterion A is especially important in forensic applications, since by definition, if that criterion is not met, there can be no trauma diagnosis even though subthreshold trauma reactions are certainly possible.

The DSM-IV-TR’s Criterion A had two prongs: a) “the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury”, and b) the person’s response involved intense fear, helplessness, or horror.
These diagnostic guidelines help establish that for diagnostic purposes there is a threshold of severity that must be satisfied before a trauma diagnosis can be applied, despite the dubious testimony of some experts that PTSD is still diagnosable in the absence of Criterion A. The DSM-5’s criterion A is notably different. Under the DSM-5, diagnosable trauma is evident only if the individual was exposed to death or threatened death, serious injury or sexual violence. Reference to the emotional reactions to a traumatic event(s) have been dropped from the Criterion A definition, although are still included under “negative alterations in cognitions and mood”. Moreover, the DSM-5 guidelines clarify the individual’s relationship to the trauma, either as directly experiencing the trauma, witnessing the trauma affecting others, learning that the trauma involved a close friend or relative (with death and threatened death, the trauma must have been violent or accidental), or repeated or extreme exposure to aversive details of the event, as with first responders.

In general, there are at least 4 implications of these changes: 1) the nature of traumatic events has been clarified and expanded, 2) sexual violence is specifically included, 3) the subjective and often difficult to assess, “intense fear, helplessness, or horror” criteria is no longer present, and 4) the nature of the relationship between the person being diagnosed and the individual(s) who actually experiences a trauma has been expanded and replace concepts like “indirect victim” or “co-victim”.

Another change involves the clarification or regrouping of the previous re-experiencing, avoidance and hyperarousal clusters. The most notable change is the inclusion of a new cluster D, negative alterations in cognition and mood. This new symptom cluster criteria allows for the recognition of important changes regarding the person’s negative mood, as distinct from “marked alterations in arousal and reactivity” that appear under Criterion E. The new symptom cluster D includes the inability to recall an important aspect of the trauma, typically due to dissociation; “persistent and exaggerated negative beliefs or expectations” about self, others, and the world; “persistent, distorted cognitions about the causes or consequences” of the trauma leading to self/other blame; “persistent, negative emotional state (e.g. fear, horror, anger, guilt or shame”; “markedly diminished interest or participation in significant activities”; “feelings of detachment or estrangement from others”; and, “persistent inability to experience positive emotions such as happiness, satisfaction or love”. While these trauma symptoms have been well documented in the trauma literature (Agabi & Wilson, 2005; Friedman, Resick, Bryant, & Brewin, 2011; Wilson, 2004), they are now included as an explicit part of the diagnosis.

Consistent with the expanded use of specifiers with other diagnoses in the DSM-5, PTSD now includes additional specifiers, in this instance those involving significant dissociation. Two types of dissociation specifiers are recognized: 1) Depersonalization, which involves a sense of detachment from oneself, a feeling as if one is in a dream state or feels a sense of unreality, or time distortions (e.g. time moving slowly), and 2) Derealization, which is experienced as a sense of unreality about one’s surroundings, such as when the world is experienced as “unreal, dreamlike, distant or distorted”. For the second specifier to be applicable, the dissociative symptoms may not be attributable to the effects of a substance (e.g. blackouts), or another medical condition (e.g. seizure activity).

These changes, particularly those within Criterion A, may mean that some “traumas” that did not meet the DSM-IV-TR criteria may be diagnosable under the DSM-5. For example, a female victim of sexual harassment who feared sexual violence due to suggestive and inappropriate behavior from a male co-worker, but did not experience the intense horror of an actual assault, may now qualify for a diagnosis of PTSD assuming that the other criteria for symptom clusters B, C, D, and E are met. This is primarily because Criterion A in the DSM-5 no longer requires that the individual specifically experiences intense fear, helplessness, or horror.

Under the DSM-IV-TR, in the absence of Criterion A having been met, these symptoms would have to have been captured as subthreshold or diagnosed as an adjustment disorder reaction, most likely with anxiety or depressive symptoms. It is also possible, although far less likely given the expanded criteria, that an individual who would have been diagnosed with PTSD under the DSM-IV-TR would no longer meet criteria under the DSM-5.

For example, an individual who was involved in a life-threatening automobile accident and exhibited intrusive, hyperarousal, and avoidance symptoms would no longer qualify for a PTSD diagnosis if their emotional reaction of fear and horror was short lived (not persistent) and the other alterations of mood and cognition were not present. Individuals who were diagnosed with PTSD under the DSM-IV-TR as a result of the unexpected death of family member or a close friend due to natural causes would also no longer meet criteria under the DSM-5 since the death must be violent or accidental.

**Forensic implications of PTSD diagnostic changes in the DSM-5**

One concern that has been expressed by lawyers and forensic mental health practitioners is the possibility that the alterations to PTSD criteria within the DSM-5 will cause an increase in frivolous civil suits, as some believe that it will now be “easier” to diagnose a broader range of individuals with a wider variety of symptom presentations and severity with PTSD.

This concern is largely based on the contention that the DSM-5 has significantly increased heterogeneity into the classification of PTSD. In light of this concern, forensic evaluators should provide particular care to document and communicate the precise psychological sequelae and functional impairments experienced by those who they evaluate. As discussed above, within the legal domain, it is the functional description of the evaluee rather than the diagnosis that is most relevant to legal decision-making.

Such concerns may be unwarranted, however, as national estimates of PTSD prevalence suggest that the DSM-5 rates may actually be lower than under the DSM-IV-TR due in part to the
The mental health professional must be cognizant of the discrepancies when utilizing measures based on DSM-IV-TR criteria. During this period of transition from the DSM-IV-TR to the DSM-5, particularly in cases involving evaluations made under the DSM-IV-TR, experts should be prepared to articulate what if any changes to diagnoses would be necessary and the implications of such adjustments to diagnoses. In other words, they need to explain why a diagnosis of PTSD based on the DSM-IV-TR may no longer qualify for diagnosis under the DSM-5, or when the opposite occurs, namely if symptoms claimed in a lawsuit that did not satisfy DSM-IV-TR criteria for diagnosis may now qualify for diagnosis under the DSM-5.

