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A NOTE FROM THE PRESIDENT

Strength Training for Professional and Organizational Resiliency

CHERYL HALL, PH.D., M.S. PSY.PHARM.
Independent Practice, Lubbock, TX

As the end of 2018 quickly approaches, I am thinking back on all that has occurred during this “interim” year. An interim year is the year between legislative sessions when legislators are in workgroups addressing interim “charges” from the previous session. This involves gathering data, doing research, talking to experts, and having public hearings to work on solving complex issues in our state. Many of these charges have involved mental health issues. TPA solicited members with relevant expertise to provide written and oral testimony on prevention of violence in schools and how to better provide mental health services for foster children, just to name two of these opportunities.

In preparation for the 2019 legislative session, TPA leaders have also been meeting frequently to discuss the ongoing attempts to consolidate our board. It was evident from the most recent TSBEP meeting that they are already starting the planning to set up a consolidated board, as if it is a foregone conclusion. Our Government Relations (GR) consultants and key contact psychologists are working with Sunset Committee members, along with the LMFT, LPC, and LCSW groups supporting consolidation to educate them about how and why TSBEP should maintain independence and why the consolidation bill, as written, will result in a loss of authority for ALL of the boards.

The rule change by TSBEP to allow Licensed Psychological Associates (LPAs) to practice independently is even more alarming than the consolidation threat, according to many psychologists I have talked to recently. According to TSBEP, a recent survey of 2,700 respondents overwhelmingly indicated that LPAs should practice independently and TSBEP has decided not to pursue any type of competency standards. We appreciate every TPA member’s effort to respond to that survey with the resounding message that the entry level for independent practice in psychology is a doctoral education, with the training, supervised experience, and requisite competency evaluations that occur along the way.

Our lawsuit against TSBEP is underway as one avenue to address this inappropriate rule change that has a profound effect on our profession, including our doctoral training programs, and internship sites. Even more critical, this rule change puts the public at risk from LPAs who profess to provide any and all services that psychologists offer. There are many ways to increase providers in underserved areas and address the negative effects of the workforce shortage without sacrificing the quality of care our patients receive. Psychologists who employ LPAs can provide more services. Telehealth services are emerging as a key avenue to provide supervision to LPAs in extremely rural areas. Providing incentives for independent mental health providers of all backgrounds to set up practice in rural areas is another strategy. In fact, many LPAs are dually licensed as Licensed Professional Counselors and can practice independently already. Wanting to practice independently as an LPA instead does not result in increased services provided; its purpose appears to be primarily to gain a perceived status boost in use of the term “psychological” in the title.

Regardless of the outcome of TPA’s lawsuit against TSBEP, we will also address the LPA issue with two other strategies. The first is through legislative action. The second is to get psychologists appointed to TSBEP who will not allow the threat of an anti-trust lawsuit to inform their decisions.

What about other legislative agenda initiatives for 2019? First, building on the support from last session, we will keep pushing for a bill to protect us from civil liability if we act on our duty to warn. The legislative process is designed to kill bills and we simply ran out of time to get the bill through the whole process last session. Second, we are working to exempt psychologists who already have expertise in treating sexual offenders from having to obtain additional training and a certificate to do so. Finally, we are continuing to work on getting bipartisan support in both chambers for the prescription privileges bill.

As you may remember, my presidential theme is resiliency. Building professional and organizational strengths when facing...
challenges and obstacles is not easy. This year I have observed professional resiliency as we continue to fight to protect psychology and prepare for the legislative session. Another example is the Business of Practice Committee working to increase reimbursement rates and reduce barriers to providing mental health services. Educating other organizations and the public about who we are and what we have to offer promotes psychology, improves mental health care, and informs policies and laws in relevant fields.

Organizational resiliency has been more apparent than ever as we create a strategic long-term plan for our organization. This plan will provide continuity from year to year and prevent good initiatives from being lost. The task force, under the direction of Drs. Brian Stagner and Rick McGraw, is hard at work interviewing groups inside and outside psychology to include TPA members, former members, and those that have never joined. Other samples include psychologists who are in early, mid, late, and retired stages of their careers, with special emphasis on early career psychologists, graduate students, and interns. Past presidents, Local Area Society Presidents, and Board of Trustee members, past and present, will be interviewed. Psychologists that work with underrepresented populations will be surveyed and legislators/aides, public agencies, media outlets, and allied organizations will be included. Watch for a “mega-survey” that will be distributed soon, and please take the time to answer a few questions that will help this group take the “pulse” of TPA. It’s a unique opportunity to have input into the priorities and goals for TPA over the next 3–5 years! You won’t want to miss out!

Building professional and organizational strengths when facing challenges and obstacles is not easy… Obviously an integral part of resiliency is working together to make TPA a stronger organization so that we can live up to our mission, “to represent and enhance the profession of psychology in Texas, promoting human health and welfare through education, science, and practice.”

In addition, the Governance and Staff Committee (GSC) has completed new job descriptions for our Executive Director and Government Relations Consultants that have been approved by the Board of Trustees. A new and improved performance evaluation for our ED will be formulated soon. A revision of the Policy and Procedures manual is underway and will serve as another tool for continuity as this document will be updated yearly. As we become a larger and more complex organization, our administrative procedures must keep step and these updates will improve TPA.

The newly formed Past Presidents group has emerged this year as a formidable force of experience, knowledge, volunteerism, and financial support, as we face daunting legislative and litigation challenges. They have pledged monthly donations to the tune of $8,727! Reach out by phone, email, or in person at convention and thank them for their continuing sacrifices for the good of TPA. Then follow their lead and give what you can to our Save the Profession fund, as we will continue to need financial resources in 2019.

Tapping into the past presidents’ experiences, we plan to write a history of TPA that will be a resource for TPA members in the future. In fact, I am looking for a volunteer who is willing to be the TPA Historian. The Historian will compile accounts of the past presidents, and ensure that future presidents write summaries of their presidential year. It will be a compilation of the many steps of our journey through the years!

Obviously an integral part of resiliency is working together to make TPA a stronger organization so that we can live up to our mission, “to represent and enhance the profession of psychology in Texas, promoting human health and welfare through education, science, and practice.” I am so grateful to have chosen psychology for a career and it has been a privilege to serve as TPA President for 2018. When we work together, we can achieve great things, and even when we don't achieve all we hope for, at least we know we put forth our best efforts. I hope you will step up and get involved in making your TPA better. Let me know if you would like to volunteer or if you have questions at challphd@yahoo.com.

Take a look at the cover of our convention program and you will see a wonderful illustration of teamwork in action! I hope to see you all in Frisco in November! Let’s build our individual and collective resiliency!
Colleagues,

Fall, my favorite time of year, has arrived. The air is theoretically crisp, the pumpkin spice lattes are brewing, and the autumnal equinox has brought harmony and balance.

Our annual convention is right around the corner. I know many are looking forward to the change of scenery, and welcome the change of venue to Frisco. I hope that you will each seek me out and give me feedback on the new format for the Texas Psychologist. I would like to hear what you feel is working and what more you would like to see. Thank you to those of you who are writing and submitting – keep ’em coming.

I was going to provide a summary, as I usually do, but I thought that I would take a moment instead to talk about the year we have ahead of us. Whether it is the change we want or the change we do not wish to occur, we will experience change. Some changes will divide us, I imagine. I think we will each experience anxiety, frustration, and perhaps anger. Change is sometimes difficult, rather than welcome, as is the fall, for some. The vast majority of us will adjust.

Whatever happens, in the end, it is vital that we value ourselves and each other, and that we project and portray that value in our work. WE are the experienced, the experts. WE are the thinkers, the leaders, and the science-based practitioners.

In looking through the articles for this issue, I see doctoral-level psychology, something to be valued, followed. I encourage you each to find your voice and take appropriate action. Call and visit your House and Senate representatives. Do the work that will lead to the outcome you desire.

A big thanks to each of the authors. As we (or is it just I?) look forward to the winter, fall is illustrated nicely, I believe, in a Stephen King passage from Salem’s Lot:

But when fall comes…it stays awhile like an old friend that you have missed. It settles in the way an old friend will settle into your favorite chair and take out his pipe and light it and then fill the afternoon with stories of places he has been and things he has done since last he saw you.

With that, I hope you allow this new issue of the Texas Psychologist to settle in like an old friend. See you at the convention!

Jennifer Rockett, Ph.D.
Private Practice, Bryan, TX

Call for submissions

The Texas Psychologist is seeking submissions for upcoming issues.

We are seeking content in the following areas: Independent Practice; Ethics; Multicultural Diversity; Forensic Issues; and Student and Early Career. Collaborations with students are encouraged. 1000–2000 word count; APA Style.

Send to drjenniferrockett@gmail.com by December 15 for the winter issue.
The Texas Psychological Association 2018 Annual Convention in Frisco is fast approaching. We invite you to become better acquainted with the Texas Psychological Foundation during that time. A special highlight during this year’s convention will be a special fundraising event. TPF invites you to join us for Painting with a Purpose on the evening of Thursday, November 15. Get in touch with your inner Picasso or O’Keeffe and enjoy a fun evening of creativity and camaraderie while also supporting the future of Psychology. No special artistic talent will be needed to create your own personal masterpiece at Painting with a Twist. We will provide transportation, as well as libations and snacks. A donation of $100 is requested for the event. For persons becoming a new Hero of TPF (donation of $250 or more), admission to the event is gratis as an expression of our gratitude for your generous support. Part of the donation is tax-deductible to the extent permitted by law.

We also invite you to get involved by becoming a Donor, Friend, or Hero of TPF. A gift of less than $100 earns the giver status as a Donor to TPF. Giving a minimum of $100 makes you a Friend of TPF. Donations of $250 or more earn the title Hero of TPF. Your donation of any amount will help TPF to encourage scholarship, fund student research, and promote knowledge of psychology to the general public.

Look for us at the convention. You may spot us as we once again thread our way through the poster session displays to evaluate the research entries. Or you may see us during the awards luncheon when we are recognizing recipients of the research awards and grant we sponsor—the Roy Scrivener LGBT Research Award, the Graduate Proposal Award, the Bo and Sally Family Psychology Award, and the Jennifer Ann Crescente Memorial Grant for research in violence against women.

Who is the Texas Psychological Foundation? We are the donors, friends and other persons who have provided financial support for research and scholarship to advance psychology for the future. We are you if you choose to become join our mission through your support.

This month I am using this space to introduce you to the TPF Board of Trustees. We represent a cross-section of TPA members, devoting time and other resources to the promotion of our field. As you will see, we include experienced psychologists, those who are new to our ranks, as well as students who represent the future of psychology. We represent roles of psychologists as clinicians, academicians, and forensic specialists. We hail from various parts of Texas. Our demographics display further diversity, but we are joined in our commitment to support research and scholarship and to expand awareness of psychology.

