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A NOTE FROM THE PRESIDENT

Responding to a Changed World

MEGAN MOONEY, PH.D.
Houston, Texas
TPA President

Dear TPA Member,

Since my last article for the Texas Psychologist, our entire world has changed. In my introductory letter to my Presidential year, I referenced the unusual times we were in with science and data being called into question and the problems within the profession of psychology and TPA more specifically that have led people to feel marginalized and excluded. I could never have predicted how the novel coronavirus pandemic and continuing acts of violence against Black Americans would have brought these exact concerns into such sharp and tragic focus.

In my first letter, I asked that each of you consider the ways in which you could help yourself to be more included in the profession of psychology and TPA and to ensure others are more included as well. This seems like an appropriate time to reiterate that request but also to ask you to go one step further. I ask that you not just consider these ideas but to develop an action plan and start taking necessary steps to improve our profession and association. I ask that you truly take the time to put your thoughts and words into action. I have had many conversations with people over the past four months about feeling helpless and like we don’t know where to start. The answer is simple – just start doing something, anything, to make life better for others.

Over the past four months about feeling helpless and like we don’t know where to start. The answer is simple – just start doing something, anything, to make life better for others.

For my part, one action I took in response to the murders of numerous Black people throughout the spring and early summer was to develop a Racial Justice Task Force within TPA. This task force has developed goals to (1) look inward at TPA to identify and address areas of injustice, (2) assemble and disseminate psychological science on inclusion, equity, and systemic racism to the people and legislators of Texas, (3) educate members on best practices for serving people of racial diversity in clinical, academic, and research contexts, and (4) acknowledge, describe, and mitigate the systemic barriers within our profession for trainees and practitioners of color. The Task Force has subsequently developed dedicated subgroups focused on specific priority projects to address these goals. We will continue this work throughout the year and our next two Presidents, Drs. Fran Douglas and Alfonso Mercado, are part of this Task Force and will ensure that the work continues on past my year as TPA President.

I have had difficult conversations with members in recent months about how COVID-19 has impacted their families, their practices, and their clients. I know that many of you are struggling with decisions regarding the upcoming school year and how to keep your families safe while balancing professional obligations and interests, as well as the need for the education and socialization of your children. There are no easy answers to these dilemmas. I have also had many exchanges with members about violence, systemic racism, and discrimination against people of color and TPA’s role in addressing and responding to this. These are not easy discussions, and they do not always lead to agreement. But I do appreciate that we can have respectful dialogue that hopefully leads to better understanding and actions taken to help people.

My hope is that we can continue to engage in these conversations. My job as President of TPA in this year in particular and with my goal of Inclusion feels like the right time to engage in difficult conversations and choosing actions that may not be easy or comfortable but will lead to improving Psychology in Texas, TPA as an organization, and most importantly, the lives of the people we serve.

As always, I welcome any questions, concerns, or invitations for continued dialogue.

Sincerely,

Megan

Meghan Mooney, Ph.D.
Houston, Texas
TPA President
Colleagues,

I want to start this issue by thanking each author who has contributed to the Texas Psychologist over my tenure as Editor and all the Presidents that I have had the pleasure of working with, our Legislative guru, Kevin Stewart, and our new Executive Director, Mrs. Jessica Magee. Without each of you, this publication would not exist!

As TPA continues to evolve and shape the future of Psychology in Texas, I will be stepping down from the Editorial position to pursue other things, including perhaps, executive committee leadership. I look forward to contributing my time and energy to an organization that has a part in raising me to be a vigilant, active advocate for psychology in Texas, other States, and our Nation.

Change comes at a time when the wave of uncertainty is upon us. In riding the wave, I invite you to explore new things and get excited about what’s in store for psychology, our community, and the world. I look upon the last seven months with awe in recognizing how quickly elements of our lives change. I’m proud of what we have accomplished with the journal. We have taken this publication to the next level! I am confident the TP will continue to publish quality, peer-reviewed, material to enhance your practice, get you thinking and exploring new things, stimulate activism towards social justice and change, and encourage you to pursue science in the application of psychology.

Thank you for all your support. Enjoy the issue; I will look forward to seeing you all again!

Jennifer

Correction

A NOTE FROM THE FOUNDATION
Inclusion in the Time of a Pandemic

MICHAEL DITSKY, PH.D.
TPF PRESIDENT

We are all in this together” has become the mantra of our present pandemic, and it resonates with this TPF’s theme of Inclusion, led by its president, Dr. Megan Mooney.

Things are different, but in many ways, it is “business as usual.” Together we have shared our telehealth experiences and what it means to offer services through a different platform. The Foundation’s monthly board meetings are now conducted via Zoom rather than by telephone. We have been fortunate to have been included in the COVID-19 blogs and messages from Drs. Mooney, Stagner, and McCoy. This time of anxiety and grief is an opportunity to include our colleagues in our communications.

Since Dr. Mooney announced that her theme for TPA 2020 Convention would be Inclusion, I have thought about ways to be more inclusive and how we function in an inclusive way.

Dr. Heyward Green resurrected the Inclusion of student board members with full voting rights and privileges. Anna Abate and Cassandra “Cassie” Bailey joined the Foundation board in August 2018. Both are students at Sam Houston State University. They will be leaving the board in June 2020 to pursue their internships: Anna in North Carolina and Cassie in California. They have added a great deal of enthusiasm and vigor to the Foundation. They will be dearly missed, and we wish them the very best. Kyle McCall, a graduate student at Fielding Graduate University, officially joined the board in January of this year. He has been very active and engaging in our Foundation’s efforts and work.