In light of the information discussed above, forensic practitioners should ensure that all diagnoses are accompanied by detailed descriptions of observable behavior and functional impairment. It is the functional impact of mental illness rather than the mental illness itself that is most often relevant in forensic cases. If evaluators utilize empirically based assessment methods, are able to describe the rationale behind their choice of measure (including any potential limitations), take care to base their opinion on the totality of the evidence rather than on a single assessment tool, and provide comprehensive descriptions of the manifestation of the evaluator’s impairments, the evaluator’s opinion will likely meet the standards of evidentiary reliability and be admissible under the guidelines set forth in Daubert v. Merrell Dow Pharmaceuticals and related state and federal rulings. More importantly, the evaluator’s opinion will likely be relevant and of assistance to the trier of fact.

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Telemedicine or telehealth technology is spreading rapidly and promises to become increasingly prominent in the future of healthcare worldwide. Telehealth programs are growing rapidly in the U.S., particularly since the technology has become more available and less expensive. At least four professional journals now focus on telehealth and telemedicine, and the literature has seen a tremendous increase in "tele-" based publications in the last decade. Programs in telestroke, teleradiology, teledermatology, and telerehabilitation are among the most commonly reported, although telepsychiatry, telepsychology, and telemental health references have seen a three- to four-fold increase in the past decade, now with over 200 such references in the PubMed database. The VA system has made wide use of telehealth services through its various outreach clinics, and Medicare's announcement in 2012 that tele-based services (albeit with some restrictions) will be covered has also helped to increase awareness and availability of distance-based healthcare services. Numerous companies now offer practitioners assistance with information, technology setup and monitoring of telehealth-based services.

The evidence base supporting the provision of mental health services using electronic means continues to grow (e.g. see Myers and Turvey, 2013, for a comprehensive review). For example, there is now good support for many of our standard psychological services (particularly therapies) being provided via video teleconference. Provider- and patient-satisfaction ratings with telemental health have consistently been high, suggesting good receptivity and acceptability. Although it may take some getting used to seeing your patient or doctor over a monitor rather than in person, adaptation is usually realized quickly, and a majority of patients and providers find it to be an "acceptable" means of service provision in many cases.

Most individuals prefer in-person interactions even if they have to travel a few hours, but distance and time are often cited as determining factors for consumers in terms of selecting telehealth-based services.

Data regarding outcome efficacy in various telemental health interventions is somewhat more limited, although research suggests similar results when compared to traditional in-person therapeutic interactions for most studies.

Most of the literature in this area has been conducted in adult and underserved populations, however, with less known about efficacy of telemental health interventions in children. Application of telehealth technology to the provision of mental health services requires a number of adaptations and special considerations (e.g. see Grosch et al., 2011). In terms of informed consent, clients must be made aware of the special circumstances that exist or may arise in the remote provision of clinical services. This includes the fact that their confidential information (visual and verbal) is being shared across a distance via electronic transmission.

This raises the possibility of inadvertent compromise of confidentiality in various ways, and implications for HIPAA also must be considered. For example, there is ongoing debate about the level of security offered by various popular internet-based videoconference applications (i.e., which ones are truly HIPAA compliant?). This merits careful exploration before services are offered, and clients must be informed of the additional potential risks of loss of confidentiality when using electronic transmission of information. Other questions that arise include: Is the transmission of data (i.e., the entire interaction during the session) fully encrypted? Is it in fact HIPAA compliant just because the vendor indicates so? Are there appropriate safeguards in place, such as firewalls, etc.? Who might have access to the information? Are third-parties involved in the process (e.g. IT personnel), and if so, what is their role and access to data? Depending upon the far-end set-up, what is the possibility of a third-party wandering into the area where the client is being seen?

The provision of mental health services using distance technology also requires that the provider be competent in this mode of intervention. Continuing education to support training in this specialized application of services is encouraged, even as preliminary guidelines are developed by the American Psychological Association and American Telemedicine Association (e.g. see their respective websites for information).

Practical issues must also be addressed, including preparedness for potential emergencies during distance-based interactions. Appropriate review of procedures with clients should be conducted, in addition to considering being given to staff availability at the far end, appropriate training in emergency situations, and IT personnel availability in the event of equipment failure should be considered.

From a diagnostic interviewing standpoint, psychological interviews appear as valid when conducted via videoteleconference as in-person, although less information exists with respect to the validity of psychological or neuropsychological assessments administered in this fashion. Preliminary studies of videoteleconference-based neuropsychological assessment have been promising in terms of patient satisfaction as well as validity of the measures that have been studied to date, although many tests have not been studied in this environment. Our research group has demonstrated the comparability of video teleconference-based and traditional in-person administration of neuropsychological tests using a brief battery of generally language-based instruments that are commonly used in dementia evaluations. This has included tests of attention, naming, verbal fluency, verbal memory, and visuoconstructional ability that required little to no modification of standard test instructions. We have also experimented with other
tasks that require the use of manipulable test materials, but such tasks require the availability of equipment for the remote client as well as alteration in instructions and in some cases, administration procedures. Our results are also limited to tests studied to date, although a list of many tests used under video teleconference conditions can be found in Cullum and Grosch (2013).

If significant modifications to procedures are required for the administration of some tests, for example, this must be noted, and the potential impact upon traditional scoring and interpretation must be understood. As such, more research needs to be done to ensure the validity of our procedures administered remotely, as some tests may require modified instructions, procedures, and/or norms, and these factors must be considered by clinicians conducting this work.

As noted above, Medicare and some insurance companies have approved reimbursement for telemedicine-based mental health services, although it is incumbent upon clinicians to verify local provider procedures along these lines.

A related issue in the provision of distance-based services is that of licensure, since many states require that the provider be licensed not only in her or his own state, but also in the state where the client is located.

As telehealth technology continues its rapid growth, opportunities for psychologists’ services will expand. Familiarity and training with these technologies, including advantages, limitations, and evidence-based support for various procedures and services, will become increasingly important for psychologists. Fortunately, many of our services are amenable to the telehealth environment, and with appropriate education and experience, we should be in a good position to help drive and participate in the provision of behavioral health and mental health services using telehealth technologies within our changing healthcare environment.

