Inclusion
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In this issue

A NOTE FROM THE PRESIDENT
Nice to Meet You
Megan Mooney, PhD

EDITOR’S REMARKS
Jennifer Rockett, PhD

NOTES FROM THE FOUNDATION
Changes - Heyward L. Green, PsyD
Co-Letter from Dr. Ditsky

MULTICULTURAL ISSUES
Culture and Language: Critical Factors in Assessing Immigrants
By William July, PhD

DIVERSITY
Best Practices in Serving African American Women Seeking Mental Health Care: From Barriers to Beyond
Nina Ellis-Hervey, PhD, LP, NCSP, LSSP, CPC

INTERVIEW
An Interview with Jessica Magee, TPA Executive Director
Conducted by Kyle A. McCall, MA
TPA Board of Trustees Student Representative

LEGISLATIVE UPDATE
Kevin Stewart, Esq., TPA Government Relations

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Nice to Meet You

MEGAN MOONEY, PHD
She/Her/Hers
Houston, Texas
TPA President

My name is Dr. Megan Mooney. My pronouns are she/her/hers. I am honored to be your new President of the Texas Psychological Association for 2020.

TPA’s mission is to “represent and enhance the profession of psychology in Texas, while promoting human health and welfare through education, science, and practice.” I think that’s really just a long way of saying that “we use psychology to help people in Texas.”

I thought, at this point, it may be helpful to tell a bit about how I got to where I am and how I seek to use psychology to help people. I did not go to college to become a psychologist – I started out with a goal to be a marine biologist. My dream was to find a way to make a career out of swimming with dolphins. Fortunately, a 38 on my first organic chemistry exam my sophomore year helped me to re-evaluate my goals. Luckily for me, my mother had made a career out of helping people find jobs that were right for them and so she gently talked to me about the classes that I was enjoying and actually doing well in that evening when I called her crying over that horrible organic chemistry test grade. My mother, who had long known that I should be doing things with people (and probably children in particular) was not surprised when I told her I was enjoying my psychology, sociology, and anthropology classes the most. And so, I changed majors and life courses.

I was fortunate enough to find a work-study job with a psychology professor on campus and, as I neared the mid-point of my senior year, he made sure I knew that I was going to have to do more than just graduate with my BA in psychology – if I wanted to do something in the field I now loved I would need to go on to graduate school. So, I applied to a dozen or more graduate programs in clinical psychology with a focus on working with children and was lucky enough to find a program that was a good fit. During graduate school, I worked in a variety of settings and gained a wealth of information about psychology. I learned to love psychological testing in addition to therapy and found the value in research and evidence-based treatments. I had diverse clinical experiences that allowed me to obtain a placement for internship at my top choice which led me to Houston in 2003. After completing my internship with Baylor College of Medicine, I completed my fellowship and became a staff psychologist at a large community mental health center in

...we need fresh, new voices and ideas to actively participate in these associations as well as the profession of psychology. To gain these new perspectives, the profession of psychology needs to more actively and intentionally invite people who have felt marginalized to participate in every level of the field. And so, I challenge each of you to consider the ways in which you can make sure that you are more included in the profession of psychology and the Texas Psychological Association but also the ways in which you can help ensure that others will feel included going forward.

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As I prepared to go to Austin, my wife

Continued from page 2

years of my career, I did not mention TPA

youth and LGBTQ youth and their families. You’ll note as I described all of the early years of my career, I did not mention TPA or advocacy work. That “branch” of my professional work was an interesting offshoot for me. Joining our state psychological association or becoming active in advocacy work was a topic that was not mentioned at all to me during my undergraduate or graduate work. However, while working in Houston, I became a clinical faculty member and part of the training committee for the Baylor College of Medicine Psychology Internship program (the same program that had led me to move to Houston). Over the years, I saw increasing difficulties in funding internship positions across our sites in Houston and the numbers of opportunities slowly dwindled. I became concerned about how we would be able to sustain the profession of psychology if we could not even keep up adequate numbers of training positions for future psychologists. And then a series of coincidences led me down the path to where I am now (and I always like for people to know that most of this is my wife’s fault).