DR. COURTNEY SWISHER BANKS received her Ph.D. in School Psychology from Texas A&M University with a specialization in Prevention Science. She is currently an assistant professor in School Psychology and director of the Family Collaboration in Tired School Supports (FaCTS2) Lab at Sam Houston State University. Dr. Banks became a licensed psychologist in May 2018 but has collaborated with families and school staff for over ten years to maximize social and emotional success for youth. She has experience in the public school system as a licensed specialist in School Psychology, special education teacher, and a special education counselor. Dr. Banks’ research focuses on promoting parent involvement and engagement in school behavior interventions and bullying prevention. Above all, Dr. Banks enjoys spending time with her husband of ten years and their beautiful children, Camille and Eric, Jr.

DR. IMAN WILLIAMS CHRISTIANS lives in Georgetown and works in Killeen, where she is the clinic director for the Steven A. Cohen Military Family Clinic at Endeavors, a nonprofit agency that serves veterans, military spouses, and families, the National Guard, and Reserves. Originally from Tulsa, Oklahoma, she completed undergraduate work at Oklahoma State University and her doctorate at Jackson State University in Mississippi. Her postdoctoral fellowship at UTHSC-San Antonio brought her to Texas. She finds relaxation in her garden where she enjoys the challenge of nurturing fruits, vegetables, and other plants not accustomed to the harsh Texas heat.
**DR. MICHAEL G. DITSKY** is originally from York, Pennsylvania, but now lives in Richmond, Texas, and has an independent practice located in Sugar Land. His scope of practice is primarily forensic psychology, addressing needs of both juveniles and adults in the civil and criminal courts. He studied at West Chester University, Temple University, and North Central University. He is a Fellow of the American College of Forensic Psychology and is licensed in both Pennsylvania and Texas. In addition to enjoying time with his wife, four children, and seven grandchildren and pursuing his hobbies of cooking, traveling, and history, he has given back to his community through volunteering for Give an Hour and the Tragedy Assistance Program for Survivors. In his spare time, he indulges his addiction to British television mysteries such as *The Unforgotten*, *Death in Paradise*, and *Midsomer Murders*.

**DR. KELLY G. ARNEMANN** lives in San Antonio and is a staff psychologist working at the South Texas Veteran Healthcare System. His practice at the VA includes assisting all of his veteran family, regardless of psychiatric diagnosis. He has been specifically trained in CBT, DBT, and CPT for PTSD. He enjoys utilizing the emotional dysregulation skills training of DBT with all veterans during their continual transition into the civilian world. Dr. Arnemann has enjoyed serving multiple years on the TPA Convention Committee and recently joined the TPF Board to encourage the education, scholarly research, and psychological innovation of all psychologists throughout Texas. During his leisure time, he enjoys watching movies, completing DIY home projects, and spending time with family.

**DR. JO VENDL,** past-president of TPF, earned her Doctor of Psychology degree with a child and family therapy specialization in 2013, and her Master of Arts degree in Clinical Psychology with an international disaster psychology specialization in 2009 from the University of Denver Graduate School of Professional Psychology. Dr. Vendl specializes in the treatment of post-traumatic stress in children, adolescents, and adults with a focus on supporting trauma recovery for those who have experienced abuse, neglect, relationship violence, combat trauma, and other life-threatening events. Dr. Vendl practices with a relational, mindfulness-based, and collaborative approach to the treatment of psychological distress. Currently, she is in private practice in Austin. She also provides expert testimony to the Travis County Assistant District Attorney's office in cases where children have been victims of abuse, domestic violence, and unsafe households and are in need of state protection. Dr. Vendl also conducts evaluations of PTSD for military veterans and contractors who have worked for the U.S. military and suffer resulting combat trauma. She balances her life with quality time with her husband, loving on her animals, practicing yoga, and enjoying Austin's amazing restaurants.

The current TPF president, **DR. HEYWARD GREEN,** practices at the Baylor Scott & White Clinic in Waco, where the psychology department is co-located within a primary care setting. After earning his Psy.D. from Baylor University in 1984 and before joining Scott & White in 1995, his private practice focused on consultation and direct services to children, adolescents, and families in various settings including psychiatric hospitals, residential treatment centers, juvenile justice settings, and public schools, as well as the outpatient clinic. He has enjoyed opportunities for mentoring budding clinicians through the creation and supervision of a practicum for the Baylor Psy.D. Program in the past, and more recently as a member of the training committee for the APA-approved internship program at Baylor Scott & White in Temple. His volunteer pursuits have included child welfare and health issues, activities in the Episcopal Diocese of Texas and his local parish, and the Waco Symphony Association. Leisure activities typically shared with his wife involve MG sports cars and cooking, as well as snorkeling, sailing, and mindful time on the beach.

**WHO IS THE TEXAS PSYCHOLOGICAL FOUNDATION?** We are the donors, friends and other persons who have provided financial support for research and scholarship to advance psychology for the future. We are you if you choose to become join our mission through your support.

**CASSANDRA BAILEY** is one of two student members who recently joined the TPF Board of Trustees. Ms. Bailey completed her undergraduate work at the University of Florida and is pursuing a Ph.D. in clinical psychology with a forensic emphasis at Sam Houston State University in Huntsville. Although still in training, she already has amassed an impressive array of publications, awards, and grants, as well as membership in Phi Beta Kappa. She has pursued a research focus on timely issues involving immigration and adolescents, as well as related matters. In addition to her academic achievements, her history includes prowess on the athletic field in women's lacrosse as a player in the past and currently as a coach at Sam Houston. Her passion for travel has taken her to locations in Central America, Europe, and the Caribbean.

**ANNA ABATE** is another student member of the TPF Board of Trustees. Ms. Abate is pursuing a Ph.D. in clinical psychology at Sam Houston State University in Huntsville after completing her undergraduate study at the University of North Carolina in Chapel Hill and her Master of Arts at Sam Houston. Her long list of publications and research include a focus on adolescence, the legal system, as well as racial factors in beliefs and perceptions. Her work has received recognition in the form of several awards. In addition to her teaching and research assistantships, she has served a leadership role in the graduate student organization and has volunteered time for mentoring younger graduate students as well as undergraduate students interested in pursuing graduate education. Her interests away from school include cooking, swimming, hiking, traveling, and playing with her cat. We look forward to seeing you in Frisco! ■

**Who is the Texas Psychological Foundation?** We are the donors, friends and other persons who have provided financial support for research and scholarship to advance psychology for the future. We are you if you choose to become join our mission through your support.
In the United States, 116 people die from opioid overdoses every day; in Texas, there has been a significant increase in synthetic opioid deaths from 2015 to 2016 (Seth, Scholl, Rudd & Bacon, 2018). As of 2017, the acting Health and Human Services Secretary, Eric D. Hargan, publicly announced that America is in the midst of a nationwide public health emergency due to the opioid crisis (U.S. Department of Health and Human Services, 2017). Recent research has identified that the general public is more likely to agree that those who abuse substances should be punished rather than treated (Meurk, Carter, Patridge, Lucke & Hall, 2014), which aligns with public statements made by President Trump, and recent policy changes made by the U.S. Department of Justice (Office of the Attorney General, 2017, 2018a, 2018b). Even when the general public is exposed to education on the biological development of addiction, they maintain the opinion that punishment is more effective than treatment for those who abuse opiates (Meurk et al., 2014; Ricardo, Henderson & Christensen, in preparation).

Conversely, the general public appears to support legalization of recreational and medical marijuana consumption. This distinction may result from the public’s perception that marijuana is less harmful, and by implication, that it may not have the same addictive properties as opioids. This line of thinking may perpetuate the belief that addictive processes may work differently for marijuana than opioids. With these potential contradictions existing in the public discourse around substance use, it is not necessarily surprising that research indicates that educating individuals on the brain disease model of addiction (BDMA) does not influence the likelihood that they provide less punitive responses on hypothetical sentencing tasks (Ricardo, et al., in preparation). If such education does not influence participants’ judgments, it suggests difficulty in receiving public support for substance use policy changes, such as harm reduction and alternatives to incarceration for opioid addiction.

HOW PSYCHOLOGY VIEWS ADDICTION

In treatment, public policy, and the justice system, there are two prevalent perspectives on drug and alcohol addiction: the BDMA and the moral weakness model (Blum, Roman & Bennett, 1989; Lawrence, Rasinski, Yoon & Curlin, 2013; Heather, 2017). In 1997, Alan I. Leshner, then the director of the National Institute of Drug Addiction (NIDA), firmly and publicly affixed the official stance of the NIDA on drug addiction as a brain disease. In his 1997 seminal article, Leshner stated that over 20 years of research had supported the assertion that the brain plays a significant factor during the transition from recreational drug use to addiction. He explained that such research unequivocally points to the need for policy reform that helps reduce stigma around treatment and that improves access to treatment for those in need. Presently, both the NIDA and the American Society of Addiction Medicine (ASAM) support Leshner’s perspective, and define drug and alcohol addiction as a chronic, relapsing disease of the brain (ASAM, 2011; NIDA, 2016).

However, opponents of the BDMA hold that it negates the responsibility of the individual to change or take accountability for their behaviors, and subsequently leads them to become more fatalistic about their own sense of agency (Bell et al., 2014; Meurk et al., 2014). This conceptually implies that individuals with substance use disorders (SUDs) tend to engage in learned helplessness and may no longer strive to obtain complete sobriety, as they do not believe they can ever be completely cured of their addiction (Bell et al., 2014). An additional concern from this perspective is that the BDMA normalizes the notion that individuals with SUDs have no self-control and must be coerced into treatment, especially when engaged in the criminal justice system (Caplan, 2008; Szott, 2015).

Practitioners are quite divided on the subject of BDMA. For instance, Lawrence and colleagues (2003) demonstrated that the moral weakness model of addiction tends to persist among both psychiatrists and primary care physicians, with a combined 11% believing that moral failings play a significant role in the development of addiction. In 2003, Kloss and Lisman found a moderate to high endorsement of the disease model by mental health clinicians, while still finding high rates of blame attribution (the responsibility for causing their problem) toward mentally ill/chemically-addicted patients. These findings are consistent with research conducted by Meurk and colleagues (2013) that endorsement of the BDMA does not automatically translate to empathic treatment of individuals with SUDs; rather, many professionals continue to attribute...
an individual’s SUD to moral failings and personal choice. In his 2017 article, Nick Heather deemed this disparity between endorsement and empathy as “lip service” to the BDMA, which has been demonstrated by both helping professionals and the general public (Meurk et al., 2014).