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References


There are several aspects to being a disaster volunteer, including:

1. Preparing you and your family for disasters
2. Being trained in your profession
3. Being trained in emergency responding (knowing the vocabulary and the protocols for responding)
4. Becoming a part of a response unit

First, prepare yourself and your family...

We have all learned that if we do not care for ourselves we cannot care for others. When we fly, the flight attendant tells us in the event of loss of cabin pressure we secure our own masks before assisting others. The same principle applies to disaster responding; take care of yourself and your family before attempting to assist others. For those of us who live in the gulf coast this means when hurricane season comes have disaster supplies laid in, a “go bag” ready for you and the family, and an emergency plan. FEMA (2013a) has an excellent website for building a “go bag” for your family (http://www.ready.gov/build-a-kit). Any emergency plan includes not only necessities such as water, food, and clothing, but also prescription medications, transportation (and a full tank of fuel), as well as a family evacuation plan in many areas. Families may also designate a point of contact outside the area to be a central communications point, in the event that the family becomes separated.

If you are willing to be deployed to provide support after a disaster, who will take care of your dog or other family pets? Do you have family members who are dependent on you? Do you or they have medical issues that would become relevant if you were away from home for several days? Answering these questions ahead of time allows you to be ready to help when you are needed.

Second, train in your profession ...

To respond to emergencies you need to be current with your professional license and perhaps have devoted some of your continuing education hours toward what you might encounter in disasters. Participation in disaster recovery efforts requires proof of current licensure to the entity in command of services. A copy of your license on a flash drive as part of your personal go bag will aid in proving your currency, otherwise keep a photocopy of the license in a protective cover in the bag. Assessing your own response style and ability to function in chaotic and stressful situations should be a part of your preparation.

Third, educate yourself ...

Educate yourself about disasters and disaster management, so as to develop a knowledge base of how psychologists can offer professional services in disaster planning, mitigation planning, disaster response, as well as, recovery efforts.

The National Child Traumatic Stress Network (NCTSN, No date) has an excellent field manual for psychological first aid, ranging in topics from engaging a client to linkages with collaborative services. This manual can be downloaded and copied to aid in your education. As noted in the manual after stabilization of a situation, the primary concern in any shelter situation is to emphasize safety.

Only then can an assessment of needs be done and initial attempts to connect people with resources. The City of Houston and Harris County have chosen the NCTSN Psychological First Aid Manual as a response strategy and have trained over 400 volunteers and staff to be a part of a disaster response team. There is a free on-line training available from NCTSN.ORG that would be a wonderful initial step in becoming “trauma informed” in terms of disaster response. The material is applicable to children and adults equally. Take courses in emergency management from the Independent Study Program of the Emergency Management Institute (FEMA, 2012). This program has dozens of on-line courses related to disaster response, ranging from personal readiness, to local problems, to national disasters.

The course list for the program can be found at http://training.fema.gov/IS/courseList.aspx. Helpful courses from this program include: Citizen’s Guide to Disaster Assistance (IS-7), Are You Ready? An In-depth Guide to Citizen Preparedness (IS-22), and Introduction to the Incident Command System for Healthcare/Hospitals (IS-100.HCb).
How does that broken leg make you feel...

The federal government developed a National Response Plan that sets the framework for development of our national resources and response to disasters, whether natural or manmade (FEMA, 2013b). While fairly technical, the plan is worth reviewing to get a sense of the many aspects of developing our nation in emergency responding.

If you are going to become a disaster volunteer, perhaps the most important courses to take initially are those that provide the common vocabulary for emergency responders. One lesson we learned from the terrorist attack on the United States in 2001 was that first responder groups could not talk to one another; literally, the communication systems were incompatible, causing confusion, lack of coordination, wasted effort, and loss of lives. Not only were communication systems incompatible but the command and control systems and language were not consistent among responding agencies, resulting in confusion, lack of coordination, wasted effort, and loss of lives. In radio communication the federal government adopted a new communications protocol, which, when fully implemented, will allow all first responders to communicate more effectively and with each other. As for the problem of command and control (who provides what, when, where, and how) the federal government proposed a single system that was applicable to all emergency response and was scalable to all disasters, the Incident Command System, or ICS for short. The ICS is adaptable from the smallest of incidents to disasters as large as the response and recovery to Hurricane Katrina.

Fourth, join a response group...

Henry Ford built his fortune by making his cars affordable to the middle class through application of a principle that we all know; group effort. Group effort produces results more efficiently and effectively than individual effort. Joining a disaster response group is better than attempting to respond individually to disasters.

Psychologists have a unique contribution to any disaster response organization. Making our expertise available in all response groups is an important way our profession can participate in disaster response to make our population safer and more resilient.

There are many groups which psychologists can join and use their varied skills, from the local level to national response groups. Experience with disaster response has shown that people who want to help and “just show up” are often more of a hindrance than a help.

Newtown, Connecticut was overwhelmed by people who wanted to help after the Sandy Hook Elementary School mass murder which resulted in the deaths of 20 children and 6 adults. As one responder put it, “How many teddy bears can one town use?” Being a part of an established response team and respecting the Incident Command Structure is vital to effective responding. At any disaster site one may encounter volunteers from many groups, all of which need to be deployed in a coordinated fashion. Depending on their interests and available time, there are many organizations that provide information and opportunities for psychologists to become involved.

American Red Cross. The American Red Cross (ARC) welcomes all individuals, including professionals, provides training, and assigns volunteers when disaster strikes. Each community has an ARC structure available to professionals to decide what they can contribute locally, as well as regionally and nationally. The ARC is not just about blood drives. Medical Reserve Corp. At the national level the Medical Reserve Corp (2011) seeks volunteers who are professionally trained, provides support in the form of training and organizes those volunteers into units for response disasters.

National Preparedness Community. There is a National Preparedness Community (FEMA, 2013c) which has as its motto, “connect, collaborate, educate, and empower” and is designed for the general public but which welcomes professionals to join. This group works toward better community preparedness through education and collaboration.

Psychology’s Own Disaster Response Networks. The American Psychological Association has a disaster response network (APA, 2013a) described as a group of approximately 2,500 licensed psychologists with training in disaster response. These psychologists offer volunteer assistance to relief workers and survivors following disasters.