In 2011, my now-wife was doing a lot of mental health policy work with the Texas Legislature. One of our friends was Chief of Staff for Rep. Garnet Coleman of Houston and he asked whether I would be willing to travel to Austin to testify as an expert on a bill they were working on related to suicide prevention programs in schools. As I prepared to go to Austin, my wife informed me that a bill that would allow for supervising psychologists to bill for the services that interns provide was being heard in the same committee I was set to testify in. I was ecstatic as I saw this as a potential solution to keep internships in Texas alive and felt fortunate that I would be able to lend my voice to the discussion. So, I drove to Austin and registered to testify on both of those bills. At the conclusion of my testimony, the members of TPA ran up to me to ask who I was because they had sponsored the bill and had no idea about me or my interest in it. Similarly, although I was a TPA member at that point, I had no idea that they were working on an issue about which I was very concerned. I continued to communicate with TPA folks about the intern bill and thus started my foray into becoming far more involved than I ever would have imagined. The “Intern Bill” eventually passed in 2015 with a lot more work by myself and others in TPA and by that time I was a TPA Board member and active member of the Legislative Committee as well. I’ve learned over the past 8 ½ years how important it is that psychologists are active and involved in the legislative process because if we are not present to advocate for our profession, we won’t be able to truly help people as we are called to do.

I think that helping people can take many different forms but psychology is distinct from the other mental health fields of study because of our emphasis on science and data to drive our interventions. We rely on research to inform our daily practice and also to inform the ways in which we advocate for public policies and legislation to help people. It’s an interesting time in this country for science and data as there has been a strong push by some to minimize or discredit the importance of evidence and data for the sake of politics and special interests. But you have all chosen an important path in which you are dedicating yourselves to using science and data to help others. TPA has been working hard to make sure that we emphasize data in our public positions on a variety of topics from the separation of families at the border to providing affirmative care for transgender children. I personally am dedicated to the part of TPA’s purpose that says, that we promote “human welfare by the encouragement of psychology in all its branches in the broadest and most liberal manner”. My attraction to this part of our goals is not purely related to my own political beliefs. It is because I think that our job as psychologists is to help as many people as we can in as many ways as we can.

My theme for my presidential year is “Inclusion”. When I ran for this office, my primary “platform” was to diversify the membership of TPA. I felt that we needed more diversity in our membership across age, gender identities and expressions, races, ethnicities, geographic locations, sexual orientations, etc. This continues to be my goal but it’s important to emphasize that just having diversity of membership without people actually feeling included and valued is meaningless. One of the definitions of Inclusion (provided conveniently by a quick Google search of the word) notes that inclusion is “the act or practice of including and accommodating people who have historically been excluded (as because of their race, gender, sexuality, or ability)”. TPA and the broader profession of psychology have unfortunately historically excluded many people from our membership or our activities. This may have been intentional or due to implicit biases or negligence. For many years, I was a psychologist in Texas and even a member of TPA but did not feel truly included. And now, something that has been clear to me while I’ve been serving as a Board member and Chair of various committees within TPA is that we need fresh, new voices and ideas to actively participate in these associations as well as the profession of psychology. To gain these new perspectives, the profession of psychology needs to more actively and intentionally invite people who have felt marginalized to participate in every level of the field. This includes research, clinical work, teaching, and the vast array of other ways that psychologists help people every day. And so, I challenge each of you to consider the ways in which you can make sure the you are more included in the profession of psychology and the Texas Psychological Association but also the ways in which you can help ensure that others will feel included going forward.

I am personally committed to this goal of inclusion, not just in TPA but for psychology more broadly. I hope that each of you will join me in this goal and find your own unique path forward towards helping others.

Best Wishes for 2020!
Editor’s Remarks

JENNIFER ROCKETT, PHD
She/Her/Hers
Private Practice, Bryan, TX

Colleagues,

Welcome to 2020! This year is starting out in a rather exciting way. Please join me in warmly welcoming our new Executive Director, Ms. Jessica Magee. Featured in this issue of the Texas Psychologist (TP), is the chair of the Student Committee, Kyle McCall’s interview of Ms. Magee. It is also time to welcome our new President, Dr. Megan Mooney. Her theme for this year, discussed in her column, is Inclusion. Change is in the air at TPA!