THE BDMA AND PUBLIC POLICY

Nora Volkow and Alan Leshner, current and previous directors of the NIDA, have both argued that use of the BDMA in explaining the development of addiction may produce beneficial changes to social policy regarding how individuals with substance use disorders are treated, both within and outside of the criminal justice system (Leshner, 1997; Volkow & Li, 2004). Anticipated changes include a reduction in stigma, increased funding for both research and treatment of addiction, as well as increased public acceptance of addiction as a medical disease; together, these changes will likely result in a favored perspective that addiction should be treated through medical services rather than punished in the criminal justice system (Bell et al., 2014; Hall & Carter, 2013; Meurk et al., 2014). To this end, both the NIDA and the National Institute of Alcohol Abuse and Alcoholism (NIAAA) have made it a priority to fund studies that investigate questions regarding substance use from the perspective of the BDMA (Hall, Carter & Barnett, 2016). In an effort to disseminate this research and support the BDMA, these same institutes have conducted “well-funded, high public profile education and advocacy efforts in favour [sic] of the BDMA over the past 20 years” (Hall, et al., 2016, pg. 104), even in the face of considerable dissent (Heim, 2014; Lewis, 2017).

WHERE WE ARE TODAY

What positive impacts on social policy have been produced by this decades-long institutional effort to shift the dominant perspective on addiction from moralistic to medical? Through the Affordable Care Act, “insurers are required to treat substance abuse disorders in the same way they would any other chronic disease” (Botticelli, 2014; Volkow & Koob, 2015). Similarly, the NIDA (2006) released its Principles of Drug Abuse Treatment for Criminal Justice Populations, for which the first principle states, “drug addiction is a brain disease that effects behavior” (Fletcher & Chandler, 2006, p. 1). This has been reflected by criminal justice systems that offer alternatives to incarceration, such as inpatient substance abuse treatment (Heather, 2017). However, this policy change comes with its own subset of ethical dilemmas. For instance, does mandated treatment as an alternative to incarceration increase the likelihood of coercive treatment by making the alternative (incarceration) noxious enough that an individual, given the choice, is unlikely to turn it down? An article by Caplan (2008), a bioethicist, encourages mandatory treatment as a means of “re-emergence of true autonomy” (p. 1920) for those with SUDs, as he believes they “do not have the full capacity to be self-determining or autonomous” prior to receiving treatment (p.1919).

Similar to the issue of violated autonomy and coercive treatment, the aim of proponents of the BDMA to reduce the stigma associated with substance abuse may have either left stigma untouched, or paradoxically created increased stigma. Specifically, prior research has indicated that when a biological explanation is used to describe a patient, clinicians are significantly less empathetic towards the potential patients than when a psychosocial explanation of the patient’s mental health disorder is given (Lebowitz & Ahn, 2014). The general public tends to regard those with biologically based behavioral abnormalities as dangerous, which leads to avoidance and isolation of those with such abnormalities (Heather, 2017). Importantly, recent research has indicated that when potential jurors are given a brief education on the BDMA before assigning a sentence length to a defendant on trial for a drug related crime, they assign nearly identical sentences to those that did not receive such information (Ricardo, et al., in preparation). This same study identified that although individuals are significantly more likely to endorse the BDMA after brief education, this does not have a positive impact on their empathetic response when faced with the opportunity to incorporate the BDMA into their decision-making. This disparity speaks to a possible lip service (Heather, 2017) of endorsement of the BDMA, as well as the lack of positive impact the BDMA appears to have on this arena of the criminal justice system. Similarly, Meurk and colleagues (2014) noted that although endorsement of the BDMA predicted lower support for imprisonment of the average, non-justice involved individual with heroin use, the effect size was small, and the results were only marginally significant (i.e., the p value for the study was not smaller than the widely used .05 criterion).

Promises made regarding the development of new pharmacological interventions to treat substance abuse (beyond the agents already available; e.g., buprenorphine and naltrexone), have not been realized. More precisely, only modest advancements have been made on this front for a host of reasons, including reluctance by pharmaceutical companies due to doubts regarding their profitability (Hall, et al., 2015; Volkow & Li, 2004). For instance, although methadone is a commonly used medical intervention for opiate use, its development occurred some decades prior to the widespread dissemination of the BDMA (Hall, et al., 2015).

WHAT DOES THIS MEAN?

For decades, proponents of the BDMA have asserted that should perspectives on the development of addiction shift from a moral model to a medical one, the impacts would be unparalleled (Hall & Carter, 2013; Leshner, 1997; Volkow & Li, 2004). In some respects, the developments have met this goal. For example, we see progress in the requirement that insurance coverage consider addiction to be the same as any other brain disease (Botticelli, 2014), and treatment within the criminal justice system reflecting the perspective that addiction is a brain disease (Fletcher & Chandler, 2006). However, as of 2004, 80–85% of prisoners that could benefit from substance abuse treatment are not receiving it (Mumola & Karberg, 2006), suggesting that there is much left to be desired regarding interventions for those in the criminal justice system. For inmates/probationers that are given the opportunity to engage in substance...
abuse treatment, mandated participation may reflect the assumption that the model encourages coercive treatment, as argued by BDMA critics. In addition, for those that are not in traditional talk-therapy/psycho-education-based programs, the medical field has only made modest progress in the treatment of substance use disorders through pharmacological interventions (Hall, et al., 2015, some of which are hotly debated, (e.g., the use of Narcan for opioid overdoses). Most importantly, recent research has identified a disparity between acceptance of the BDMA and empathic responses towards those with SUDs by both the general public and by helping/criminal justice professionals (Meurk, et al., 2014; Ricardo, et al., in preparation). There also appears to be weak support that use of the BDMA leads to a reduction in stigmatization (Heather, 2017; Lebowitz & Ahn, 2014; Meurk, et al. 2014), which presents an additional area of concern. When examined as a whole, the promises made by use of the BDMA are met in some areas, although they may be unmet and potentially worsened in others.

At a time when the nation is considered to be in the midst of an opioid crisis, it is imperative that we find ways to address this health emergency with both proactive and reactive sociopolitical policies. Where the BDMA appears to have the least positive impact is on the general public’s treatment of those with SUDs, which is arguably the most important area for intervention as public support drives public policy (Goot, 2005). The ultimate question is this: if the BDMA is not garnering the necessary support from the general public to affect sociopolitical policy change via empathic response in conjunction with an understanding of the biological basis of addiction, what do we do now? How do we shift our perspectives, explanations, and understandings of substance abuse such that we can disseminate the necessary information to unify both the general public and our goals around treatment and reduction of addiction? There is likely no single or best answer to these questions; instead, they are meant to promote positive discussion with members of the public regarding the implications of the field’s predominant model for conceptualizing SUDs—the BDMA—for public policy and treatment.

**REFERENCES**


WHAT IS HIV?

Human immunodeficiency virus (HIV) can be transmitted through direct contact with blood or bodily fluids (Elizabeth Glaser Pediatric AIDS Foundation, 2018). When the virus enters the body, it enters into the vital immune cells called CD4. In its later and most severe stage, HIV causes acquired immunodeficiency syndrome (AIDS). Most children (90%) who contract HIV have acquired the virus from their mother in utero, during childbirth, or while breastfeeding. Due to the severely diminished immune system, the body cannot defeat infections or cancers that could normally be withstood by a healthy immune system; causing a greater amount of infections and illnesses in the now HIV-positive child. Without treatment, this disease leads to chronic illness and death (Elizabeth Glaser Pediatric AIDS Foundation, 2018).

TREATMENT FOR HIV

The current treatment for children with HIV is medication to keep the virus contained, which requires strict medication adherence with the medications being taken every day. Antiretroviral therapy (ART) was introduced in 1995 and consists of medications (ARV) that maintain the CD4 cell count to prevent the growth of the virus (International Association of Providers of AIDS Care, 2014). This medication regimen increases levels of CD4 cells and allows the child to live a longer and healthier life; however, it does not cure HIV.

Cognitive and Adaptive Functioning

Despite the advances in medication treatment, neurocognitive and psychological deficits among HIV-positive children persist. The neuropathological effects of HIV cause neurocognitive impairment in 50–60% of HIV-positive children (Malee et al., 2008). With greater awareness, the practitioner can help the family achieve a realistic outlook toward quality of life, educational planning, career options, high-risk behaviors, and general adult living skills (adaptive functioning/independent living). Neurocognitive abilities are naturally developed, brain-based skills that, to a degree, have the potential to be enhanced or shaped over time. These composites allow us to carry out simple to complex tasks.
HIV-associated neurocognitive disorders (HAND) differ in severity. HIV-positive children in their early stages generally fall in the global low average range (M=86.2) (Smith et al., 2012). As the virus progresses there are greater degrees of neurocognitive impairment. Asymptomatic neurocognitive disorder (ANI) is the least severe with a prevalence of 30–35% and is characterized by at least mild cognitive impairment in two domains, but with no difficulties in adaptive functioning (Laughton et al., 2013). Mild neurocognitive disorder (MND) is the second most common and has a prevalence of 20–25% and is characterized as having at least mild neurocognitive impairment in two domains and with mild interference in adaptive functioning. The most severe is called HIV-associated dementia (HAD) with a prevalence of 2–3% with moderate to severe impairments in neurocognitive functioning in multiple domains and significant difficulties with adaptive functions.

**NEUROCOGNITIVE CONSTRUCTS**

**COMPREHENSIVE KNOWLEDGE**

While most global cognitive scores remain in the low average range with medication adherence, research has highlighted difficulties with expressive and receptive language (Martin et al., 2006). Comprehensive knowledge allows for verbal communication and reasoning using acquired knowledge and skills through previously learned experiences. Language includes the ability to associate words and objects to one another, produce concepts based on nonverbal and verbal images, and the ability to listen and retain information in order to recall it or apply it to another concept. Research showed vocabulary and reading declined in HIV-positive children when compared to normative groups (Laughton et al., 2013). Of importance to note, the prevalence of hearing loss in HIV-positive children is high and ranges from 20% in higher income countries to 38% in low-resource settings. This may drastically affect an HIV-positive child’s ability to acquire and process auditory information.

**VISUAL-SPATIAL PROCESSING**

Visual-spatial processing is the ability to utilize visual patterns, relationships, spatial orientations, or mental imagery in order to solve problems. Lower scores on visual-spatial processing have been described in HIV-positive children. Visual-spatial processing is important for adolescents as it impacts general cognitive tasks, reading, writing, and mathematics. HIV-positive children have been shown to be slower and less accurate on pattern recognition and to have lower scores on sequential processing, simultaneous processing, planning/reasoning and visual memory (Laughton et al., 2013).