These professionals help responders and survivors employ their own coping skills and resources, assisting them to problem solve, making referrals to community resources, by advocacy, and listening. The APA (2013b) also maintains information on disasters as part of the help center. As described in the companion article, the Texas Psychological Association has a very active disaster response network with liaison in local area societies. In addition to Dr. Hamlin’s article, the TPA website provides an excellent description of the activities of that group as well as direction on how to join.

Texas State Guard. The Texas State Guard Medical Brigade (2011) is part of the Texas Military forces, provides training, and during disasters is deployed only in Texas by order of the Governor. Recent deployments of the Texas State Guard were during Hurricane Alex in June, 2010, in the Rio Grande Valley where the State Guard assisted in opening 14 evacuation shelters and for shelter operations during the wildfires fires in Bastrop in September and October, 2011. Prior military experience is not required and all helping professionals are welcomed to the Medical Brigade, which has units throughout Texas. The Medical Response Groups have monthly drills with a week-long annual training deployment to the Rio Grande Valley to set up and operate clinics that provide medical care to underserved persons in that part of the state. The
State Guard has a military structure, uniforms, and operates as any military organization with the exception that all deployments are voluntary and units are typically not requested to deploy for disasters in their geographic area. When deployed on state active duty members receive a stipend, room, and board.

**IN CONCLUSION...**

We are entering a new age of preparedness as individuals and families, as communities, and as a nation. Psychologists have the knowledge and skill to assist in this move toward better readiness to respond. Volunteering ourselves and our expertise to help others in time of need is no less than what we should do as a profession.

**References**


**TPA/DRN 2012-2013**

Rebecca Hamlin, Ph.D.

It has been more than 20 years since the American Psychological Association (APA) entered into a Memorandum of Understanding (MOU) with the American Red Cross. This collaborative document led to the establishment of the APA Disaster Response Network (DRN) in 1991. That MOU along with similar MOUs between other mental health (MH) professional organizations and Red Cross has led to thousands of MH volunteers becoming a vital part of disaster response in our country. In addition to the Red Cross, MH professionals trained in disaster response can now be found in numerous other non-governmental volunteer organizations as well as in local, state, and federal governmental agencies. We have responded to hurricanes, floods, earthquakes, tornadoes, house fires, wildfires, mass fatalities, active shooters, and explosions (both accidental as well as terrorist-driven). We have provided support to responders as well as victims and their families. What was 20 years ago “a good idea” has now become an integral piece in promoting resiliency for our communities. Texas Psychological Association’s (TPA) DRN is part of and supports this larger response network. TPA/DRN is both a Special Interest Group (SIG) and designated committee of the TPA.

In light of the recent discussions on diversity training in Texas with new requirements for additional CEUs recently established by our state board, it appears relevant to look at diversity in disaster response. Disaster responders have always acknowledged the need for sensitivity in this area – diversity that goes beyond the more obvious concerns to include the diversity of our states, regions, and local communities. 2012 and 2013 brought us two very different incidents that could not be better examples. In late October, Hurricane Sandy hit the shores of New Jersey, one of the most populous areas of the United States. Hurricane Sandy was the second-costliest hurricane ever recorded in the United States and the largest storm every recorded in the Atlantic. More than 200 people were killed either directly or indirectly by this storm. An area not as familiar as the Gulf Coast with hurricane preparedness, our Northeast struggled to find its bearings. Neighborhoods rich in diverse cultures and faiths had to quickly come together in the recovery.

MH professionals from the South, well-versed in hurricane response, were faced with navigating more than downed power lines and the typical challenges of mega-shelters. Nevertheless, there was a sense of community, even when the day-to-day social connectedness may have been less easily identified.

Compare that with West, TX, a small community of 2800 people. Fourteen people died in the explosion of April 17th, a number of them first responders. A small number in comparison to Hurricane Sandy, but no less profound. West is a community of tough Texas people, largely of Czech heritage. Fiercely independent and typically resilient, everyone in West was affected. If not related, each resident knew someone who was lost in the explosion or who lost their homes or livelihood. MH responders were charged with helping this rather private community with their recovery in the face of national attention.
These two incidents were vastly different but both required our first responders to be “experts” in diversity. By all accounts, our DRN members met this challenge and we are deeply grateful. Perhaps not the diversity training we think about when we consider therapeutic interventions, but diversity nevertheless. This past year has brought successes in other areas as well. One such success was our Texas legislators passing HB 746 under the sponsorship of Representative Ashby with strong support by TPA. HB 746 is the Texas version of the Uniform Emergency Volunteer Health Practitioners Act that offers civil liability protections for professional volunteers, including psychologists, who come into our state temporarily during declared disasters. Texas joins 14 other states in this efforts including surrounding states of New Mexico, Colorado, Oklahoma, Arkansas, and Louisiana. This level of regional cooperation is vital during disasters as costly national deployments may be hampered by budgets as well as the logistics of moving volunteers in large-scale disasters.

Finally, the Texas DRN remains committed to communication as well as to the training and development of our TPA members in disaster response.

Although largely volunteer, disaster response is a specific area of expertise. We encourage you to get this training and join our DRN. There is no obligation to respond. Nevertheless, we are faced far too frequently with disasters that pull on our professional heartstrings to help. Responding, even with “just-in-time” training is often inadequate, leaving MH volunteers and their families ill-prepared for what lies ahead. Please consider being a part of the preparedness and get your training today. If you need further information, please contact you TPA/DRN Co-Coordinators, Dr. Judith Andrews (judithphdjudith@yahoo.com) or Dr. Rebecca Hamlin (rj.hamlin@earthlink.net). We will be happy to assist you. A special thanks to Dr. Andrews for her valuable input on the West, TX response. Dr. Andrews responded to West and, as always, represented us well. We would also like to thank all of our responders – you help make our communities strong.