He is also the student representative to TPAs Board of Trustees.

The recent TPF Survey that went out on May 12, 2020, was the brainchild of Dr. Linda Ladd. I urge members to take the opportunity and share your thoughts and wisdom in completing the survey. Responses will be used to construct a larger strategic plan for the Foundation.

We are looking for ways to engage a wider TPA membership audience besides raising funds. As the survey letter states, “TPF board is looking for ways to support research and travel by graduate psychology students, identify clinical issues beneficial for research funding awarded to TPA members, and strengthen service to the TPA community and profession of psychology.”

The TPF Survey was truly a team effort that included Drs. Courtney Banks and Linda Ladd, Kyle McCall, and our Executive Director, Jessica Magee.

Including the Platinum Advocate Reception with TPF’s Halloween Party at our 2019 Convention was widely accepted, and TPF looks forward to many more inclusions as we move forward with our developing strategic plan.

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 admin@texaspsyc.org by 9/15/2020 for the next issue.
International Psychology and Multicultural Diversity

Saajan Bhakta, Ph.D. 1 & Angela Quiroz, Ph.D. 2

There is a growing need for a contextual and cultural understanding of psychology in the United States (US) in order to provide ethical and effective care that not only acknowledges multicultural diversity, but also embraces and empowers those who share different belief and value systems. Perez and Hirschman (2009) argued that by the year 2043, racial and ethnic minorities will become a numerical majority in the United States. This further highlights the need for a proactive approach to developing cultural competency for mental healthcare professionals. As highlighted by the recent social events in the nation, there is a growing demand for diverse perspectives to adapt to challenges. In the year 2018, there were 1,096,611 individuals who were granted lawful permanent resident status in the US (United States Department of Homeland Security, 2020). These new residents come from diverse backgrounds and will be tasked with integrating and building successful lives in the US. Psychologists and professionals in the US will provide important support to these immigrants from diverse cultures and backgrounds. The need for an international psychological approach and perspective is more important now than ever. In 1997, the American Psychological Association (APA) created Division 52, which is focused on International Psychology. Division 52 works to create a culturally inclusive and contextually informed practice of psychology.

Often, Western tools and interventions are transported across cultures without regard to the implications that this can create. Psychologists have an ethical and professional responsibility to avoid assuming cultural equivalence across constructs and instruments. International psychology, which encompasses cultural, cross-cultural, and indigenous psychology, focuses on understanding the similarities and differences in psychological phenomena across diverse global contexts and seeks to promote contextualization and the idea that Western concepts of psychology are not always effective across various cultures (Stevens et al., 2018; Stevens & McGrath, 2017). In an increasingly diverse, complex, and ever-changing world, psychological instruments, evaluations, and tools must be cross-culturally explored and validated to ensure validity and reliability before use across different populations (Ogden & McFarlane-Nathan, 1997). For example, within neuropsychology specifically, using neuropsychological tests for populations and cultures other than those for which they have been normed or standardized can result in clinical diagnostic errors (Mastumoto, 2003; Ogden & McFarlane-Nathan, 1997).

Practitioners need to be able to integrate the social ecology of a presenting client when developing interventions for addressing their needs (Ungar, 2013). As practitioners of psychology, it is imperative that the insider-outsider continuum (Herr & Anderson, 2015) be considered carefully before each interaction. Understanding the role and position of the provider is critical in order to provide contextually informed care. For example, many cultures view the mere title of “doctor” to create a distance in power, and this can directly impact the relationship. More than acknowledging this, the psychologist has a responsibility to understand how this can impact the care they aim to provide and develop a plan to integrate such cultural variables into their support. It is also important to remember that while the provider might identify from the same or similar culture as the client, they may still be viewed by the client as an outsider on the continuum due to many different factors and variables that separate the two individuals. Assumption of surface-level relatability should be made very carefully and sparingly.

An example of a potential care adaptation that may become necessary with the growing diversity of immigrants in the US is collaboration with traditional and indigenous healers. Now more than ever, it will become critical for practitioners to work in collaboration with traditional and indigenous healers that their clients see. Rather than creating an “us” versus “them” dynamic, the client will benefit far more from therapeutic services and interventions when practitioners leverage the support of their cultural systems and processes. If a client presents and says they are currently also working with an indigenous healer, practitioners should avoid passing judgement. Krippner (1995)

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argued that while the intellectual quality and processes do not differ between traditional healing and scientific models, the mode of delivery does. The logic of tribal healing is as rigorous and comprehensive as that of scientific Western models.

Lack of cultural competence can result in ethical challenges for psychologists. For example, an International Psychologist chooses to conduct a qualitative study using interviews to better understand suicidality in India. The respective regulatory Institutional Review Boards have approved the study, and the researcher travels to India to collect data through interviews. After nine successful, insightful interviews, the researcher meets an ethical challenge. For the tenth interview, the participant begins by begging the psychologist that everything he says be kept strictly confidential no matter what. He then goes on to share that his aging parents have become an emotional, financial, and physical burden for him. In India, from a cultural perspective, aging parents generally live with their eldest son. Retirement homes or assisted living facilities in rural India are rare. The man shares that he has witnessed his aging parents go through much pain in their final years. He shares that they have taken a lot of his time, and the burden is now creating much stress and anxiety for him because he cannot focus on working at the farm to earn money to feed his children. He then goes on to disclose that he overdosed his mother on her medications a few months ago to "put her out of her misery." He claims that she was "very old" and that nobody would have questioned her death from natural causes. He shared that he simply could not see her suffer in pain anymore. He also admits that he overdosed her without her knowing. He expressed feelings of intense guilt, but also feelings of relief. The man's father is still alive and living in the home. He is also aging very quickly with many different health problems. He is bedridden and must be fed daily. The man does not explicitly express intentions to overdose his father, but he does elude multiple times that his father is suffering. The interview ends with the man begging the psychologist to maintain confidentiality. While this example is specific to the Indian culture in India, it is important to understand the foundation and norms of various cultures, especially the cultures from which your clients come from. Practitioners in the United States may encounter similar cultural challenges when working with Indians in their own practice even though they are not physically in India.