**PROCESSING SPEED**

Processing speed is the ability to perform both simple and complex cognitive tasks under time constraints, and manipulate items from memory effectively. It also enhances inductive reasoning and accuracy for academic work such as arithmetic. Research has examined scores among HIV-positive children ranging from early childhood to adolescence and found vulnerabilities in processing speed. A weakened ability to quickly process information can lead to vulnerabilities in working memory, attention, and other executive functions.

**MEMORY**

The primary effect that HIV causes is atrophy in white matter and deep gray matter, leaving weakened areas such as the basal ganglia, which plays a major role in learning and memory (Martin et al., 2006). Impairments have been found in all areas of memory for HIV-positive children, but working memory has been researched more, partially because it correlates heavily with the ability to perform executive functions. Working memory is the ability to hold, manipulate, and reproduce information in immediate awareness. Processing speed is associated with increased capacity for working memory, which enhances cognitive flexibility and greater chances for accuracy in solving academic and general problems. HIV-positive children have been found to perform significantly poorer on working memory tasks (Martin et al., 2006).

The staggering percentage of neurocognitive disorders in HIV-positive children speaks to the necessity for practitioners to be involved in helping address neurodevelopmental and adaptive outcomes.

**EXECUTIVE FUNCTIONS**

Executive function (EF) processes are voluntary response inhibition, working memory, response planning, improved processing speed, cognitive flexibility, and rule-guided behavior. Having executive control gives us the ability to attain a more conscious, self-directed, and self-regulating mind (Laughton et al., 2013). HIV not only causes atrophy in the basal ganglia and cerebral white matter but also causes neuronal loss in the prefrontal cortical regions, which may cause difficulty in complex mental processing over time. When coupled with the high risk for difficulties with working memory and processing speed, HIV-positive children are likely to experience impairments in EF (Laughton et al., 2013).

**SCHOOL PERFORMANCE**

School performance is a functional outcome that is highly relevant in terms of future quality of life and employment opportunities (Laughton et al., 2013). A child’s school performance is dependent on numerous variables including social and family factors. In addition, the indirect effects of HIV infection – including hearing loss, school absenteeism due to ill health or ART management, depression and/or social problems – need to be considered when interpreting school performance. In exploring school performance among HIV-positive children, it was identified that they have poorer outcomes compared with typically developing peers. Outcome measurements were highly variable and included 42% with a learning disability specifically in math and/or reading, 33% receiving special education, 15% having repeated two or more grades, and 51% having failed at least one grade (Laughton et al., 2013; Brackis-Cott, Kang, Dolezal, Abrams, & Mellins, 2009).

**MENTAL HEALTH**

There is a strong association between psychological and neurocognitive functioning in children who are HIV-positive. Research has shown that a 25% prevalence of
mental health problems among HIV-positive children exists, which is well above the general population (Laughton et al., 2013). Another study reported 18% of 17-year-old HIV-positive children having a lifetime history of psychiatric medications, 13% on stimulants and/or antidepressants, and 22% having a past or current history of non-medication psychological intervention (Laughton et al., 2013). Depressive symptoms, conduct problems, exhibiting high-risk behaviors, and abnormal personality traits in HIV-positive children have been linked to a combination of negative coping skills and poor neuropsychological functioning. With the combined deficits across neurocognitive constructs, this can lead to risk-taking behavior such as sexual promiscuity and substance abuse. Furthermore, psychiatric disorders and behavioral health challenges in HIV-positive children can lead to poor ART adherence.

**DISCUSSION**

The staggering percentage of neurocognitive disorders in HIV-positive children speaks to the necessity for practitioners to be involved in helping address neurodevelopmental and adaptive outcomes. ART alone is not sufficient to reverse the neurodevelopmental consequences, but there is evidence to suggest a strong link between psychological well-being and the immunological impact of disease progression – meaning that, first and foremost, these children need additional love, care, and support. This can help boost self-esteem, resiliency, and promote self-advocacy. A practitioner’s role can vary in working with this population, but the smallest ounce of care and concern can make a vast impact on a child who is HIV-positive.

In addition, cognitive rehabilitation paired with the social-emotional curriculum is essential for well-rounded intervention planning. There are effective screening measures can assist with assessing cognitive functions with this population. Specifically, the Developmental NEuroPSy chological Assessment, Second Edition (NEPSY-II),CogState, the Screening Algorithm, WAIS-IV, WISC-V, Hopkins Verbal Learning Test, Grooved Pegboard Non-Dominant Hand Combination, and the Computerized Assessment of Mild Cognitive Impairment (CAMCI), are assessments found for identifying neurocognitive impairments in children. There are also a wide variety of social-emotional curriculums (i.e., Dr. Dan Siegel) available to assist with child and caregiver training on practical strategies to enrich the milestones of these children, neurologically, psychologically, and sociologically.

In the school setting, children who are HIV-positive and have a neurocognitive disorder to warrant special education services should be considered for classification under Other Health Impairment (OHI) (Individuals With Disabilities Act, 2004). Otherwise, accommodations under Section 504 of the Rehabilitation Act of 1973 should be considered at a minimum to assist with any health care needs (i.e., blood procedures, fatigue, illness/missing school, medication management in school, exposure to others who are ill, and counseling within the school, etc.).

Parental support has been shown to provide a stress-buffering effect for the effects of depression. Some approaches to fostering resilience in HIV-positive children have centered on family dynamics within a cultural framework. A systematic, strengths-based approach to treatment where school personnel, CASA workers, social workers, families, and the education and health care workers work together with the family may be beneficial to this population. Perseverance, self-esteem/self-confidence, family unity/trust, good parenting, and collective/communal support have all been found to increase when there is a sense of support and care for the child. Children who are HIV-positive who exhibited signs of resilience tended to have better neurodevelopmental functioning, social-emotional, and gross motor functioning.

**REFERENCES**


There are 1,496,724 veterans in Texas (Veterans in Texas Demographic Study, 2016), and of those 374,036 are disabled (Texas Workforce Investment Council, 2016). Approximately 20.5% of Texas veterans have a documented disability that was caused by or incurred during service in one of the military services: Army, Air Force, Navy, Marines, Coast Guard, or the Texas National Guard. Each member of the services is entitled to a disability exam upon discharge to determine whether service-related "stressors" are sufficiently significant to contribute to disability. The Veterans Administration has a specific exam process to evaluate disability.

The Compensation and Pension process (C&P) began in 1776 when the Continental Congress adopted the first national pension law providing for compensation payments to be made to "every officer, soldier, or sailor losing a limb in any engagement or being so disabled in the service of the United States as to render him incapable of earning a livelihood" (Samet & Bodurow, 2008). The current compensation rule provides a retirement to any service member who served in the military for 20 years (Department of Defense, 2018). The veteran may also be eligible for compensation due to disability if the veteran was exposed to a significant "stressor" (traumatic event) that occurred in service which contributes to a long-term negative outcome, and who was honorably discharged (or under honorable conditions).

The C&P process utilizes the Disability Benefits Questionnaire (DBQ) which has evolved over the years, and changes have been made when there are revisions to the Diagnostic and Statistical Manual, now in the 5th edition (APA, 2013). One challenge in the process is that many veterans do not know about the C&P process. Another challenge is that many veterans are not members of a veteran's advocacy groups, for example, G.I. Forum and Disabled Veterans of Americans (DAV). A representative from one of these advocacy groups can educate and inform the veteran about their disability rights. In fact, many veterans don't even access VA resources. Another group of veterans believe that they cannot access VA resources until they have had the DBQ. Finally, there is another large group of veterans who don't want to talk about their service and/or even admit to weakness. These challenges leave many veterans in the dark and unable to access the VA disability entitlement.

CONTENTS OF THE DBQ

The first goal of the DBQ is to identify the stressor(s) of service. The examiner determines whether the stressor is significantly "stressful or traumatizing" to meet the criteria of PTSD per the DSM-5 criterion (APA, 2013). Once the diagnostic is made the examiner determines all possible symptoms related to PTSD, including depressed mood, anxiety, panic attacks, disturbances in motivation and mood, flattened affect, impaired judgment, etc. The examiner also has to determine if there is a second diagnosis commonly found in the veteran population, e.g., alcohol use, nightmare disorder, panic disorder, MDD, or OCD. It is also important to determine if a veteran has a TBI and whether head injury plays a role in psychiatric symptoms. It is critically important to review the medical record to look for antecedents, treatments, and past and current medications. For example, "Did the veteran seek mental health during service prior to service? During service?"

PTSD: COMBAT AND PERSONAL TRAUMA

The VA concedes that if a veteran was deployed to a combat zone, the veteran needs to only describe those combat experiences. Then the examiner determines whether the veteran qualifies for a diagnosis of PTSD. However, what is frequently overlooked are the numerous other stressful, traumatizing experiences that occur for many service members, including racist commanders in basic training, being assaulted by other service members or civilians, or serious injury that delays advancement or alters duty assignment. A central dilemma for service members is coping with the trauma on their own because if they report symptoms during service, they might either be reassigned or never deployed again, or even worse,
Many veterans do not know about the C&P process and are unable to access the VA disability entitlement.

get medically boarded out of the service. Depending on the service member and years of service, treatment can be delayed for years.

Recently, a type of trauma that has been acknowledged to have the potential for causing PTSD is sexual assault by another service member, commonly known as Military Sexual Trauma (MST). MST is a term used by the VA to refer to experiences of sexual assault or repeated, threatening sexual harassment that a veteran experienced during his or her military service. The definition used by the VA comes from federal law (Title 38 U.S. Code 1720D) and is “psychological trauma, which in the judgment of a VA mental health professional, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty, active duty for training, or inactive duty training.” Sexual harassment is further defined as “repeated, unsolicited verbal or physical contact of a sexual nature which is threatening in character.” (U.S. Veterans Administration, 2015).

PREVALENCE OF MST

National data reveals that 1 in 4 female service members and 1 in 100 male service members reported experiencing MST (U.S. Department of Veterans Affairs, 2018). In 2016, 6,172 MST cases were reported (Reuters Staff, 2017). Using reported data, this means there could be a total of 224,508 MST reported cases just in Texas. According to VA estimates (Suris & Lind, 2008), since there are many more men than women in service, there are roughly equal numbers of MST for both genders. This means in Texas each gender has probably experienced over 100,000 cases of MST.

The dilemma of the MST evaluation is that the veteran has a much higher bar to qualify the MST as a stressor. There are fifteen additional “markers” which must be investigated in order for the veteran to prove that the MST actually happened. For example, the veteran has to show that they got a pregnancy test or STD test, or that there was increased medication or drug use, or they had requested reassignment of duties, or show insubordination to authority, etc. Reports from MST victims help explain why many either do not report the MST at the time it happened or do not seek medical/psychiatric help. One reason is some victims think they will not be believed because they have heard from other MST victims that the military did not respond appropriately. Sometimes they believe they are at fault for the assault. Still others fear they will be found not fit for duty and prematurely discharged.