We would like to leave you with some recent resources courtesy of APA/DRN:

**Communication/Technology**

**Tips and Tools**

- **WeatherChannel:**
  - WeatherChannel App
  - Weather on-the-go
  - [http://www.weather.com/services/mobilesplash.html](http://www.weather.com/services/mobilesplash.html)

- **SAMHSA:**
  - GO2AID App
  - A mobile app that will make it easy to provide quality disaster behavioral health support to survivors. Provides access to resources for any type of traumatic event that can be instantly accessed online or pre-downloaded in case of limited internet connectivity in the field. Also provides preparedness materials for review and can send information to colleagues and survivors via text message, email, or transfer to a computer for printing. This app is not available as of yet, but you can sign up to be notified via email as soon as it is.
  - [http://store.samhsa.gov/apps/go2aid/?WT.ac=EB_20130812_go2aid](http://store.samhsa.gov/apps/go2aid/?WT.ac=EB_20130812_go2aid)

- **VueToo.com:**
  - National Hurricane Situation Page 2013
  - Instant access to real-time information intercommunication across official department lines (government agencies and businesses during emergencies).

**Culture**

- **HelpAge International:**
  - Older People in Emergencies
  - Provides tips concerning the elderly and how to care for them and help them cope after disaster.

- **FEMA:**
  - **FEMA & NAACP:**
    - Partnering to Empower Preparedness for All
    - An article that describes the recent partnership between FEMA and the NCAAP.

**Articles**

**General Resources and Articles:**

- **Kentucky Community Crisis Response Board:**
  - KCCRB Resource Library
  - Information and resources on managing disaster related stress, resiliency and talking to children.
  - [http://kccrb.ky.gov/resources/](http://kccrb.ky.gov/resources/)

- **The National Preparedness Community:**
  - A site that focuses on regional information for disaster preparedness and provides an opportunity to connect with local discussions and events.
  - [http://community.fema.gov/connect.ti/READYNPM](http://community.fema.gov/connect.ti/READYNPM)

**Articles:**

- **Shareable: Cites:**
  - San Francisco’s Mayor Lee Launches Sharing Economy Partnership for Disaster Response An article that details a new partnership between San Francisco’s Department of Emergency Management and BayShare, a sharing economy advocacy group in the San Francisco Bay Area whose mission is to make the Bay Area the best place on the planet for sharing.
  - [http://www.shareable.net/blog/san-francisco-mayor-launches-sharing-economy-partnership-for-disaster-response](http://www.shareable.net/blog/san-francisco-mayor-launches-sharing-economy-partnership-for-disaster-response)

- **The Behavior Therapist:**
  - Ethical Issues in Disaster Response: Doing No Harm, Doing Some Good (pg. 132-137)
  - [http://www.abct.org/docs/PastIssue/35n7.pdf](http://www.abct.org/docs/PastIssue/35n7.pdf)
  - The California Psychologist July/Aug 2013 issue: (written by DRN Members Rick Allen and Chip Schreiber)

- **Toward the Way Forward in Disaster Mental Health:**
  - The Contribution of an Evidence Based Rapid Triage and Incident Management System: PsychSTART
Early Career Psychologist...

David Hill, Psy.D.

Early Career Psychologist Special Interest Group Chair

recently about your application, please get back in touch! It is likely that your email to me was deleted, and I would like to get you matched with a mentor. In addition to the mentor program, the ECP Special Interest Group and the Student Division present workshops and symposia at TPAs annual conference. This year’s symposium covers the development of training goals and professional identity after graduate school and internship. We have a panel of psychologists and ECPs from a broad range of settings and training backgrounds who will answer questions about career development. Please come out to the symposium and bring your questions! Last year’s conference included a similar panel plus a presentation on the Texas State Board of Examiners of Psychologists, licensure, and the oral exam that I found to be extremely helpful. Please feel free to email me with ideas for topics that you would like to see covered at future conferences. Additionally, please introduce yourself if you see me wandering the halls during the conference in November. I’m always happy to meet new people, and I love hearing ideas of how we can use the vehicle of the ECP Special Interest Group to assist our members. I do have two future projects in the works. There isn’t much currently available on TPAs website specifically for ECPs. However, there is a wealth of resources available on the Internet. I plan on collecting the best of these resources and having a webpage created for ECPs on TPAs website. This page will function as a “best of the web” resource page for ECPs. Please let me know if you have any favorite resources that you would like to see included.

Regional meetings are another project that I would like to see come to fruition. I enjoy community and building a sense of community. I think that networking with each other in person can be extremely beneficial in the early stages of our careers. Having occasional meetings in a casual environment where we can share a meal and talk about our professional goals and challenges will give us all the opportunity for support as well as additional professional opportunities. I am located in Austin and will begin hosting occasional ECP meetings in 2014. I would like to hear from you if you are interested in being a regional representative for the ECP Special Interest Group. I would like us to create a community in which we can be of mutual assistance and support to each other. Let me know how I can best be of service to you as you move toward the establishment of a prosperous and rewarding career in psychology.

Lone Star State leads the way in national efforts to heal the invisible wounds of war...

South-Central Texas is now the epicenter of national efforts to alleviate posttraumatic stress disorder (PTSD) and related conditions among military service members and veterans. This development was made possible by $45 million in funding recently awarded by the U.S. Departments of Defense (DoD) and Veterans Affairs (VA) to establish the STRONG STAR Consortium to Alleviate PTSD, or STRONG STAR-CAP. Led by The University of Texas Health Science Center at San Antonio and the VA National Center for PTSD, STRONG STAR-CAP builds upon the substantial infrastructure and broad array of clinical trials already in place in South-Central Texas under the umbrella network led by the UT Health Science Center, called the South Texas Research Organizational Network Guiding Studies on Trauma and Resilience, or simply, STRONG STAR. The new STRONG STAR-CAP award effectively establishes the largest network of expert civilian, military, and VA researchers and clinicians with specialization in trauma-related disorders and creates unprecedented potential to advance the prevention, detection, diagnosis, and treatment of combat-related PTSD and co-occurring conditions among our nation’s war fighters.
Considered one of the invisible wounds of war—and one of the signature wounds of the wars in Iraq and Afghanistan—PTSD is a potentially debilitating psychiatric disorder that develops after exposure to a traumatic event such as death or threatened death, injury, or sexual violence. According to the recently published fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), PTSD is characterized by re-experiencing symptoms (e.g., nightmares, flashbacks, ); avoidant behaviors (e.g., effortful avoidance of trauma reminders); negative mood and cognitions (e.g., distorted blame, inability to experience positive emotions); and increased arousal (e.g., sleep disturbances, hyper-vigilance) that are present for more than one month and cause significant functional impairment or distress. Since 2001, approximately 2.5 million U.S. military personnel have deployed to Iraq and Afghanistan in support of Operation Iraqi Freedom (OIF), Operation Enduring Freedom (OEF), and Operation New Dawn (OND). Recent findings suggest that approximately 14 percent of this population, or approximately 350,000, U.S. service members returning from deployments, report symptoms of PTSD, and as many as 25 percent report some type of psychological problem.