One of the major changes you may have noticed with the TP, is that we are now a digital only publication. For each of the four issues this year, TPA staff will send out an alert that the publication is ready to view. My hope is that we transition with ease, and should you have difficulty accessing the issue, please contact me or Ms. Magee.

Finally, I’d like to formally introduce your 2020 TP Editorial Board:

» Dr. Alice Ann Holland
» Dr. Brian Stagner
» Dr. Christian LoBue
» Dr. Alfonso Mercado
» Dr. Tamara Brown
» Dr. Temi Salami
» Dr. Heidi Rossetti
» Dr. Bret Moore

As we continue to move the journal in the direction of a peer-reviewed publication, above are the individuals who help make this happen. Over the past two years, we have moved away from Op-Eds towards empirical works and research review articles. By the end of 2020, the goal is to publish at least one true peer-reviewed article. The long-term goal is to include a peer-reviewed article in each published issue of the TP. In addition to the one peer-reviewed article, we are working to create a new column: Research Briefs, where you will find summaries of timely and important articles. As always, the TP Editorial Board welcomes articles from all! Thank you to those of you who have made the TP what it is!

May you all have a wonderful winter!

Jennifer
Several months ago, my wife and I watched the movie Christopher Robin together. It is a light, friendly and entertaining piece. Given that it is a product of the Disney machine, it follows a certain formula leading to a predictably happy-ending after a reasonable amount of tension, humor, and calamity. The plot is not what captured my attention. The comments from Pooh did.

With experience derived from several workshops led by Marsha Linehan, in which mindfulness was a major component for learning and discussion, I was struck by the exquisitely mindful observations of the simple, forever hungry honey-seeking bear as he meandered through one situation after another. There were the delightfully humorous double entendres such as, “People say nothing is impossible, but I do nothing every day.” But what garnered my attention were the nuggets of wisdom within Pooh’s simple and accurate observations.

Seeing the movie brought to mind the book The Tao of Pooh by Benjamin Hoff. Published while I was in my doctoral program, it was not on my reading list at the time and had drifted to obscurity in my memory. It was quite popular when published, but at the time it had seemed to me more a pop novelty than anything else. But what garnered my attention were the nuggets of wisdom within Pooh’s simple and accurate observations.

As we enter a new era in TPA, we are faced with the prospect of change with new leadership and an evolving organization. Coincidental to that are major changes in the governance of our profession at the state level. We also are witness to changes in perception and attitude at a national level with ongoing developments and shifting emphases at APA. Looking back we see a range of experiences that felt familiar and to some degree predictable, contributing to a sense of security whether valid or not. What lies ahead is change and uncertainty, and the stress that accompanies.

In his book, Mr. Hoff reminds us:

*Things just happen in the right way, at the right time. At least when you let them, when you work with circumstances instead of saying, ‘This isn’t supposed to be happening this way,’ and trying harder to make it happen some other way.*

His words echo the concept of radical acceptance as described by Linehan. Employing use of our “wise mind,” another Linehan construct, we can accept reality without being judgmental and can act with purpose and effectiveness as we move forward into change and the future. Our feelings are genuine and we are not required to ignore them. But moving forward asks that we acknowledge what is real and seek to form our actions in a manner that will be effective. In addition to effectiveness, we have the opportunity to be civil, tolerant, respectful and observant as we work together to strengthen our science, our profession and our organization.

Elsewhere in the book, Hoff observes:

*There are things about ourselves that we need to get rid of; there are things we need to change. But at the same time, we do not need to be too desperate, too ruthless, too combative. Along the way to usefulness and happiness, many of those things will change themselves, and the others can be worked on as we go. The first thing we need to do is recognize and trust our own Inner Nature, and not lose sight of it.*

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We maintain our sense of who we are and our context of community that invites us to be respectful of each other and accepting that in time things will adjust and change and become what they will be. We are reminded to maintain the values we know support our cause and are a part of who we are. We do what we can when we can, and trust and recognize change will continue beyond our current moment in time.