The common dilemma for both combat and MST is that if the examiner does not ask, the veteran will not reveal the history. There are some veterans that have reported in their second or subsequent DBQ that the examiner did not ask about combat experiences or did not ask if there were any “stressful” experiences during service. It appears that some examiners believe only combat experiences qualify for PTSD while other examiners believe that you had to be injured in combat to qualify for PTSD. Across the board, veterans have several obstacles and personal dilemmas to reach the point to apply for disability, show up for the DBQ, and to report the extent of the stressor(s) of service.

RECOMMENDATIONS TO COMPLETE THE DBQ PROCESS

Encourage veterans to explore the possibility of scheduling a DBQ. Both examiners and veterans can communicate the availability of the DBQ to any and all veterans. Encourage them to identify a veteran's advocacy group where they can find a veterans' representative who can help guide them through the process of making a “disability claim” and establishing contact and services through their local VA hospital/clinic.

As an examiner, if you are going to make an error, err on the side of assuming and believing that the veteran’s service was stressful. Give the veteran time to talk about their service experiences without interruption. Many agonize about talking to anyone about their service years, and as the examiner, you might be the first person ever to hear their stressors. You have two hours to complete the DBQ, so don’t rush the veteran.

Remember that the VA only requires a 50% or greater probability that a veteran has a specific diagnosis that was caused by or incurred during service to make the diagnosis.

Conduct the DBQ as a therapeutic assessment. If you listen and explore the stressor and the long-term impact of the stressor, the veteran can feel heard and perhaps encouraged to follow through with treatment. The veteran has probably heard from spouses, family, and friends about the impact of their symptoms on daily living and the workplace. They also need the final confirmation from the evaluator that they are not “crazy” but do have long-term consequences of service stressors. This could be the confirmation to them that they need to seek help. Hopefully, the more veterans who complete the DBQ, the more will seek mental health care and therefore hopefully reduce the suicide rate among veterans.

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The experience of puberty for transmen has emerged as an issue in transgender research. From a larger sample of 11 transgendered persons who were interviewed about their identity formation, Morgan and Stevens (2008, p. 588) reported the four FTM adults described their experience of puberty as a time of unhappiness using words such as “traitor, repugnance, and humiliation.” The present article focuses on the experience of puberty as shared through qualitative interviews conducted by the primary authors with 16 transpersons. That dissertation study explored the narratives of 16 transpersons who were asked to share their transition to their true self – either as transmale or transfemale -- by sharing their unique life experiences. This article focuses on an unexpected finding in the narratives shared by the participants – the finding that puberty was an experience that was horrific for most of the FTM but less traumatic for the MTF participants in this study.

RESULTS

After transcribing the interviews, the principal author read and re-read the transcripts and identified keywords. Together with the second author, the coders met to compare keywords and develop categories which led to a final grouping of four dimensions: childhood, adolescence, adulthood and gender-related (Saldana, 2013). For the present article, the theme of puberty was the only identified theme within the gender-related dimension; the theme of puberty included two subthemes: 1) How could THIS happen and 2) This is confusing.

HOW COULD THIS HAPPEN?
The five FTM participants reported that the developmental marker of menstruation was uncomfortable and confusing; puberty was a time of despair for four of the five participants. For these participants, puberty and first menstruation were reported as catastrophic and humiliating and brought to the forefront the internal battle about who they are on the outside and who they are internally. Those five FTM participants reported that they were convinced that they were boys and, subsequently, they engaged in boy behavior. They stated emphatically that they knew that they were boys inside and that one day they would be boys.

Puberty was an ordeal especially for four of the five FTM participants. The realization of who they were biologically resulted in mental health issues for all participants. One called menstruation the “highest form of emasculation.” Menstruation, or the upcoming event of first menstruation, was a “confirmatory message” that the nagging thing in the back of the FTM participants’ mind was in fact, true. “I’m not really a boy” was a reality that seemed to crush most of the FTM participants. Many FTM participants had to mourn the loss of “boyhood” while coping with the realization that they could never again attain “boyhood.” A core self-identifying marker (I’m a boy) was suddenly gone, and none of the FTM participants spoke of being a tomboy after puberty.

A few FTM participants did not speak specifically of feeling the internal conflict until their early teens, when biological girls were taught about menstruation. For FTM participants, the onset of puberty and menstruation were reported as a horrible betrayal by their “obviously” male bodies. “The talk” was generally done as part of elementary school education, where biological girls were separated from biological boys so that the boys didn’t have to hear this discussion about the “shaming” and “secretive” process of menstruation. For most of the participants, puberty marked a jarring end to the thoughts that the FTM participants were really boys. Puberty also confirmed an even deeper suspicion, i.e., “I really am a girl.” From the perspective of the FTM participants, puberty dramatically altered the “envisioned life” trajectory of most participants. On the other hand, the MTF participants identified puberty as a time of confusion rather than being a traumatic experience.

THIS IS CONFUSING

The seven MTF participants had a much different response to the onset of puberty; MTF participants viewed puberty as a

Qualitative Interviews with Transpersons About Their Experience of Puberty

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time of confusion rather than a horror or a betrayal as did the FTM participants when they discussed menstruation. They all understood the gender role activities associated with being teen boys and their relationships with teen girls. Several spoke of not being sexually attracted to girls or having only a slight sexual interest in girls. Other participants went through the motions of dating, but never fully accepted that gender role expectation of biological boys.

MTF participants who viewed themselves as internally “girls,” “different” or “confused” had less difficulty with puberty. First erections were viewed as “bewildering” and sexual thoughts of girls were “muted.” Puberty was not seen as the catastrophic event visited on the FTM participants. Most of the MTF participants spoke of not having any sexual thoughts of girls, but other characteristics of girls did become focal points of interest for a majority of MTF participants. For example, how girls looked, what girls did, what they wore, and how they behaved were far more fascinating to the participants than thoughts of being sexual with biological girls. Several dated girls during high school, but never engaged in sexual contact. “Petting” was viewed as “nice,” but most did not have a desire to “go further.” One participant, while having sexual contact with a biological girl, wondered what it is like to have sex as a girl.

**DISCUSSION**

Qualitative interviews of FTM persons yielded similar findings to Morgan and Stevens (2008) and Cavanaugh and Ladd (2017) in that both groups identified puberty as a traumatic experience. FTM persons in both studies believed themselves to be boys “for as long as I can remember” (Cavanaugh & Ladd, 2017; Morgan & Stevens, 2008, p. 88). Each group used words such as “catastrophic” to describe their shock at having their body betray them when their body began changing physically and they began having menstrual cycles. The FTM participants in both studies identified as boys, behaved as boys and were emotionally and psychologically upset when they learned that their body functions were operating as a female. In both studies, the FTM persons reported reacting to puberty with negative emotional reactions.

As a life event, puberty appears to be an experience that is very different for transgender males and females. Participant stories about how they came to recognize and experience their identity as transgendered, when analyzed from a lifespan perspective, displayed a similar pattern of life experience until the onset of puberty was discussed. Based on the findings from this qualitative study of 16 transgendered persons, mental health professionals should be aware that puberty is a very different and often negative experience for female-to-male transgendered persons. More research is needed to explore this experience in more depth and with a more racially diverse audience.

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A cording to statistics on March 31, 2018, from the Department of State Bureau of Population, Refugees, and Migration Office (PRM) of Admissions, the United States has accepted roughly 3.4 million refugees since 1975. The numbers fluctuate each year, which is greatly impacted by the political changes worldwide and within the United States. Texas is one of the top five states where refugees resettle after migration and has become a popular state for refugees migrating from other states in the United States (Smith, 2016). From October 2016 to March 2017, 3,518 people were resettled in Texas (Lopez, 2018). Although the number significantly decreased in the following year due to policy changes, Texas still is home to a large refugee population. PRM (2018) also indicates that a large percentage of refugees come from Southeast Asian countries and speak Nepali and Burmese.

Theorists Sue and Sue (2012) have developed a conceptual model called Multicultural Counseling Competence, which is defined as a $3 \times 3$ matrix with the following components: knowledge for working with a specific population, self- and other- awareness, as well as essential skills for clinical work and research. More specifically, professionals need to have cultural self-awareness, awareness of other people's culture, and appropriate strategies for intervening on three levels: understanding and potentially challenging others' attitudes and beliefs, intervention skills to facilitate new actions, and knowledge of the psychotherapy process. Unfortunately, there has been little application of this theoretical foundation to refugees. For example, Sue and Sue (2012) explained that they developed the construct of multicultural counseling competence primarily for clinicians to serve racially different clients, rather than refugees. Refugees have their cultural heritage and experiences of leaving their countries and so the racial oppression they have experienced has occurred in a framework different from that of other groups. To address this gap, this article aims to focus on general information about refugees' experiences, a description of refugees from Southeast Asia, and advice for working with Southeast Asian Refugees (SEARs).

By definition, refugees left their countries of origin because of humanitarian concerns after being forced from their homes by war, and/or persecutions based on their race, religion, membership in a political or social group, or political opinions. There is a time-consuming and complex process that a person must complete before they are allowed into the United States, which begins with registration with the United Nations, and includes multiple background checks, screenings, and interviews. After finally entering the United States, they face higher incidence of poor mental health, a loss of sense of identity and belonging, language barriers (if their native language is not English), acculturative stress, and potentially discrimination and microaggression toward their race/ethnicity, country of origins, or accents. As such, they experience pre-migration trauma, migration trauma, and post-migration trauma, which collectively could contribute to psychological distress.

Clinicians should be equipped with knowledge of Southeast Asian cultures, and how migration impacts SEARs' mental health. Asians share multiple commonalities such as core values impacted by religions and history, but are also distinct from each other given the various levels of socioeconomic status, living environments, and cultures. When focusing on SEARs, who in Texas mainly include Bhutanese, Burmese, Cambodian, Vietnamese, Hmong, and Laotian, some factors are more salient to consider in working with them as a therapist. The factors include power dynamics within the family, embedded perspectives toward suffering, and challenges caused by immigration.

As the primary social unit in Asian cultures (Hsu, Davies, & Hansen, 2004), family is a significant resource for social support, meaning that they provide accompaniment, emotional comfort, language facilitation, and financial assistance to each other. The level of closeness in Asian families may appear to Westerners to be lacking in boundaries, but it truly serves as a protective function in counseling. In traditional Asian cultures, hierarchy plays an important role that can be reflected in the dynamic of relationships between male and female, as well as older and younger generations. But immigration and acculturation decrease grand/parents' authority since youngsters learn English much faster, and change men's role as major food provider via unemployment and underemployment (Hsu, etc., 2004).