In this particular example, the psychologist is faced with a difficult and complex ethical challenge that is tightly interwoven with culture. Leach et al. (2012) outlined and explained a nine-step model for ethical decision making that takes cultural considerations into account. The first step is to analyze the ethical challenge and situation. This involves considering the various ethical principles involved, how they are in competition, the specific people involved, the culture, and other contexts that need to be taken into consideration. For this example, the Indian culture must be taken into consideration to understand the situation of aging parents and the burden of care. Next, the psychologist should consider his or her personal biases, perspective, and thoughts within the context of the ethical challenge (Leach et al., 2012). The psychologist should consider these factors in how they may influence the decision-making process in addition to how they may be influencing the stress of the psychologist. For example, if the psychologist used to work within the criminal justice and legal system, he or she may have biases and preconceived notions about those who commit crimes. This must be actively considered as part of the decision-making process to ensure a successful outcome.

Principle D from the APA's Ethical Principles of Psychologists and Code of Conduct (2010) explains that psychologists should work to prevent unjust practices and to ensure awareness of all biases. In addition, the principle also states that there should be a level of competence and expertise in the area in which the psychologists are working in. When working among a diverse community, it is imperative to ensure that practitioners are trained in cultural humility to gain cultural competency in order to provide services. Cultural humility is the ability to maintain an interpersonal stance that is placed in relation to aspects of cultural identity that are most important to the person (Hook et al., 2013). Cultural humility is different from other culturally based training ideals as it focuses on self-humility rather than achieving a state of knowledge or awareness. Hook et al. (2013) argued that cultural humility was formed in the healthcare field and tailored for therapists, social workers, and medical staff to learn more about experiences and cultural identities of others and to increase the quality of their interactions with clients and community members.

Cross et al. (1989) developed one of the more universally accepted definitions of cultural competence within the field of mental health. They defined it as "A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable the system, agency, or professionals to work effectively in cross-cultural situations" (Cross et al., 1989, p. 13). This definition places the concept within the systemic framework. It is argued that the influence of a culture while ignoring the needs of the target population poses danger to a program and to recovery (Frierson et al., 2010). The collaborative response taken by medical and mental health service providers will need to respect cultural competence and cultural humility. Cultural humility serves as a tool to be utilized at both the macro- and micro-levels to better connect with individuals and communities as well as to gain more insight into personal biases and identities (Hohman, 2013). Cultural humility can lead to both personal and professional growth of mental health care practitioners.
Practitioners, professors, and social service personnel cannot know everything about every culture, but individuals can become familiar with how culture influences health beliefs and health practices.

For example, some cultural groups have a long history of migration and resettlement across the globe that have contributed to their present-day customs, beliefs, and living conditions (Hook et al., 2013). Many populations have been colonized by at least one nation, which adds to the cultural systems of these groups and populations.

Practitioners and social service personnel should be prepared to provide ethical and culturally appropriate interventions that are collaborative in nature. A specific case is that of a 56-year-old, male, first generation, US citizen who is of Persian/Iranian descent. He is diagnosed with paranoid schizophrenia. For the protection of the client identified and in line with HIPPA regulations, names have been withheld. The client had a history of manic behavior and a long history of psychiatric hospitalizations for stabilization. This client continuously fell into the cycle of believing he was “cured” once stabilized, and he would stop taking medications regularly causing mood imbalances, auditory hallucinations, and suicidal ideation. This client and his elderly mother requested holistic alternatives to prescribed medications because they were in contact with an indigenous healer. As a result, the client’s treatment team comprised of a case manager, psychiatric nurse, and psychiatrist created a treatment plan with the client to better understand his needs, cultural views, and assess his knowledge of his triggers. Service providers trained in cultural humility understand the importance of including a client’s cultural values and views into interventions and treatment plans. It is a collaborative effort rather than directive.

Health care delivery often takes a one-size-fits-all approach. Practitioners often provide similar interventions to patients with a diagnosis similar to the last patient seen with the same diagnosis under the faulty assumption of matched efficacy across cultures. Shifting that mindset provides practitioners with one of the best opportunities to help people truly thrive and live sustainable lives (McGee-Avila, 2018). An individual’s lived experience is rich, diverse, and complicated. As such, every individual’s treatment should be unique and customized in order to live his or her healthiest life possible.

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Incarceration is associated with various mental health concerns, including a higher prevalence of psychotic disorders, major depression, substance use disorders, personality disorders, and post-traumatic stress disorder, and jails are generally ill equipped to provide adequate treatment to mentally ill inmates (Baranyi et al., 2018; Fazel et al., 2006; Fazel & Danesh, 2002; Fazel & Seewald, 2012). For comparison, approximately half the incarcerated population report symptomatology, compared to 25% of the general population (Daniel, 2007). Without treatment, individuals in correctional facilities can experience irreversible worsening of symptoms of psychosis, as well as increased risk for self-harm, suicide, and victimization (Altamura et al., 2011; Hayes, 1995; Lieberman & Fenton, 2000). Further, deinstitutionalization and poor community mental health care have led to significant growth in the number of mentally ill inmates (Daniel, 2007) and subsequent Competency to Stand Trial (CST) evaluations.