Within the Texas Psychological Foundation, we are experiencing change in the form of transition of leadership. My term as president is ending as Dr. Mike Ditsky begins his own term in that role, bringing with him his keen insights and his own unique set of skills. Some things will remain the same. Some things will be different. In either case, we will continue to pursue our mission under his capable leadership. Similarly, Dr. Megan Mooney is beginning her role of leading TPA through the next year. She has witnessed changes in the operations of TPA and she is poised to lead us into a year of self-assessment, reflection, adjustment, and re-definition. We all are invited to become part of the journey to engage with each other and to move forward in pursuit of our common goals.

As I end my current role within TPF and TPA, I am mindful of the counsel and support of many colleagues and friends. The past and present leadership and staff members in the TPA office have provided immeasurable assistance through so many situations and projects. The TPA Board of Trustees has been supportive and respectful of TPF. I am especially grateful for the patience, kindness, humor, devotion, and perseverance of members of the TPF Board of Trustees, both current and past, who have so generously shared their time, insights and other resources to support our mission. I am thankful for those of you who have shown support to TPF as donors, and in so doing allow us to continue our effort to support the discipline of Psychology.

And now let us move boldly into the future.
The population of immigrants is growing in the United States. The number of foreign-born people in the U.S. was 44.4 million in 2017, which is quadruple the number of immigrants since 1965 (Pew Research Center, 2019). The largest immigrant populations are found in California, Texas, and New York (Pew, 2019). Currently, the largest immigrant group in the United States comes from Mexico, but Asian immigrants have been the largest groups since 2010 (Pew, 2019). This reality is calling for the profession of psychology to respond with larger and more diverse spectrum of services for immigrants with varied cultures and languages. Indeed, this is an issue not only for psychologists, but it also includes our medical colleagues and other allied healthcare service providers.

**IMMIGRANT REALITIES**

The growing need for accurate clinical instruments to measure emotions, personality, and intelligence in non-English speaking patients is a critical issue as the demand continues to increase for psychological assessments in diagnosis, treatment, and forensic cases involving immigrants.

Consider this scenario: An attorney approaches a psychologist to provide an evaluation of the emotional and psychological status of a male, age 23, with four years of formal education. The man grew up all of his life in Mexico and has been in the United States for three years. American culture is foreign to him and he doesn't speak English.

Here is another typical scenario. A psychologist is assessing the effects of trauma on a 25-year-old female immigrant from China who has suffered severe domestic violence. She was raised in China and has the equivalent of a high school education she earned in China. She has been in the United States for five years but speaks little English and she is not significantly acculturated.

In the third scenario, the psychologist is attempting to assess the cognitive status of an immigrant from Burundi who is complaining of memory loss symptoms and cognitive impairment symptoms. She has little insight, a history of trauma sustained as a war refugee, and she is illiterate. She has been in the United States for ten years. She reports she has not sought medical help due to not having the ability to pay.

While each of these situations are different, there is a common theme among them all. If these patients were English speakers, there would be a myriad of psychometrically valid and reliable instruments appropriate for use in their evaluations. However, when the patient is non-English speaking, there is a paucity of instruments available. Furthermore, for many patients, there are virtually no assessments published which are directly appropriate for their language and culture. In these situations, the psychologist is challenged in finding appropriate assessments. The following are two major factors in finding the assessments.

**CULTURAL RELEVANCY**

The first issue in determining the appropriate assessments is to consider cultural relevancy. Most of the assessments with which we are familiar and consider valid and reliable for our purposes are limited in their cultural relevancy. Popular instruments such as the Beck Depression Inventory-II (BDI-II), Minnesota Multiphasic Personality Inventory-II (MMPI-2), Millon Clinical Multiaxial Inventory-IV (MCMI-IV), Personality Assessment Inventory (PAI), and the Wechsler Adult Intelligence Scales-IV (WAIS-IV) are standard tools in the array of assessments used by many psychologists. However, they must be culturally aligned with the background of the examinee to produce accurate results. This creates a challenge when assessing immigrants because even if a test or assessment has been translated into another language, that doesn't mean it is accurate for use. Franklin (2017) noted that a direct literal translation may have many cultural and language inaccuracies.