As a result, the power dynamic within the household often reverses, which creates unsteadiness and emotional stress for certain family members, and further challenges the traditional structure of SEAR communities. Although religious beliefs vary among SEARs, the majority of them follow some core values derived from Buddhism. Hsu, etc. (2004) point out that fatalism and karma are two salient features that combine to encourage acceptance of difficulties, and to boost continuity of hard work towards ultimate goals. Fatalism and karma can
Culture affects the understanding and expression of mental disorder (Singh, 2015), and self-reported symptoms for SEARs often center on the body. For example, a SEAR might describe depression as “the water in my heart is fallen.”

Culture affects the understanding and expression of mental disorder (Singh, 2015), and self-reported symptoms for SEARs often center on the body. For example, a SEAR might describe depression as “the water in my heart is fallen.” This is likely due to a culturally different understanding of mental health, stigmas about seeking help for mental health concerns, and/or lacking terminology in their native languages about it. This expression definitely builds up obstacles for assessment. Hence, we as mental health providers could increase the proportion of psychological education, not only to bridge with the settings and policies we have to follow in the United States, but also to show unconditional positive regards by bringing up conceptual differences, to deliver understanding by addressing discrepancies, and to better establish therapeutic rapport by noticing nonverbal language. Other than attention to the out-of-proportion occurrence of certain mental disorders, including depression, somatization and physical disorders, adjustment disorders, anxiety, and posttraumatic stress disorder, clinicians could also use existing scales to form diagnostic impressions such as the Harvard Trauma Questionnaire, Post Migration Living Difficulties Scale, Vietnamese Depression Scale, and Refugee Health Screener (Mollica, Caspi-Yavin, Bollini, Truong, Tor, & Lavelle, 1992; Silove, Sinnerbrink, Field, Manicavasagar, & Steel, 1997; Kinzie, Manson, Tolan, Anh, & Pho, 1982; Hollifield, Verbillis-Kolp, Farmer, et al., 2013). Currently, a research team at the University of Denver is developing a new tool to assess clinicians’ multicultural competence to work with refugee populations (Chao, Wei, Ali, & Galluzzo, in progress).

As the majority of SEARs identify a native language that is different from English, such as Nepali and Burmese, clinicians are likely to work with an in-session interpreter during treatment. However, most clinicians do not train in graduate school to work with interpreters. O’Hara and Akinsulure-Smith (2011) provide clear guidelines for clinicians to work with interpreters. Before meeting with clients, it is suggested to arrange a pre-session meeting with interpreters to set the frame for the relationship and the service, explore manageable length and expression for this interpreter, and process therapeutic boundaries with considerations for culturally accepted behaviors and therapeutic relationship (O’Hara & Akinsulure-Smith, 2011). In the first session with both the interpreter and the client, clinicians should clarify the interpreter’s role with client, set up a triangular formation with a focus on the client, articulate confidentiality and its exceptions, pay attention to the interaction between the interpreter and the client (e.g., hierarchy), and debrief after the session regarding issues such as cutting off, redirecting, and clarification to improve collaboration in the future (O’Hara & Akinsulure-Smith, 2011).

Furthermore, selecting an appropriate treatment plan regardless of one’s theoretical orientation can magnify outcomes in psychotherapy. Chu and Sue (2011) describe a culturally adapted cognitive behavioral intervention to use when treating the somatic symptoms that accompany post-traumatic stress disorder in Cambodian refugees. Some therapy approaches relate more to Asian cultures such as Acceptance and Commitment Therapy. Hence, clinicians are encouraged to integrate some of these techniques, transferring Western terminology into Eastern concepts, asking fitness and discrepancy with their beliefs, and providing concrete exercises such as breathing exercises and progressive muscle relaxation technique. A good example of combining cognitive, emotional, and behavioral approaches is using the mind-body-spirit model, which emphasizes the effect of psychotherapy on mental health, the positive impact of physical exercises (e.g., farming, gardening, yoga) on physical health, and possibly religious practices or spiritual healing activities. The Women’s Circle: Education and Support Group for Bhutanese Women by the Center for Victims of Torture (2012) incorporates the mind-body-spirit model and specified strategies to work with SEAR women.

Besides taking pre-migration and migration trauma into consideration, clinicians should also increase awareness and gain knowledge about SEARs’ post-migration trauma, which is often referred to as accumulative stress. In his theoretical framework of acculturative stress, Berry (1997) emphasizes the impact of societal factors on the degree of accumulative stress. If the society a migrant settles in values cultural diversity and accepts the idea of multiculturalism, refugees tend to experience less stress (Berry, 1997). Conversely, perceived ethnocentrism, racism, microaggression, and discrimination may lead them feeling alienated and rejected. These -isms stem from concerns for competition for access to limited resources as noted by realistic group conflict theory; they may also relate to in-group individuals’ feelings of threat to their self-image (such as being embarrassed when in contact with something unfamiliar) when interacting with members of the out-group as articulated by the integrated theory of prejudice; or they might also result from negative stereotypes about out-group members to be aggressive, unintelligent, and lazy, which further leads to concerns for the prosperity of their own culture/nation (Yakushko, 2009). The majority of the SEAR population presents an appearance that is visibly distinct from the dominant racial group in the United States, which makes them more vulnerable to discrimination and microaggression.
As a clinician who works with refugees, one needs to constantly reflect on his/her own internal reaction to other ethnic groups and cultural backgrounds, in order to recognize and address the sociopolitical factors that are detrimental to SEARs' well-being and to advocate for eliminating prejudice against refugees in the larger society. For example, recent studies about social support conceptualize a fourth type of social support besides emotional support, instrumental support, and informational support. It is termed as companionship support, which is described as one’s perception of having access to resources and social activities (Taylor, 2011). Understanding how the -isms toward refugees decrease their sense of companionship support helps increase clinicians’ empathy for SEARs.

Last but not least, it is effective and adaptive to bring up clients’ inner strengths, and protective variables (Hsu, 2004), such as the closeness among family members, the attitude of acceptance and objection of sufferings that buffers SEARs from adversities, as well as some folk medicine and religious beliefs. Quoting from a previous client of this author, “we were the lucky ones because it wasn’t all bad.”

To sum up, acquiring knowledge of the SEAR population, increasing cultural awareness about one’s own cultural group and the similarities to and differences from SEAR cultures, as well as developing skills for clinical practices are intertwined and integral components of the multicultural counseling competence with SEAR clients.

REFERENCES


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“Will I Ever Be “Culturally Competent”?: How to Infuse and Utilize Diversity in Daily Practice

Laura S. Howe-Martin, Ph.D., Mona A. Robbins, Ph.D., & Tori K. Knox-Rice, B.A.
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This article is based on a professional development workshop the authors presented at the annual Texas Psychological Association convention in 2017.

Formal expectations regarding “multicultural competence,” “diversity,” and “inclusion” are increasingly emphasized as part of psychology practice and training (American Psychological Association, 2017). Beyond training, professionals are encouraged to enhance these skills in licensure requirements through completion of continuing education on cultural diversity. However, the ability to meaningfully integrate “cultural competence” into routine clinical care remains a challenge, as cultural factors can often be perceived as an afterthought or a trivial mandate, not an asset (Betancourt, Green, Carrillo & Park, 2005). This article seeks to demystify the idea of cultural competence by asserting the concept of cultural humility (Hook, Davis, Owen, Worthington, Utsey, 2013) as a tool to infuse cultural awareness and sensitivity into daily clinical practice. In our discussion, we present a candid view of common challenges faced by many clinicians with attention toward patient preferences and worldview through examination of a broader, evidence-based practice model (Norcross, Beutler, & Levant, 2005). We will highlight brief methods for integrating cultural humility across clinical assessment, intervention, and supervisory practices.

As we begin, we recognize the value of embracing cultural humility with an understanding that development of this stance is beneficial regardless of one’s background or belief. However, we acknowledge common obstacles in exploring cultural competence, as this can often be an uncomfortable discussion topic. Common obstacles include defensiveness, fear, emotional discomfort or guilt, lack of concrete knowledge, and insistence on maintaining a narrow worldview (Hook et al., 2016). These obstacles are complex as they can easily be assumed by the patient or clinician and ultimately influence rapport development. As providers in a service-oriented field, psychologists are particularly vulnerable to the bias blind spot (i.e., of course I don’t endorse stereotypes or engage in discrimination, because I am a good person) out of their desire to “do good” and develop the “good” in others. Therefore, it is especially important to continuously recognize these barriers and biases on a personal and social level, so as to engage meaningfully in diversity education as part of lifelong learning practices.

CULTURAL HUMILITY VS. CULTURAL COMPETENCE

Multicultural competence is defined as “the ability to understand, appreciate, and interact with people from cultures or belief systems different from one’s own” (DeAngelas, 2015, pg. 66). This definition emphasizes the versatility of working across groups with consideration of how differences are valued and understood. However, it has been our experience that teaching and training around cultural diversity issues through emphasizing competence quickly becomes a lost cause. Not only is diversity training challenging, due to the requirement for honest self-assessment, but the concept that one can reach the goal of becoming truly “competent in culture” creates an untenable expectation for clinicians. When faced with this dilemma, some clinicians may experience anxiety about their ability to be knowledgeable across all cultural groups. Others may question how they can not only consistently acknowledge diversity, but also intentionally and meaningfully include diverse perspectives into every aspect of care.

An alternative to this focus on competence is to embrace the concept of “cultural humility.” Much of the recent work on cultural humility has been conducted by Hook and colleagues (2013), who define it as “the ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the [person]” (p. 2). This emphasizes the importance of knowing what you don’t know as a clinician and being willing to allow the patient to provide expertise and guidance in their worldview. This allows clinicians to reduce reliance on perhaps unhelpful stereotypes, anecdotal fallacies, or limited interpretation of the literature (although as we will discuss, consulting the empirical literature is also necessary as part of evidence-based practice). Instead, encouragement to take a culturally humble stance provides a space wherein the patient can educate the clinician, which can also lessen any initial gap in rapport due to fear of misunderstanding.
CULTURAL HUMILITY IN ASSESSMENT

Kleinman’s Explanatory Model of Distress (1978) promoted a cross-cultural approach to medical care that exemplifies the concept of cultural humility. This interview begins with asking patients about their perceived definition of the illness and its cause, and the type of treatment that may be most useful. A similar technique was developed and published as the Cultural Formulation Interview in the DSM-5 (American Psychiatric Association, 2013) and includes additional questions such as ways in which a patient would describe their identified problem to others within their family, friends, and/or community, and defining the cause of the problem within a sociocultural context. This consideration allows for the patient to not only describe the problem or concern in their own words, but provides a valuable opportunity to assess the level of involvement of spiritual, physical, and mental health factors into the patient’s explanation of distress. This tailored perspective also allows for a quick assessment of the patient’s view of mental health care with attention towards cultural differences that may affect diagnostic considerations.