CST evaluations assess a defendant’s ability to understand their charges and engage in the legal process (Dusky v. United States, 1960). These evaluations are the most frequently court-ordered mental health evaluations (Melton et al., 2017), with more than 60,000 conducted each year (Bonnie & Grisso, 2000) – this statistic is two decades old and likely an underestimate of the number of yearly evaluations today (Murrie et al., 2020). With a recent and rapid increase in court-ordered CST evaluations (Gowensmith, 2019), long wait-times have been noted to exacerbate mental health concerns, resulting in a “competency services crisis,” during which decompensation of inmates often leads without treatment, individuals in correctional facilities can experience irreversible worsening of symptoms of psychosis, as well as increased risk for self-harm, suicide, and victimization.

Without treatment, individuals in correctional facilities can experience irreversible worsening of symptoms of psychosis, as well as increased risk for self-harm, suicide, and victimization.
consistent between evaluations conducted via VC and those conducted in-person (Manguna-Mire et al., 2007); however, more recent research has noted practitioners hold some concern regarding using VC for CST evaluations (Batastini et al., 2019).

Major topics of concern include technological, practical, and ethical considerations. Regarding technological challenges, potential negative consequences include internet reliability, equipment, and sound/picture (Adjorlolo & Chan, 2015; Batastini et al., 2019). Despite often having the most need due to a lack of qualified mental health professionals (Thomas et al., 2009), rural locations may be disproportionately affected by technological concerns, as they often have less access to and familiarity with necessary technology. In these situations, forensic evaluators might serve as de facto technology consultants, which highlights the importance of their proficiency with this equipment. Regarding more practical considerations, there is some concern about establishing rapport, administering assessment measures, and the loss of potentially important behavioral data (Batastini et al., 2019). Further, particular defendant characteristics may influence information collected over VC. For example, if a defendant is experiencing delusions surrounding technology, they may refuse to participate in the evaluation because of the use of VC, when this refusal may not occur if the evaluation were to be done in-person.

Lastly, adherence to ethical standards is especially important given that CST opinions can be scrutinized by the court. Potential issues related to security, privacy, informed consent/disclosure, confidentiality, and professional liability have been noted as sources of apprehension (Adjorlolo & Chan, 2015; Batastini et al., 2019). However, it is still unclear how mental health professionals view the use of VC to complete CST evaluations in the context of relevant standards and guidelines (e.g., ability to assess for prongs of competency, adherence to APA Specialty Guidelines for Forensic Psychology). Due to the potentially contentious nature of CST evaluations and the importance of reliability and validity in the context of criminal justice decisions, further research is needed regarding how CST evaluations conducted over VC relate to these standards and guidelines.

It is possible that much of the concern regarding utilizing VC to conduct CST evaluations is due to lack of experience with this type of technology. Immediately prior to the COVID-19 pandemic, research indicated that the majority of forensic practitioners (65%) had never employed the use of VC for the purpose of FMHAs, while half had never used VC to conduct CST evaluations (Batastini et al., 2019). However, in response to the recent COVID-19 related restrictions on in-person services, clinicians are utilizing VC in a wider array of capacities. To avoid further exacerbation of the “competency services crisis,” conducting CST evaluations via VC might be a reasonable next step. Although some practitioners have proffered recommendations, guidelines addressing the intersection of forensic and telepsychology do not yet exist, contributing to uncertainty as practitioners attempt to adhere to the most closely relevant guidelines in this changing landscape. Further research is needed to investigate these considerations and their impact on CST evaluations, with the aim of providing best practice guidelines in the field.

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Online resources

Find resources for coping with disasters (e.g., mass shootings, hurricanes) on our website: advice for how to talk to children, a call for a public health approach to gun problems, managing traumatic stress after disasters, and more. bit.ly/tpa-disaster-resources
Jumping Right In: Embracing the Moment as an Early Career Psychologist in a Pandemic

Christopher R. Glowacki, Psy.D.
University of Texas at Southwestern Medical Center

As we look ahead to start forming our professional identity and articulating our voice as an independently licensed clinical psychologist, there are of course unique challenges in this exciting endeavor. Some of the more apparent challenges might include no longer having the “safety net” of a supervisor, “imposter phenomenon,” or increased workload (Benedetto & Swadling, 2013; Hutchins, 2015; Parkman, 2016). Additionally, there are new responsibilities for the early career psychologist such as supervising trainees and understanding the business side of how a clinic runs administratively. These specific challenges and responsibilities, among others, understandably take time to develop and incorporate into our professional identity; they are not considered to be done overnight. Unless, of course, you begin independent practice at the same time as a global pandemic occurs.

Further research suggests that mental health implications of pandemics can last longer, have greater prevalence than the pandemic itself, and that the psychosocial and economic impacts can be incalculable if we consider their resonance in different contexts.