The impact of PTSD on our nation’s military is particularly salient in Texas, where a significant proportion of active duty, reserve, and guard troops reside. In fact, Texas is home to Fort Hood, the largest active duty armored post in the United States Armed Services. More troops have deployed to Iraq and Afghanistan from Fort Hood than from any other military installation. In addition, San Antonio, Texas, is affectionately known as “Military City, USA” given the city’s deep connection with the military. For instance, the city is home to the DoD’s largest military installation, Joint-Base San Antonio, which includes the DoD’s largest inpatient medical facility, San Antonio Military Medical Center, and largest outpatient surgery center, Wilford Hall Ambulatory Surgical Center. In addition to its leadership in medical treatment, the San Antonio Military Health System (SAMHS) is the center for military graduate medical education and training while simultaneously providing state-of-the-art research and maintaining a first-class global readiness mission. Given the extensive presence of the military in South-Central Texas, the STRONG STAR-CAP is primed to effectively address combat-related disorders in our service members and veterans.STRONG STAR Programs Already Underway

The STRONG STAR Multidisciplinary PTSD Research Consortium was originally founded in 2008 with approximately $35 million in funding from the DoD’s Psychological Health and Traumatic Brain Injury Research Program. Under the leadership of the UT Health Science Center and STRONG STAR Director Alan Peterson, PhD, the consortium has brought together the expertise of a world-class team of more than 125 military, civilian, and VA investigators at more than 20 partnering institutions. These highly qualified researchers and clinicians have combined expertise in PTSD, neuroscience, genetics, comorbid conditions, traumatic brain injury, suicide, medical trauma, and research in military settings, as well as “boots on the ground” experience in assessing and treating combat-related PTSD. The majority of STRONG STAR studies are led by psychologists who are evaluating the efficacy of various cognitive-behavioral treatments for combat-related PTSD. Importantly, the consortium has also established research operations within Carl R. Darnall Army Medical Center at Fort Hood, the San Antonio Military Health System, and the South Texas Veterans Affairs Health Care System. STRONG STAR’s broad expertise and its success in developing strong military and VA partnerships are enabling the development and evaluation of PTSD treatment programs designed to be relevant, effective, and feasible in military and VA settings. To date, consortium investigators have launched a broad array of clinical, exploratory, and preclinical trials, with the support of specialized research cores, to evaluate, for the first time, the leading civilian PTSD treatments with active duty military personnel and recently discharged veterans. Simultaneously, the consortium is looking at the biological influences on PTSD; the influence of comorbid physical and psychological ailments, such as traumatic brain injury, chronic pain, substance use disorders, sleep disorders, and suicide risk; and the interaction of cognitive-behavioral therapies and pharmacologic treatments. Current STRONG STAR investigations include 14 studies from the original consortium grant in 2008, along with nearly a dozen new affiliated projects that have been separately funded by various federal agencies.

Lone Star State leads the way in national efforts to heal the invisible wounds of war

Prior to the formation of STRONG STAR, PTSD treatments studies were exclusively conducted with civilians and veterans from prior war eras within the Veterans Affairs Health System. In fact, no clinical trials of treatment for combat-related PTSD in active duty military personnel have been published, leaving myriad questions as to how best to use the evidence-based therapies for the treatment of PTSD in military personnel. Since VA-based studies have typically included veterans who served in the Vietnam War, questions also remain about why some treatments that are effective with civilians have not been as successful with veteran populations. Is PTSD among veterans more difficult to treat because it is combat-related, because too much time has passed since its onset, or because there may be compensation benefits associated with the diagnosis of PTSD? The primary aim of STRONG STAR has been to inform, develop, and evaluate the most effective early interventions possible for the detection, prevention,
Lone Star State leads the way in national efforts to heal the invisible wounds of war

PTSD and Alcohol Dependence (PI: John Roache, Ph.D., University of Texas Health Science Center at San Antonio).

Alcohol dependence is another condition that co-occurs frequently in combat veterans with PTSD. Another STRONG STAR randomized clinical trial is examining how comorbid alcohol dependence impacts the effectiveness of selective serotonin reuptake inhibitors (SSRIs), the only FDA-approved medication for the long-term treatment of PTSD, when used in combination with cognitive-behavioral therapy. As part of this currently ongoing study, researchers hope to identify baseline predictors of response to SSRI treatment, including subtypes of alcohol dependence, which could provide clinicians a valuable tool to assess who would benefit from such therapy and who would be neutrally or even negatively affected by it.

Couples Therapy for PTSD (PI: Candice Monson, Ph.D., Ryerson University).

Recognizing the impact that an individual's PTSD can have on relationships with loved ones, as well as the importance of social support in a patient's effort to recover from the disorder, STRONG STAR researchers have recently launched a randomized clinical trial to examine the efficacy of Cognitive-Behavioral Conjoint Therapy (CBCT) in treating a sample of active-duty military personnel with combat-related PTSD. CBCT includes behavioral communication skills training in addition to psychoeducation and cognitive interventions based on Cognitive Processing Therapy. This study is comparing traditional PE, which involves only the individual service member, to CBCT, which involves the service member and his or her spouse. Because the CBCT protocol addresses both individual and couple-level distress, researchers expect to see greater improvement in couple functioning with this treatment as they explore the role that military spouses can play in PTSD treatment and recovery.

Prolonged Exposure for PTSD (Principal Investigator [PI] Edna Foa, Ph.D., University of Pennsylvania).

With a large body of evidence showing that PE can be used to treat PTSD effectively and efficiently, one randomized clinical trial by STRONG STAR seeks to determine if it can be delivered even more efficiently so as to better serve the needs of military patients. This study was designed to determine if the timeframe can be condensed into a massed format without decreasing the treatment's efficacy. With recruitment currently ongoing, response to treatment has been promising and preliminary findings suggest massed treatment may offer a valuable option for military personnel.