ADDRESSING METHOD

Another useful method we teach and use on a routine basis, both in fast-paced and longer-term treatment settings, is the integration of Hays' ADDRESSING framework (Hays, 1996) into the early assessment, diagnostic, and conceptualization process. This fairly easy mnemonic (i.e., Age and generational influences, Developmental or other Disabilities, Religion and spiritual orientation, Ethnic and racial identity, Socioeconomic status, Sexual orientation, Indigenous heritage, National origin, and Gender; Hays, 2016) provides the basic foundation outlining a patient's varied and intersecting identities. This approach encourages the clinician to move beyond race, biological sex, and age to also consider aspects of identity such as disability status, socioeconomic status, and national origin. We encourage the routine utility of a framework such as this because it helps highlight aspects of a patient's cultural identity that remain unknown and are areas for further assessment and discourse.

CULTURAL CONSIDERATIONS AND EVIDENCE-BASED PRACTICE

Evidence-based practice (EBP) is defined as the integration of clinical expertise, patient values, and the best research evidence into the decision-making process for patient care (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996; Norcross, Beutler, & Levant 2005). This triad of 1) best research evidence, 2) patient values, and 3) clinical expertise, requires that a clinician encourage scientific mindedness while also gathering information regarding patient values and preferences (i.e., culture-specific elements; Sue, 1998). Many of us feel more comfortable relying on one of these three areas of the EBP model in our practice. However, through constant awareness of the three components as a comprehensive whole, we can recognize areas for personal improvement, particularly if assessing patient values is an area of relative clinical weakness. Attentiveness to how each area informs the other can strengthen skills in clinical inquiry, assessment, and implementation of interventions.

Moreover, the remaining aspect ("clinician expertise") requires what Sue (1998) refers to as "dynamic sizing." This is the ability to generalize population-based empirical evidence in a way that allows useful application to the unique patient, without assigning hard-and-fast rules to all groups. When utilized appropriately, dynamic sizing allows cultural nuances of groups to be appreciated, while also drawing from common behaviors and interactions that may be characteristic of a population.

CULTURAL DIVERSITY IN SUPERVISION

Finally, although there is a significant emphasis on the importance of "cultural competence" for professionals (Whaley & Davis, 2007), there is also significant emphasis placed on developing this among trainees. Therefore, we would argue that there is a professional and ethical requirement to model and teach cultural diversity issues as a necessary part of supervision. Knapp and VandeCreek (2012) described professional competence as a combination of emotional competence, technical skills, professional role socialization, and knowledge of cultural issues.

Unfortunately, supervisors often rely on a critical events model for supervision, in that issues surrounding culture are only brought forth if a significant event occurs. Even in those situations, it is not uncommon for the supervisee (not the supervisor) to be the one to initiate conversations regarding cultural diversity, particularly for minority supervisees (Wong, Wong & Ishiyama, 2013; Christiansen, et al., 2011). Even for supervisees who do not have a minority identity status, trainee discomfort with being perceived as incompetent or inadvertently discriminatory can act as a barrier to truly integrating issues of cultural diversity into the supervisory process. In addition, fears regarding a lack of receptiveness or understanding by the supervisor to frank conversations regarding diversity can lead to a regressive supervisory relationship (Constantine & Sue, 2007).

Cultural humility as applied to supervision is described as a process of initiating, inviting, and instilling cultural humility in trainees (Hook et al., 2016). Of note, the first step in this model is the initiation process. This can take the form of a formal assessment of cultural concepts at the beginning of the supervisory process, such as having supervisees define acculturation and related models or describe common identity development models, and culturally appropriate test interpretations and cautions (Berry, 1997; Cross, 1971; Jones, Sander, & Booker, 2013, for specific examples). This acknowledgement helps with identification of specific knowledge gaps. Another is to assess supervisee experiences with various cultural groups at the beginning, middle, and end of a supervisory period. This process helps identify specific patient populations to which trainees may not be familiar. Finally, it is possible in some supervisory relationships to engage in cultural history self-disclosure.
for the purpose of emotional and professional growth and competency development. For example, if supervisees are comfortable and willing, the supervisor and supervisee may complete the ADDRESSING framework for themselves and have an open dialogue about what this means for the supervisory relationship and power dynamics (Robinson, Bradley & Hendricks, 2000; Safran, Muran, Stevens & Rothman, 2007). Of course, this last activity requires careful considerations and sensitivity, so as to not create an environment of forced self-disclosure. In our practice, it is not uncommon for us to bring our own cultural identities into supervision as a way of initiating the dialogue about the importance of cultural worldview on our own practices.

**FINAL THOUGHTS**

Regardless of the methods used to initiate, invite, and instill cultural competence, it is our hope that clinicians will embody the concept of cultural humility through a process of asking questions, consulting, and admitting when we do not understand a patient's worldview or perspective. We recognize and anticipate that alliance ruptures can occur across assessment, intervention, or supervision. However, it becomes important to acknowledge the rupture and provide validation for the repair process to begin. Cultural humility is a way of being that challenges one to consider how another's truth came to be. The concepts reviewed in this article are meant to spark further interest in how to improve your everyday work as we all learn to incorporate cultural diversity issues in a more seamless way, and not as a mandated afterthought, to carefully apply clinical practice and science to the person in front of you. ■

**REFERENCES**


Dallas Independent School District is the second largest public school district in Texas and the 14th largest school district in the nation. Dallas ISD serves approximately 155,000 students in pre-kindergarten through the 12th grade, in 230 schools. The student ethnic composition is: Hispanic (70.06%); Black American (22.46%), White (4.87%); Asian (1.37%); American Indian (0.22%); National Hawaiian/Pacific Islander (0.04%); Two or more (0.88%).

**Psychological and Social Services**

Psychological and Social Services (PSS), under the directorship of Connie Rodriguez, is a unique department within the Dallas ISD serving students who are experiencing social, emotional, and/or academic difficulties. PSS is a member of the Association of Psychology Postdoctoral and Internship Centers (APPIC), and therefore PSS participates in the annual APPIC matching procedure.

**Juhn’s & My Reflections**

I am on the Leadership Team for Psychological Social Services within Dallas ISD serving as a supervisor for licensed psychologists and LSSPs. I have had the awesome opportunity to train and supervise doctoral and LSSP interns for more than 25 years in the Dallas Independent School District. During the 2017–2018 school year, I supervised Yuet Juhn Tse from the University of Washington's School Psychology Program.

As our successful 2017-2018 school year drew to a close, Juhn and I decided that we would like to share the wealth of our supervisory experience to help other doctoral interns and early career psychologists.

During his 2017-2018 doctoral internship program in the Dallas Independent School District (DISD), Juhn counseled at one of our DISD Youth & Family Centers working with a diverse clientele, assisting families with parenting skills for students with behaviors such as ADHD, ODD, physical and verbal aggression, sadness, depression, anxiety, suicidal ideation, and low academic achievement. At the Young Men's Leadership Academy, Juhn designed and implemented a student leadership curriculum on leadership styles. In two elementary schools, Juhn worked with students on mindfulness to assist with their self-regulation and provided them with calming techniques. Many of the students Juhn worked with had been diagnosed with depression, anxiety, trauma, bipolarity, or PTSD. Juhn also worked on DISD's Crisis Team with Psychological and Social Services and assisted with school-wide crises. Some of these crises included student murder, suicide, and deaths due to leukemia, teacher deaths due to a motorcycle accident and cancer, and gang-related violence and crime in a few of the DISD schools.

Juhn’s assessment rotation was with the DISD’s special education department with the Individualized Evaluation Department.
Juhn administered comprehensive evaluations on students who were later diagnosed with intellectual, emotional, and/or learning disabilities. He conducted evaluations with an external agency with children on the autism spectrum.

OUR OWN ISSUES OF CULTURAL DIVERSITY
Initially, Juhn and I realized that we had intersectionality factors that might have impacted our rapport, building of trust, respect, and relatedness during supervision: I am a Black American female Baby Boomer, born in Chicago, Illinois, raised in the Houston, and educated in the Houston Public Schools, Texas Southern University, and Texas Woman's University.

Juhn, on the other hand, is a Chinese-American male Millennial, born in Hong Kong, who came to the U.S. with his family and settled in Seattle when he was 14; he was educated in the Issaquah School District and at University of Washington.

Juhn and I were always polite, cautious, and professional with one another. We both were aware of the Elephant in the Room, our ethnic/cultural differences. However, once we had a frank discussion about our concerns in regards to racial stereotypes, Juhn and I were able to bond and move forward professionally in a less tense climate.

There were four questions Juhn answered in an interview format for this article:

HOW DID YOUR DOCTORAL PROGRAM PREPARE YOU FOR YOUR INTERNSHIP IN THE DISD?
With my program experiences in Seattle and perspectives as an immigrant, I felt quite well equipped with the knowledge and skills to serve students from various backgrounds. I felt that I was well educated in making meaningful connections with the schools in addition to learning about the administration of different interventions. Since school psychologists are often seen as advocates for students' mental health needs in the schools, I think it is essential that we help school personnel to see us as assets when it comes to interacting with students and their families. This was a major motivation for me to come to Dallas to further sharpen my skills as a school-based practitioner.

WHAT WERE THE MOST CHALLENGING ASPECTS OF YOUR INTERNSHIP YEAR?
The foremost challenge was settling in a new city. These adjustments included establishing a budget of living expenses around a limited stipend, different weather climates, and not being able to hike. Separation from my spouse was the hardest of all other challenges in that we were newlyweds.

In the schools, the diversity of the school staff, students, and parents was overwhelming, and attempts to develop positive relationships with everyone was difficult. Although I am skillful in school-based interventions, I had to work hard to prove that I was capable and competent. I had to become sensitive to the unique culture of each school and carve out my role according to the needs of the schools. When working with my students and their families, I encountered barriers to the therapeutic alliance, including my emerging professionalism, being a privileged person with a graduate level education, and also being an immigrant coming from out of state. One of the tasks that really pushed me out of my comfort zone was working in the district crisis response team, which was an area that I had no exposure to in the past. I was grateful for the collaboration and guidance from my supervisor and the crisis team; they helped me understand how I could best help with students and teachers who were affected so soon after a traumatic event (e.g., suicides, murders, illnesses). I became better apt at becoming a mindful, empathic listener and providing coping tools.

DISCUSS YOUR PERSONAL AND PROFESSIONAL GROWTH AND DEVELOPMENT.
By forming genuine connections with the students and families I served, I now have increased fluidity in identifying and implementing appropriate interventions. As an intern, I frequently found myself trying to make progress on session agendas, being too preoccupied with getting my clients through intervention activities without focusing on the quality of the relationships. Being able to reflect on this with my individual supervisor has helped me enormously to refocus on letting the clients be the center of the therapy sessions and walking at the right pace with my clients.