The COVID-19 pandemic has certainly turned the world upside down with wide-ranging collective effects on people across the globe. According to Johns Hopkins University (2020), there are just under seven million globally confirmed cases and approximately 400,000 deaths. In the United States, we contribute two million of those confirmed cases, as well as approximately 114,000 deaths (JHU, 2020). Unemployment skyrocketed in the U.S. with numbers being reported as high as 20.5 million and approximately 36 million people applied for unemployment (U.S. Department of Labor, 2020). Additionally, involuntary job loss has been associated with poorer mental health outcomes (Howe, Levy, & Caplan, 2004; Lorenz, Perkonigg, & Maercker, 2018; Mandal & Roe, 2008). Further research suggests that mental health implications of pandemics can last longer, have greater prevalence than the pandemic itself, and that the psychosocial and economic impacts can be incalculable if we consider their resonance in different contexts (Ornell et al., 2020).

Needless to say, there is a societal and global crisis in our midst and the state of our collective mental health is at risk. On the whole, mental health professionals have been forced to adapt quickly to implementing teletherapy, working from home, and managing the rise in mental health issues of their patients. For the new early career psychologists, we metaphorically have been thrust in to the final two minutes of a championship game with very limited time to stretch. This pandemic may be the

Author Note:
Information presented in this article is based on this writer’s subjective experience as an early career psychologist. This writer has no conflicts of interest to disclose.

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defining moment of our careers and how we respond to this unique task will shape the course of mental health for years to come. This article will provide considerations of an early career psychologist in the midst of a pandemic and some practical ideas of how to effectively navigate the challenge.

RESPONSIBILITIES AND CONSIDERATIONS
Taking on new responsibilities as a new early career psychologist during the midst of a pandemic can be simultaneously challenging and rewarding. Areas of consideration include teletherapy with patients during the pandemic and addressing burnout.

TELEThERAPY DURING COVID-19
Teletherapy is broadly defined as the provision of psychological services by phone, text, email, video chat, and other digital means to an individual in a different geographic area (Doherty, Coyle, & Matthews, 2010; Martin, 2013). Teletherapy is considered an efficacious medium for intervention for a variety of presenting complaints including depression, posttraumatic stress disorder (PTSD), eating disorders, bereavement, social anxiety, marriage counseling, among others (Ashwick et al., 2019; Rehm, 2008; Sproch & Anderson, 2019; Tutty et al., 2010). Teletherapy has evolved over the past two decades as a convenient alternative to in-person appointments to account for barriers (Martin, 2013); however, it now has become a necessity in the midst of COVID-19.

As with any psychological service we provide, we want to maximize the synthesis of patient efficacy and patient safety. In doing so, utilizing evidence-based practice will give patients the best chance of success and keep the provider accountable to the available research. Grady et al. (2010) provides a thorough set of standards and guidelines for any type of service one may provide (e.g., individual/group therapy, psychological assessment, medication management, safety planning, social work, physician assistant, nurse practitioner, emergency assessment). Luxton et al. (2012) also provides meticulous considerations for safety planning including legal and policy guidelines, appropriateness for telehealth, technology and infrastructure guidelines, and emergency management planning.

BURNOUT
Burnout is a topic psychologists are all aware of, though it can creep in if we are not observing our limits. Burnout is described as the loss of energy and purpose by people in the helping professions as a result of the conditions of their work (Edelwich, 1980; Suran & Sheridan, 1985). It is important to note that meeting the demand of the moment and taking care of ourselves are both valid and true statements. If we view this from a dialectical perspective, we might say, “Meeting the demand of the moment is a noble cause and we need to make sure we recognize when we need a break.”

There is a mix of past studies noting years of experience as positively correlated with burnout (Ackerly et al., 1988) and negatively correlated in others (Benedetto & Swadling, 2013; Vredenburgh et al., 1999). Regardless of years of experience as a psychologist, there appears to be a consensus in the literature about “career-sustaining behaviors” (Stevanovic & Rupert, 2004, p. 302). These behaviors include self-awareness, self-compassion, engaging in physical activities, spending time with friends and family, and taking breaks between sessions (Benedetto & Swadling, 2013; Neff, 2009; Richards et al., 2010).

PUTTING OUR BEST FOOT FORWARD
There are many things to consider when beginning your career during a pandemic. As illustrated, if not attended to appropriately and thoughtfully, we could experience burnout at a quicker pace, leaving us ineffectual in our personal and professional lives. Another element to consider is that despite our role to help and facilitate change with our patients, we are also human beings who are not immune to experiencing the effects of the current circumstances. Therefore, below are some general ideas to reflect on for minimizing our distress and maximizing patient success.

VALUES
Values are statements and guiding principles that can lead and motivate us as we move through life (Harris, 2009). Values are utilized in the framework of Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999) to help facilitate a patient’s identification of their “how” and “what” by discovering their “why.” Applying this tenet of ACT to this particular situation for early career psychologists, we can ask ourselves questions that may be similar to what we ask our patients. The following questions are some examples:

- What is it that I want to remember about this time?
- In five years, how do I want to be able to speak about my behavior during this pandemic?
- How is it that I want to deliver services to patients in need? (e.g., compassionately, sensitively, thoughtfully)
- Do you think what you’re doing today matches up with how you see yourself as a person/professional?
- How do you hope a colleague describes your contributions during this pandemic in five years?
Most likely, the responses to these questions will be your value set of where your behaviors should come from. If someone’s value is to be a team player, what behaviors would reflect that value? How might this person behave without having to tell others they are a “team player”? When values precede our behavior, we tend to be more thoughtful of our actions and are much more in-line with who we want to be.