Cognitive Processing Therapy for PTSD (PI: Patricia Resick, Ph.D., National Center for PTSD in Boston).

STRONG STAR is also exploring the most efficient way of delivering CPT, another gold standard treatment for PTSD. A two-phase randomized clinical trial is testing the efficacy of CPT for the first time with active-duty military personnel. Phase 1 of this study compared group-administered CPT to a present-centered supportive group therapy, and data collection for this study is complete. Investigators are preparing final results for presentation at a national conference this November, with manuscript development to follow. Phase 2, currently in progress, is comparing the delivery of CPT in individual versus group settings to determine if this more efficient delivery method maintains its efficacy. Study completion is anticipated within one year. Willingness of service members to participate in group treatment has been highly positive, and anecdotal evidence suggests that participants find the supportive nature of the group setting to be beneficial.

PTSD and Chronic Pain (PI: Robert Gatchel, Ph.D., University of Texas at Austin).

Because orthopedic trauma can frequently lead to comorbid pain and PTSD symptoms, and because research suggests that patients coping with both chronic pain and PTSD symptoms respond poorly to treatment targeting only one diagnosis, one particularly novel investigation by STRONG STAR is examining the effects of combining preventive pain and PTSD treatments for trauma patients. Findings will address the hypothesis that treating individuals with chronic pain and PTSD symptoms through a proven psychosocial model will help to improve psychological, socioeconomic and physical symptoms; facilitate the return to active duty of military personnel; and have a positive impact on other psychosocial and socioeconomic outcomes such as work retention, additional health-care utilization, depression symptoms, health-related quality of life, and perceived disability.
A group of STRONG STAR investigators has developed a condensed cognitive-behavioral therapy (CBT) for PTSD that can be implemented by mental health providers working in an integrated primary care setting. It is believed that treatment in this setting might be better utilized by patients than treatment at a mental health clinic because of its more discreet nature and decreased stigma, and because the shorter sessions would more easily fit into a busy work schedule. A pilot study has been completed, and preliminary results have been published that indicate that this treatment delivery method is well received by military personnel; it is efficacious in reducing PTSD symptoms; and it can be used to effectively treat various levels of symptom severity, from sub-clinical symptomatology to PTSD diagnosis with mild to moderate severity. The success of the pilot study led to enhancement of the treatment protocol and implementation in a currently ongoing randomized controlled trial that seeks to replicate and improve upon the positive results of the pilot study. Study completion for the randomized trial is anticipated in early 2014.

The military’s long-standing policy on mental health therapy during combat deployment is that brief treatment should be provided near the battlefield and as soon as possible to increase the likelihood of a positive outcome. In addition, more than 500 military mental health professionals have been trained to provide PE and CPT. However, little to no research has been conducted on the use of early interventions for PTSD with active-duty military personnel serving in a deployed setting, where the unique environment could impact both the delivery and outcome of treatment. A STRONG STAR pilot study, near completion, has allowed researchers to collect and evaluate outcome measures of deployed U.S. military personnel who show symptoms of combat operational stress reactions, including PTSD and acute stress disorder, and who receive CPT or PE therapy from military mental health providers in Iraq and Afghanistan. Researchers are assessing the reduction in symptoms upon completion of therapy and how well treatment gains are maintained after 3- and 6-month follow-up periods. Their findings will provide much-needed insight on the efficacy of the leading non-pharmacologic treatments for stress-related disorders when delivered “in theater.” They anticipate positive results that will lead to a randomized clinical trial.

Due to the significant overlap between PTSD and a painful rheumatic disorder known as fibromyalgia, one STRONG STAR exploratory study seeks to determine whether it is important to assess for fibromyalgia in active-duty military personnel with PTSD. As part of this currently ongoing research effort, PTSD patients enrolled in STRONG STAR clinical trials are screened for fibromyalgia. Investigators will then calculate the prevalence of fibromyalgia among PTSD patients and observe its influence on their prognosis. The prevalence of fibromyalgia among patients’ spouses is being similarly investigated, as researchers look for secondary familial consequences of PTSD. Study findings could shed light on yet another painful effect of PTSD and reveal additional complications for health care professionals to consider when treating PTSD or fibromyalgia.

The STRONG STAR genetics study has collected pre-deployment data and biological samples from over 4,000 service members and is currently in the process of contacting these participants post-deployment. To date, over 1,000 service members have been interviewed and have provided blood samples during the follow-up phase of this groundbreaking effort.

STRONG STAR’s sole preclinical trial is testing the hypothesis that early life stressors cause alterations in the expression of genes, specifically genes that regulate hypothalamic-pituitary adrenal (HPA) axis activity, and that these genetic changes increase an individual’s susceptibility to PTSD following a traumatic event in later life. The HPA axis is an important component of the neuroendocrine system that regulates several bodily functions, including response to stress. Overarching research efforts focus on identifying a molecular link between early environment, gene expression, and susceptibility to PTSD. Researchers published a manuscript in the journal Neuroscience (Green et al., 2011) reporting results of their study on the development of a rat model for PTSD to examine prenatal stress as a factor in vulnerability to adult stress. Findings indicate that prenatal stress exacerbated the...
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negative effects of adult stress, and maintained fear after conditioning. Results suggest potential mechanisms of vulnerability to stress-related psychiatric disorders, such as PTSD, and their treatment. A subsequent manuscript published in Neuropharmacology (Roth et al., 2012) that further validated a Chronic plus Acute Prolonged Stress (CAPS) treatment for rats as an animal model of relevance to PTSD. Combined with their results reported previously, the group’s findings suggest that CAPS impairs fear extinction, shifts coping behavior from an active to a more passive strategy, increases anxiety, and alters HPA reactivity, resembling many aspects of human PTSD.

Epidemiological Research (PIs: Jim Mintz, Ph.D., and Stacey Young-McCaughan, RN, Ph.D., University of Texas Health Science Center at San Antonio; Brett Litz, Ph.D., VA Boston Healthcare System).