Moreover, understanding how to effectively communicate with other professionals has been key to my continued advancement as a clinician. During individual and group supervision, I learned how to communicate about the difficulties I faced with my cases which allowed cohort and supervisory support.

At my schools, effective communication was essential for developing trust between school personnel and me. Such trust was vital for positive work collaboration among the school staff, which subsequently maximized the chance that the students’ needs would be met efficiently.

My internship also gave me important life lessons. For example, I learned to give myself some grace and appreciation for the work I had done, which was critical to helping me move past my mistakes and strive for better future outcomes. My internship year helped me with work-life balance.

More importantly, I found myself learning from my families, who demonstrated strengths in the face of extreme adversity. I was humbled by these experiences.

WHAT SUGGESTIONS WOULD YOU GIVE TO INCOMING PRE-DOCTORAL INTERNS?
Reach out to those who recently completed their internship and listen to their experiences. Specifically, talk to the graduates from your program. Despite having different internship sites, there may be common tips.
on daily living issues as well as organizational strategies to handle the work demands from both the internship site and your academic program during the internship year.

Have confidence in your qualifications as a professional. Incoming interns can be certain that the skills and experiences they bring to the internship sites are valuable to their clients.

Have in mind the kind of specialty experience you would like to have. While some internship programs may already have a specific clinical focus up front (e.g., autism, trauma), you may want to have more exposure with something different. Advocate for yourself early in the internship year to enhance your satisfaction of your training experience.

Be ready to have an open mind for getting out of your comfort zone. New opportunities during your internship will help you to acquire new skills and experiences. Learn to accept your own flaws and criticisms from others. Missteps are to be expected; an intern has to be open to challenges with a ready revamped mindset.

Lastly, remember to be kind to yourself as well as everyone around you. While graduate students are known for their good work ethic and resilience, the internship year can still be quite a daunting process. Please be reminded that you are not walking alone and be sure to connect with those who support your work, including your supervisor, cohort members, program staff, family members, and significant others. Remember self-care, such as treating yourself with healthy food, outdoor activities, and frequent chats with love ones who are away. When you take good care of yourself, it empowers you to pass on your positivity to people around you, such as your colleagues, families, students, and school staff.

END OF A SUCCESSFUL INTERNSHIP YEAR

As Juhn and I completed our last supervisory session, we both marveled at our own personal growth and development. I congratulated Dr. Tse (because Juhn has since graduated). Finally, see the sidebar at right for some helpful tips from us.

HELPFUL TIPS FOR SUPERVISORY RELATIONSHIPS

» Always share open communication.
» Share background information.
» Establish rapport.
» Seek to understand the other’s point of view.
» Always ask questions.
» View the person as an individual, not a culture.
» Have patience with one another.
» Have acceptance of the individual.
» Avoid cultural/ethnic stereotypes; good or bad.
» Take geographical and regional differences in account, e.g., Texas vs. Pacific Northwest.
» Never assume you know all of the answers.
» Don’t make assumptions.
» Expect gender differences.
» Expect generational differences (in our case, Baby Boomer vs. Millennial)
» Expect differences in theoretical formulations, e.g., CBT vs. Eclectic.
» If you leave a supervision session feeling uncomfortable about outcomes, bring it up in the next session.
» Learn to trust the supervisory process.
» Learn to trust each other.
» Be open and frank.

» If either of you feel that there is an “the elephant in the room,” voice it.
» Be vulnerable.
» Never assume you know more about someone else’s culture than they do.
» Try humor when all else fails.
» Find a commonality in anything such as food, fashion, literature, travel, sports, technology, family life, music, etc.
» A year is a long time. Always let the other person know how much you appreciate him/her.
» Share feedback.
» Offer gratitude for successful outcomes.
» Let the other person know how much they have grown from the supervisory experience.
» Continue to improve in your own level of competencies.
» Understand that social media can be a great friend during a year-long supervisory experience.
» Seek advice from a trusted colleague or cohort team.
» Treat each other with respect.
» Respect each other’s value system.
» Ask for feedback occasionally during that internship journey by simply asking, “How are we doing?” and “How can we make this internship experience better for the both of us?”

REFERENCES

KEYNOTE

Alan L. Peterson, Ph.D., ABPP

Enhancing Psychological Resiliency after Trauma Exposure

Dr. Peterson retired from the U.S. Air Force in 2005 after 21 years of active duty including service as the Chair of the Department of Psychology and the Director of the American Psychological Association-accredited Clinical Health Psychology Postdoctoral Fellowship Program at Wilford Hall Medical Center.

While on active duty he deployed in support of Operation Noble Eagle, Operation Enduring Freedom, and Operation Iraqi Freedom.

Dr. Peterson has clinical and research experience in the areas of behavioral medicine, clinical health psychology, and combat-related stress disorders. He has conducted research in the areas of post-traumatic stress disorder (PTSD), psychological risk and resiliency, Tourette Syndrome, tobacco cessation, pain management, insomnia, weight management, and managing suicidal behaviors.

He is also Research Health Scientist at the South Texas Veterans Health Care System in San Antonio and a Professor in the Department of Psychology at the University of Texas at San Antonio where he teaches and mentors doctoral students in the Ph.D. program in Military Health Psychology.

Dr. Peterson is an avid ultra-endurance trail runner.

KEYNOTE

Rosie Phillips Davis, Ph.D., ABPP

Persisting in the Face of Poverty

Rosie Phillips Davis, Ph.D. ABPP, is former Vice President for Student Affairs and current Professor of Counseling Psychology at the University of Memphis. She earned a doctorate in Counseling Psychology from The Ohio State University. Her primary practical and scholarly passions are the power of inclusion, multicultural vocational psychology, ethics, and living well in a diverse society. She currently serves on the American Psychological Association Finance Committee and the American Psychological Foundation Board.

She previously served on the APA Board of Directors, The Council of Representatives for Divisions 1 and 17, and is past President of the Society of Counseling Psychology (17). She has served on the editorial boards of several journals, including current service on the Journal of Career Assessment, and is the author of numerous articles and book chapters on career counseling and has co-edited two books.

Her awards include the Janet E. Helms Award for Mentoring and Scholarship, the Author S. Holman Lifetime Achievement Award, the Charles and Shirley Thomas Award (Division 45, 2004), the Dalmas A. Taylor Award, the National Multicultural Conference Certificate of Appreciation (2007), the APA Society for the Psychological Study of Lesbian, Gay, and Bisexual Issues (2007). Dr. Bingham has received an APA Presidential Citation, was named an Elder by the National Multicultural Conference and Summit and received the Distinguished Professional Contributions to Institutional Practice for APA Award, 2015.

Dr. Davis, along with Drs. Lisa Porche-Burke, Derald Wing Sue, and Melba Vasquez is a founder of the National Multicultural Conference and Summit.

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KEYNOTE

Christine Runyan, Ph.D.
Leveraging The Tend-and-Befriend Response to Manage Cumulative Secondary Stress in Professional Practice

Dr. Runyan is the director and primary clinical supervisor of the Primary Care Psychology Fellowship at University of Massachusetts Medical School. She joined the faculty as Associate Director of Behavioral Science and is the Behavioral Science Director for the Worcester Family Medicine Residency. She has extensive experience in health psychology in primary care. She has been a leader in developing integrated primary care in the Air Force and has experience in teaching and academic leadership in health psychology graduate training.

Her primary clinical interests are in the role of trauma in primary care and physician wellness, including teaching mindfulness based skills to residents.

INVITED

Beth Rom-Rymer, Ph.D.
First Person – Prescribing Psychologists: Who We Are, What We Do, and How We Are Changing the World

Dr. Rom-Rymer received her undergraduate degree in psychology from Princeton University in 1973, as a member of the first class of women there. She received her M.A. and Ph.D. in clinical psychology from The University of Illinois, with an emphasis on community organization and gerontology. Dr. Rom-Rymer did her internship training at The Vanderbilt University Medical Center, where she did rotations in the transsexual diagnostic surgical center as well as with the Metropolitan Police Department, working with adult and child survivors of sexual assault.

Dr. Rom-Rymer currently has a national consulting practice in forensics, working as a forensic expert witness in civil litigation in which there are allegations of sexual abuse and physical abuse, sexual and physical harassment, and other forms of violence: in nursing homes, in the context of child custody litigation, in the workplace, and on pleasure cruises. She has helped to create the field of forensic geriatrics and has published multiple articles in this area. Dr. Rom-Rymer is on the editorial board of the Journal of Child and Adolescent Trauma. She has recently been appointed co-chair of the Division 56 (Trauma) Inter-divisional Task Force on Ethical Practice with Traumatized Populations in Forensic Cases.

One of Dr. Rom-Rymer’s passions is expanding the scope of practice for psychologists. She is currently working nationally to create training and practice opportunities for prescribing psychologists in public service venues: state hospital systems, federal and state prisons, military bases, and Indian reservations. Dr. Rom-Rymer was co-chair of a mini-conference at APA San Diego 2010 in which the partnership between Prescribing Medical Psychologists and the Indian Health Service was celebrated with symposia and a cultural hour of tribal performance. Dr. Rom-Rymer continues to work with Indian tribal representatives and the Federal Indian Health Service (IHS) to expand mental health services for Native Americans and to provide broader opportunities for practice for psychologists.

INVITED

Lisa Blue Baron, Ph.D., J.D.
How to Communicate to a Modern Jury: The Pitfalls of Being a Psychologist in Court

As partner with her late husband Fred Baron is one of the largest environmental law firm in the U.S., Blue's accomplishments have been nationally recognized. She has been named one of the Top 100 Most Influential Lawyers in America, one of the Top 50 Women Litigators in the U.S. by National Law Journal, and received numerous other state and national recognitions for her legal expertise. She served as president of the American Association for Justice from 2014-2015 and was inducted into the National Trial Lawyer Hall of Fame in 2015.

Blue received her undergraduate degree from the University of Georgia and two master's degrees from the University of Virginia in Counseling Psychology. After a brief teaching career, she returned to school and earned a Ph.D. in Counseling Psychology from North Texas State University and a Juris Doctorate from the South Texas College of Law.

After completing law school, Blue joined the Dallas County District Attorney's office where she prosecuted more than 125 cases to verdict and later advanced to the DA's Organized Crime Division. In 1985, she moved to the law firm Baron & Budd where she specialized in environmental and toxic tort law. Lisa and her husband, Fred Baron, supervised 800+ employees and managed all financial aspects at Baron & Budd, the largest environmental law firm in the United States.
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