PARTICIPATE
Participation is one of the core mindfulness “what” skills in Dialectical Behavior Therapy (DBT; Linehan, 2015). A person who participates enters completely into the activities of the current moment, without separating themselves from ongoing events and interactions (Linehan, 2015, p. 154). In doing so, they become one with the environment and develop a sense of connectedness to their experience. Practically, this skill would encourage us to be quicker to say “yes” than we are to say “no.” Leaning in to the discomfort we might experience and joining the dance provides a sense of accomplishment and reduces our tendency for avoidance. Personally, this has proven helpful as I was willing to participate in various projects in our clinic surrounding our COVID-19 effort which included two group papers, three COVID-19 presentations to various departments, and starting supervision three months early for a trainee.

Participation with attention is critical for us to be effective in our environment and behave in accordance with how we view ourselves (Linehan, 2015).

CONSULTATION
Consultation and interprofessional collaboration in psychology is a long documented professional behavior of importance and competence (Arredondo et al., 2004; Caplan & Caplan, 1993; Edmonds et al., 2013; Ponce et al., 2019). As this generation of psychologists embarks on uncharted territory of providing services during a pandemic, questions will undoubtedly arise on topics such as best practice, risk management issues in teletherapy, and how to best collaborate with other disciplines to best meet patients’ needs. Consultation is an important skill to develop and now, more than ever, appears to be an appropriate time to reach out to your peers, colleagues, supervisors and other professionals to facilitate the most ethical and clinically appropriate decision making.

DISCUSSION
The COVID-19 pandemic has impacted people on a global scale. Financially, mentally, physically and socially, there is no shortage of ways in which our worlds have been turned upside down. The pandemic also has not discriminated among whom it affects – we all have a different struggle and call to answer during this time. As the early career psychologist embraces this tough task for our collective mental health, our focus is split and divided in service of answering this call. Focusing on values, participating with other professionals and consulting with trusted colleagues, all serve as protective factors that enable us to mitigate stress and function at our highest level. In essence, they contribute to our sense of resiliency.

Resiliency is the ability to recover quickly from difficulties (Khanlou & Wray, 2014). Resiliency is considered to develop as a process (rather than a single event) and on a continuum (not dichotomously; Khanlou & Wray, 2014). Further, resilience is perceived as a skill that can be fostered; a muscle that can be flexed (see Khanlou & Wray 2014 for discussion of resiliency models). Therefore, there is hope not only for the early career psychologist beginning their career at a difficult time, but for our world at-large. Our collective resiliency will grow through this pandemic based on how we respond at the individual, community, state and national level. Human nature favors resiliency. It has helped our species meet the moment time and time again over the course of our existence and I anticipate our resiliency muscle to grow bigger and stronger after COVID-19.

REFERENCES


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Students with disabilities attend college at a rate lower than their peers without disabilities; according to the National Center for Learning Disabilities (2017), young people with learning disabilities attend college at 50% of the overall population rate. However, once there, students with disabilities are often successful, with retention rates and 6-year graduation rates similar to their peers (Wessel, Jones, Markle, & Westfall, 2009). In order to support the students who are not currently bridging the gap from high school to college, the authors sought to identify and address barriers relevant to the role of psychologists. These barriers include differences in the laws governing access in higher education as opposed to K-12, lack of information sharing between professional disciplines, and individual differences among the students themselves related to persistence and self-esteem.

The transition from high school to college for students with disabilities also entails a transition from coverage under success-focused entitlement law (Individuals with Disabilities Education Act; IDEA) to access-focused civil rights law (Americans with Disabilities Act; ADA). Results of a recent national survey of practitioners of school psychology and disability service providers (Robertson & Geye, 2020) suggest that licensed specialists in school psychology and psychologists working with college-bound students with disabilities are unfamiliar with the differences between these two laws although they report that approximately half of the students they serve are college bound. There is little overlap in the typical accommodations provided in high school and those provided in higher education, and the lack of familiarity with typical accommodations among students and support professionals inhibits effective advocacy and self-advocacy. Additionally, university disability services providers are not adhering to their own professional best practices from the Association on Higher Education and Disability (AHEAD), resulting in unreasonable documentation requirements for incoming students (Geye, Roberston, & Glover, 2019). Part of the lack of familiarity with higher education processes in K-12 professionals is attributed to the limited amount of time outside of their mounting daily responsibilities. For example, in a national survey (Robertson & Geye, 2020) less than a third of the high school counselors surveyed responded that they spent any time at all in transition planning on a weekly basis. Only 9% of the school psychologists reported that a university disability services provider participated in transition plan meetings. Conversely, disability services providers in higher education do not have uniform knowledge of K-12 practices or opportunities for professional development. Few disability services providers have K-12 experience (particularly in the northeast), and there are no standard requirements for training or licensure in the field. Community college staff members, who are more likely to work with underprepared students, had less access to national training than their university counterparts.

**HIGHER EDUCATION POLICY AND THE LAW**

As students transition from K-12 to higher education, protective laws shift from primarily the Individuals with Disabilities Education Act (IDEA), which is an entitlement law assuring that students receive a free and appropriate education,
As clients and their families explore the transition to college, psychologists can facilitate important discussions about resources available on campuses.

Unfortunately, Robertson and Geye (2020) found that over 90% of Disability Service Coordinators do not adhere to this guidance.

SUPPORTING CLIENTS
Psychologists are trained to support the needs and individual development of their clients. The addition of a small number of interventions specific to the transition process can help families to navigate this anxiety-provoking process. Knowledge of laws and relevant policy is an important starting point, but other targeted interventions may help assist families navigate an uncertain process. The following recommendations are based on the authors’ experiences as a college Disability Services Officer and College Counseling Center Director.