STRONG STAR is capitalizing on the data collected through these research trials to address ongoing and future research endeavors through the development of the STRONG STAR Repository, a comprehensive database of clinical and biological information collected from consenting STRONG STAR study participants. Data such as self-assessments, epidemiological information, treatment outcomes, neuroimaging, genetic information, and other valuable measures are collected from consenting participants. Two studies utilizing this approach are currently underway. The first study aims to identify risk and resilience variables that predict the trajectory of service members over time as they adapt to war-zone trauma and/or respond to PTSD treatments. A second study will utilize repository data to investigate the relationship between comorbid insomnia and pain, and whether comorbid insomnia and/or pain have a negative effect on participants’ response to PTSD treatment. The long-term objective of the repository is to make this valuable resource widely available to support future investigations by other researchers exploring questions about combat-related PTSD.

STRONG STAR Affiliated Studies and Future Efforts

Seeing the STRONG STAR Consortium’s ability to successfully implement research within several large military medical systems and the impressive scope of expertise of the Consortium collaborators, civilian and military researchers have sought opportunities to partner with STRONG STAR to conduct additional research in areas related to PTSD. Capitalizing on the STRONG STAR infrastructure, affiliated investigators have launched new studies further examining PTSD and a variety of related topics. A sampling of active or soon-to-launch affiliated studies include the following:

- A brief cognitive-behavioral intervention for managing suicidal behaviors in military settings (PI: David Rudd, Ph.D., University of Memphis)
- The role of exercise in the treatment of PTSD symptoms (PI: Stacey Young-McCaughan, RN, Ph.D., University of Texas Health Science Center at San Antonio)
- An epidemiological study to inform the proper diagnosis of traumatic brain injury, PTSD, and acute stress disorder in patients exposed to IED blasts (PI: Lt Col Monty Baker, Ph.D., RAF Alconbury, UK)
- The delivery of existing evidence-based PTSD treatments in varying doses in an effort to tailor treatment to patient needs and improve outcomes (PI: Patricia Resick, Ph.D., National Center for PTSD in Boston)
- The delivery of evidence-based PTSD treatments in patients’ homes or via telehealth to increase access and reduce concerns about stigma (PI: Alan Peterson, Ph.D., University of Texas Health Science Center at San Antonio)
- An evaluation of whether the adoption of dogs as pets benefits veterans with PTSD symptoms (PI: Steven Stern, M.D., South Texas Veterans Healthcare System)
- An epidemiological study to evaluate factors related to the aeromedical evacuation of U.S. military psychiatric patients from Iraq and Afghanistan between 2001-2013 (PI: Lt Col Monty Baker, Ph.D., RAF Alconbury, UK)

STRONG STAR-CAP

Recognition of STRONG STAR’s success to date and its tremendous future potential to improve the lives of wounded war fighters came in August, when President Obama announced the establishment of the STRONG STAR Consortium to Alleviate PTSD (STRONG STAR-CAP). The new consortium is part of a National Research Action Plan for Improving Access to Mental Health for Veterans, Service Members, and Military Families. This plan builds upon work already underway in federal agencies to provide a framework for improved coordination across governmental organizations with scientists from the academic and industrial sectors to share information, brainstorm innovations, and accelerate science.

The $45 million award for STRONG STAR-CAP includes approximately $20.3 million to the UT Health Science Center San Antonio as coordinating center for STRONG STAR-CAP. In addition, the Department of Veterans Affairs has committed to provide up to $25 million over five years for the consortium. The CAP award
The Lone Star State leads the way in national efforts to heal the invisible wounds of war. For STRONG STAR-CAP, the original STRONG STAR consortium has partnered with the seven divisions of the National Center for PTSD and other VA, military and civilian investigators and institutions across the world to establish the largest research consortium in history dedicated to the alleviation of combat-related PTSD. STRONG STAR-CAP will be led by Consortium Director Alan Peterson, Ph.D., in the School of Medicine at the UT Health Science Center, and Co-Director Terence Keane, Ph.D., of the National Center for PTSD, VA Boston Healthcare System. Dr. Keane will serve as the primary director for all of the CAP’s VA research projects.

The overarching aim of all STRONG STAR-CAP initiatives will be to develop the most effective diagnostic, prognostic, novel treatment, and rehabilitation strategies to treat acute PTSD and prevent chronic PTSD.

Clinical trials will be conducted to develop programs to treat the largest percentage of service members possible to the point of remission or recovery so that they can remain operationally and functionally fit for military service. The clinical trials will also recruit prior-service veterans to allow them to regain their full potential for social and occupational functioning.

In keeping with the National Research Action Plan, STRONG STAR-CAP also will focus on the interplay and alleviation of commonly co-occurring conditions, and substantial efforts will be made to learn more about the biology and physiology of PTSD development and treatment response. Specifically, investigators will explore the association between genome sequences and elevated risk for mental health conditions; study and identify brain circuitry changes related to positive treatment response; and identify potential predictive or diagnostic biomarkers for PTSD through both genetic and clinical studies. Findings will be used to inform diagnosis, prediction of treatment outcome, and new or improved treatment methods.

Through expected scientific advances in our understanding of the best methods to diagnose, prevent and treat combat-related PTSD and co-occurring conditions, STRONG STAR and STRONG STAR-CAP investigators’ ultimate aim is to reduce the suffering of our nation’s warriors, helping them continue to live healthy and productive lives. This, in turn, should contribute to the resilience of our armed forces and could potentially save the federal government billions of dollars each year in direct healthcare expenses and disability payments.

The peer-reviewed funding to support the original STRONG STAR Consortium, additional STRONG STAR-affiliated projects, and STRONG STAR-CAP brings the total research funding for STRONG STAR to over $100 million.

For more information on STRONG STAR and all its research initiatives: visit www.strongstar.org.

By Julie Collins, B.A., Tabatha Blount, Ph.D., Antoinette Brundige, M.A., Ann Marie Hernandez, Ph.D., Cindy McGeary, Ph.D., and Alan L. Peterson, Ph.D.

As a reminder, the Texas Psychological Association urges all Psychologists to make sure that they have completed the mandatory CE/Professional Development requirements before the current biennial licensure period ends on November 30. Psychologists who need more hours of CE/Professional Development for this renewal period may want to attend TPA’s Annual Convention in Houston, TX at The Westin Galleria. Psychologists and students may register at any time between now and the convention. Visit: www.texaspsyc.org for more information.
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