If an immigrant was born and raised in another culture or is living by the cultural norms of their country-of-origin, they are probably not going to be accurately assessed by tests and assessments which were developed on a sample derived from another culture. It isn't comparing apples.

*Continue on next page*
to apples. Investigators have performed studies in which the psychometric properties of assessments have been analyzed after attempts at cross-cultural adaptation. The studies have found the adaptations are not sufficient (Uysal-Bozkir, Parlevliet, & de Rooij, 2013).

Perhaps it could be argued that some symptoms and disorders are relevant across cultures. However, the lens of culture vastly changes how individuals view the symptoms. Therefore, for example, if one argues that depression is experienced worldwide, the perception of what we call depression is still going to vary from culture to culture. What we in the U.S. consider as major depression might be a set of symptoms ignored in another culture or considered to be some type of spiritual problem in another. Interpreting a disorder through a different cultural lens is a process requiring consideration of multiple factors and should involve a variety of cultural stakeholders contributing to the meaning and interpretation ultimately defining what is normal and what is abnormal in a given culture (Naeem, Kingdon, Saeed, Zaidi, & Ayub, 2011).

This presents a problematic situation in assessing other cultures because inappropriately applied tests and assessments can have a variety of inaccurate results such as symptoms being grossly under-reported, misunderstood, or denied when the patient is guarded because the questions are unusual to them and inappropriately invasive in their cultures. Other issues caused from basic misunderstandings, such as unintentionally alarming responses to critical items, are also possible.

**TRANSLATION AND INTERPRETATION AREN’T THE SIMPLE ANSWER**

Translation is transferring information in written form from one language to another. But interpretation is referring to oral information (Globalization and Localization Association, 2019). When examining a patient from another culture who speaks another language it is advisable to use a professional interpreter, especially one trained for mental health, healthcare, or legal cases, when possible. Specific attention should be used in selecting interpreters with appropriate dialects of the language, if applicable. One should also be aware of potential cultural, political, or religious biases which may exist between the interpreter and the examinee because that can also affect the evaluation process. For example, the interpreter and patient could be from the same country but different sects of bitter religious rivals. In other words, just because they speak the same language doesn’t mean they are culturally compatible. Additionally, caution should be advised in using family members and friends. Children should not be used because it can place a child in a situation in which they may have to be involved in interpreting highly sensitive information not emotionally or psychologically appropriate for children.

After establishing a way to communicate using an interpreter, some evaluators have attempted to resolve the language issues by simply having an interpreter translate, or interpret, test items. However, if the assessment hasn’t been cross-culturally developed, it may not be a valid method for assessing an immigrant because it has not been developed with an evidence-based translation process in which culture is also considered (Hambleton & Van de Vijver, 1996; Simonsen & Mortensen, 1990). Considering whether a test or assessment has been appropriately translated is another critical point. Appropriate translation would include a process such as forward-translation and back translation of the instrument with proper research protocols employed (Hambleton & Van de Vijver, 1996; Hilton & Skrutkowski, 2002).

**EMERGING BEST PRACTICES**

For psychologists, it is an exciting time as we are on the forefront of pioneering new areas in cross-cultural evaluation and treatment. However, it is equally challenging. As we adhere to our training and clinical best practices, evaluations of non-English speaking immigrants will require additional effort. Research is growing in this area but simultaneously those of us in the clinical world are responding with logic solutions answering the call by carefully studying and preparing for evaluations of immigrants. It is possible to provide culturally appropriate evaluations with awareness of culture and language factors and by making adjustments to the process which incorporate culture specific issues and appropriate translation (Franklin, 2017).