As clients and their families explore the transition to college, psychologists can facilitate important discussions about resources available on campuses. According to the Center for Collegiate Mental Health (2019), only about 66% of campuses offer psychiatric care. If medication management is a consideration for the client, this is an important component. It is also important for families to understand the policies about counseling and mental health services on individual campuses, as many colleges offer only short-term care for clients. This information can often be found on Counseling Services webpages or by calling the center. Further, students may need assistance considering the costs and benefits of communal (dormitory) living, where students experience both social opportunities and frustrations of living with others. Psychoeducation is also important, as students navigate management of the cognitive load of both coursework and self-management. In addition, psychoeducation for parents is critical as they transition from the role of primary to secondary advocate for the student; Family Educational Rights and Privacy Act (FERPA; 1974) severely limits college and university personnel from discussing students, even with parents.

Psychologists play a critical role in the development of self-advocacy and self-efficacy which are especially important for transitioning students. Strategies for developing self-efficacy for students with disabilities include helping the student to memorize their diagnosis, helping them understand the interventions and accommodations they received in K-12, and how those might be applied in a college setting. Further, educating students about the difference in laws and allowable accommodations from K-12 to Higher Education can help to establish their expectations and empower them about their options. Clinicians can also facilitate self-advocacy by role-playing meetings in which the student has to request accommodations from disability services offices and/or individual faculty members.
Psychologists may also support families by helping them implement concrete support strategies including providing documentation to provide to the disability services offices, helping clients save important campus telephone numbers in their telephones (including counseling services, health services, disability services, academic support services, and student health services), and teaching clients to externalize and automate as much as possible. For example, instructing clients on adding due dates with notifications to digital calendars as soon as students receive syllabi from professors and assisting students in establishing routines and daily structure.

Psychologists are very skilled at helping clients build resilience and self-efficacy. Adaptations of these existing skill-sets and the incorporation of college-specific interventions can make the psychologist an invaluable team member in supporting clients as they make this major life transition. It may also be beneficial for psychologists to build relationships with Disability Services Offices of campuses near their area of practice. Psychologists’ knowledge of disorders and human behavior make them invaluable as consultants and may also serve as a source for referrals. Texas psychologists are in the unique position to serve individual clients and to inform university policy to support our students as they transition from K-12 to higher education.

REFERENCES


A Cautionary Note About “Privilege” in Legal Proceedings

Floyd L. Jennings, J.D., Ph.D.

It is unequivocal that psychology has made a powerful impact upon a host of societal issues as they emerged in court proceedings.

In the December 2019 issue of Monitor on Psychology, Tori DeAngelis, a well-known professional writer, reviewed the contribution of psychology to the resolution of significant legal disputes over the past sixty years, through reliance upon amici briefs. Such offerings to courts have included mental health parity, (Blue Shield v. McCready, 1982), gender discrimination at work, (Price Waterhouse v. Watkins, 1982), psychotherapist-patient privilege, (Jaffee v. Redmond, 1996), rights of persons with disabilities, (Atkins v. Virginia, 2002), juveniles and the death penalty (Roper v. Simmons, 2005) – to name but a few of the issues and cases reviewed.

It is unequivocal that psychology has made a powerful impact upon a host of societal issues as they emerged in court proceedings. And this article in the Monitor on Psychology, well highlights the contribution of psychology as a discipline. A brief note of caution is required in discussing psychotherapist-patient privilege, and the decision in Jaffee, supra.

The article emphasized the following ruling: Psychotherapists have a duty to maintain the confidentiality of patient sessions. Therefore, courts cannot compel therapists to release patient records (An exception is that a number of states require therapists to warn appropriate parties if a patient threatens them with bodily harm). The court’s decision supported the arguments presented in APAs brief.

It is important to note that the foregoing statement is subject to serious limitations in Texas, and psychologists should not rely on this case as universally applicable.

JAFFEE V. REDMOND (1996): A REVIEW

In 1991, a police officer, Mary Lu Redmond, employed by the Village of Hoffman Estates, Illinois, shot and killed one Ricky Allen. Thereafter, Ms. Redmond sought psychotherapy with Karen Breyer, LCSW for some fifty sessions. Much later, the administrator of Allen’s estate filed suit in federal court alleging that the decedent’s constitutional rights had been violated. In the course of legal proceedings, the court ordered Ms. Breyer and Officer Redmond to turn over notes made during psychotherapy sessions – which they did not. At trial, and because of the refusal to turn over requested information, the defendant, Officer Redmond and the city, were found liable for damages. The Court of Appeals for the Seventh Circuit reversed and remanded for a new trial, concluding that “reason and experience” argued for a psychotherapist privilege – not theretofore existing in federal courts.

The court noted that Illinois would provide such a privilege in state courts. Because the courts in the several federal circuits had held differing and contrary opinions, the case was appealed to the United States Supreme Court, which then held in Jaffee, supra., that the trial court had erred by failing to protect the confidential communications between Redmond and Breyer.

The decision was that a psychotherapist-patient privilege should exist: “The federal privilege, which clearly applies to psychiatrists and psychologists, also extends to confidential communications made to licensed social workers in the course of psychotherapy. The reasons for recognizing the privilege for treatment
by psychiatrists and psychologists apply with equal force to clinical social workers, and the vast majority of States explicitly extend a testimonial privilege to them."