Possible solutions include searching the literature for tests and assessments which have been psychometrically developed for cross-cultural use. It takes a significant amount of effort to find them but there are options. Also, solutions can be found by consulting the research literature to find investigations of existing tests and assessments and their applicability to other cultures. The use of nonverbal instruments offers opportunities to at least minimize cultural influences while eliminating the need for English. However, even nonverbal approaches have potential cultural issues (Rosselli & Alfredo, 2003). Finally, Franklin (2017) posits assessments and evaluations with non-English speaking immigrants are possible when approached with a holistic and qualitative approach to culture and language and other relevant factors. However, examiners must be attentive to the effects of language and culture in considering the meaning of the results (Ortiz, Ortiz, & Devine, 2016).

Ultimately, more research is needed for developing tests and assessments for specific cultures and languages. Development of such tools will increase our ability to provide culturally accurate evaluations and treatment minimizing the misunderstandings and errors which can be caused by language and culture differences.

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*Continued on next page*
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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 kids, a call for a public health approach to gun problems, managing traumatic stress after disasters, and more. bit.ly/tpa-disaster-resources

COVID-19 specific information can be found here: bit.ly/tpacovid19
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ABSTRACT

In the United States today, 13.4 percent of the population is reported to be Black American and the percentage is slightly lower, but growing, in the state of Texas at 12.8 percent with cities such as Houston and Dallas having larger Black American populations (U.S. Census Bureau, 2018). In fact, in 2017, Texas was among one of the top ten states with the largest Black population. Authors report that Black women are twice as likely to experience mental health issues than men, and compared to their Caucasian counterparts, that Black American women are only half as likely to seek help. It is important to confront challenges that arise when learning about Black women, their needs, cultural differences and best practices in providing them with high levels of care. It is also essential that practitioners dedicate efforts to positively attracting, retaining and building relationships with Black American women clients, which may add to more positive therapeutic outcomes for the population.

BEST PRACTICES IN SERVING AFRICAN AMERICAN WOMEN SEEKING MENTAL HEALTH CARE: FROM BARRIERS TO BEYOND

In the United States today, 13.4 percent of the population is reported to be Black American and the percentage is slightly lower, but growing, in the state of Texas at 12.8 percent with cities such as Houston and Dallas having larger Black American populations (U.S. Census Bureau, 2018). In fact, in 2017, Texas was among one of the top ten states with the largest Black population. Though this population is rising, Marrast, Himmelstein, and Woolhandler (2016) reported that Black young people, especially women, were less able to get mental health services than white children and young adults. In fact, in this state, only 25 percent of Black Americans seek treatment for a mental health issue, compared to 40 percent of white individuals. That is despite the statistics that show that Blacks are at a higher risk for mental health problems and recognition of poor mental health status, and that adult Black Americans are 20 percent more likely to report serious psychological distress than adult Whites.

In specific to Black women, the National Alliance on Mental Health (2019) found that this population are twice as likely to experience mental health issues than men, and compared to their Caucasian counterparts, and that Black American women are only half as likely to seek help. Barriers for Black Americans women to receive quality mental health care include but are not limited to; stigma associated with mental illness, distrust of the health care system, lack of providers from diverse racial/ethnic backgrounds, lack of culturally competent providers, lack of insurance and underinsurance (American Psychiatric Association, 2017). Person-centered barriers include the desire to uphold the importance of family privacy, lack of knowledge regarding available mental health treatments, denial of mental health problems, concerns about stigma, unwillingness to take medications, and lack of trust in receiving appropriate information about services. Thus, gender and racial inequality and stigma are the major obstacles of mental health service use for this population (Masuda et al., 2012).

Psychologists and future psychologists in Texas working with Black Americans women need to work harder and smarter than ever to become credible sources of care, which means that they must gain cultural competence, show a greater understanding of inter-intra individual differences, and get armed with more factual and less inferred knowledge of the women in Black community. The purpose of this article is to summarize the most relevant factors that influence as well as provide recommendations for mental professionals in Texas who which to work with women.

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from a Black race. The following sections describe how Black women’s inter and intrapersonal interactions can affect the action of seeking mental health.