APPLICATION TO TEXAS LAW
First, all communications between a mental health professional and a patient, or client, are confidential (Tex. Health and Safety Code § 611, 1991). Privilege is a different matter as it is a legal term relating to the court's decision on the admissibility of evidence. No psychologist should use the term, “Oh, this is privileged,” as that is language belonging to the court after reviewing the proffered testimony. For example, communications between husband and wife are privileged in criminal cases (Tex. R. Evid. § 504, 2018) and Physician-patient communications (Tex. R. Evid § 509, 2018).

Second, there are, however, protections afforded to communications with a mental health provider (Tex. R. Evid. § 510, 2018):

(1) Definitions. In this rule:

(1) A “professional” is a person:

(A) authorized to practice medicine in any state or nation;

(1) who the patient reasonably believes to be a professional under this rule.

(A) consults or is interviewed by a professional for diagnosis, evaluation, or treatment of any mental or emotional condition or disorder, including alcoholism and drug addiction; or

(2) A “patient” is a person who:

(A) is being treated voluntarily or being examined for admission to voluntary treatment for drug abuse.

(B) is treated for alcoholism or drug addiction in a mental health treatment facility supervised by a professional;

(3) A “patient's representative” is:

(A) any person who has the patient's written consent;

(B) the parent of a minor patient;

(B) having received information privileged under this rule may disclose the information only to the extent consistent with the purposes for which it was obtained.

(C) who may claim. The privilege may be claimed by:

(1) the patient; or

(2) the patient's representative on the patient's behalf.

The professional may claim the privilege on the patient's behalf—and is presumed to have the authority to do so.

(d) Exceptions. This privilege does not apply:

(1) Proceeding Against Professional. If the communication or record is relevant to a claim or defense in:

(A) a proceeding the patient brings against a professional; or

(B) the personal representative of a deceased patient.

(2) Written Waiver. If the patient or a person authorized to act on the patient's behalf waives the privilege in writing.

(3) Action to Collect. In action to collect a claim for mental or emotional health services rendered to the patient.
(4) Communication Made in Court-Ordered Examination. To a communication the patient made to a professional during a court-ordered examination relating to the patient’s mental or emotional condition or disorder if:

(A) the patient made the communication after being informed that it would not be privileged;

(B) the communication is offered to prove an issue involving the patient’s mental or emotional health; and

(C) the court imposes appropriate safeguards against unauthorized disclosure.

(5) Party Relies on Patient’s Condition. If any party relies on the patient’s physical, mental, or emotional condition as a part of the party’s claim or defense and the communication or record is relevant to that condition.

(6) Abuse or Neglect of “Institution” Resident. In a proceeding regarding the abuse or neglect, or the cause of any abuse or neglect of a resident of an “institution” as defined in the (Tex. Health & Safety Code § 242.002, 1997).

LIMITATIONS
Thus, there is a psychotherapist-patient privilege in Texas, but only in civil cases. For in criminal matters, there is no privilege extended. Nor does privilege extend when an evaluation is court-ordered in either civil or criminal matters.

In addition, however, Jaffee, supra. applies only in federal cases. And, indeed, if the psychologist is testifying in a federal court, this privilege could be claimed by the patient or the psychologist acting on behalf of the patient.

Note, that the privilege is the patient’s to either claim or waive, not some undefined right of the psychologist not to release information (See In re Lifschutz, 1970).

CONCLUSIONS
It is wise to avoid broad, sweeping claims about privilege (or in any other circumstance for that matter), for though Jaffe, supra, is oft-cited its applicability in Texas is limited.

REFERENCES


In re Lifschutz, 2 Cal 3d 415 (Cal 1970).


Roper v Simmons, 543 U.S. 551 (2005).


First and foremost, I hope that you and your loved ones are healthy and in good spirits as you read this. I have personally heard from many of you as we adjust to the new normal. While not everything on the state level happens as quickly as we would like it to, TPA has seen unprecedented success regarding licensure and reimbursement. We certainly have our passionate members to thank for much of that.

Looking toward the legislative session, COVID-19’s impact is already being felt. Interim committee hearings have not happened, the state is in the process of outfitting hearing rooms with plexiglass dividers, and there have even been discussions of limiting public access to the capitol building. Outside of COVID-19, the legislature will be facing one of the tightest budget years in recent history due to the dramatic drop in oil prices. Also, the legislature was scheduled to redistrict this year, although that may not happen if there is a significant delay in census data. All that to say, this could be a difficult session to pass bills that are unrelated to disaster response.

The good news is, the progress that we’ve made in responding to the disaster will likely lead to similar, more permanent success at the legislature. For example, telehealth parity has become a widely discussed issue. Insurers have been pushed to expand their offerings, and restrictions on the types of platforms that providers may use have, in many cases, been lifted. These are positive changes, and we will be urging the legislature to make them permanent. While there is plenty of doom and gloom surrounding the legislative session, if we remain flexible and take swift action when an opportunity presents itself, TPA could have one of its most productive legislative sessions in recent history.

On the regulatory front, TSBEP has taken strong and decisive action to ensure that psychologists are equipped to handle the pandemic. TPA has been in touch with TSBEP staff regularly to seek clarification on existing standards of care and request waivers of certain rules from the governor’s office. We greatly appreciate the responsiveness and support that TPA and Texas psychologists have received from TSBEP staff. TSBEP has certainly been one of the best functioning boards throughout this disaster.

I know this was not a traditional legislative update, but the state is not functioning in a traditional manner right now. I sincerely hope that we can return to normalcy sometime soon, but in the meantime, rest assured that TPA will be supporting you in every way possible. Please do not hesitate to contact us with any issues you may be having—it is our pleasure to help you, help your patients.

Sincerely,
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