DISCRIMINATION AND REPORT OF SYMPTOMS

Historically, Black Americans have been and continue to be negatively affected by prejudice and discrimination in the health care system (Gary, 2005), and Black American women have consistently reported experiences of racism and sexism more than any other racial group (Mucherah & Frazier, 2012; Settles et al., 2010). Marrast et al. (2016) highlighted that, in general, Black Americans received markedly less care regardless of socioeconomic or health status and also asserted that mental health specialists sometimes discriminate based on race when seeing clients and patients. This is an indicator that reservations against treatment may be rooted in actual experiences and not assumptions of this population. Factors including misdiagnoses, socioeconomic inequalities, below standard treatment and lack of cultural competence by mental health professionals may cause distrust and prevent many Black Americans from searching out and further staying in treatment (Gary, 2005; Artiga, Orgera, & Damico, 2019). Authors indicate that instead of welcoming and retaining clients, many psychologists often demonstrate a lack of education, cultural competence and limited desire to learn more about the struggles faced by Black Americans, especially women.

Manifestations of psychological distress and chronic discrimination in Black American women may not be described in mental symptoms, but in physical symptoms such as bodily aches and pains (National Alliance on Mental Illness, 2019). For instance, data shows that for Black women, anxiety is more chronic and the symptoms more intense than their White counterparts. However, Black women are less likely to report the classical symptoms of anxiety when they see the therapist, instead, they express anxiety as unexplained physical symptoms, culturally accepted expressions, and narratives of trauma (Hunter & Schmidt, 2010). Research has also found that even with severe psychopathologies, many Black Americans rely on faith, family and social communities for symptom report rather than turning to health care professionals (Cooper-Patrick et al. 1999, Snowden, 2001). There are additional reasons this population does not seek treatment including: a belief that need for treatment could reflect negatively on their family, heightened anxiety about the therapeutic process, failure to recognize mental illness as an illness, fear of unfair treatment due to race, high levels of religiosity to replace perceived need for treatment, and concerns of inability to identify with current mental health professionals culturally and through experiences (Alvidrez, Snowden, & Kaiser, 2008; Ellis-Hervey et al., 2016; Ellis-Hervey et al., 2016; Suite, et al., 2007; Thompson, Bazile, & Akbar, 2004).

SELF-IMAGE, PERCEPTION AND CONTROL

Self-esteem and locus of control also play a large role in the journey of psychological wellness of Black American women. The many challenges faced by Black American women on a daily basis can be stress inducing but adding to that stress is critical judgement of personal presentation and comparison to societal standards of beauty. In a previous investigation, (Ellis-Hervey et al., 2016), we asserted that an increased understanding of struggles Black American women encounter in relation to being critically judged on appearance may further raise awareness of interventions and supports, reducing instances of negative self-perception in the population. In other words, if the Black woman client feels instantly judged, especially by those providing care, she would likely shy away from treatment.

As if the pressures this population is under is not enough, Black women consistently feel they are not good enough, are not loveable and perceived as less desirable (Molloy, & Herzberger, 1998). For instance, in the United States, beauty is influenced heavily by the White population, and this includes lighter skin complexions and straighter textures of hair (Johnson & Bankhead, 2014). Historically, Black American women adopted certain White cultural ideals such as the “groomed image of docility” as a survival tactic to convey a non-threatening image to White society (Abdullah, 1998). Currently, in the professional realm, a Black American women with natural hair (or hair that is non-chemically altered or straightened from the curly state) is often deemed unkempt and unemployable (Abdullah, 1998; Badillo, 2001; Rock, George, & Stilson, 2009; Thompson, 2009). It has been common practice for employers to take “penalizing actions to prohibit natural hair in the workplace” (Thompson, 2009, p. 836). In such circumstances, the decision to alter or not alter her hair can become a source of distress, discrimination, and rejection by the care professional.

DISCUSSION AND RECOMMENDATIONS FOR PSYCHOLOGISTS

Treatments for Black American women should explore deeper cultural concepts, and client concerns in order to yield more positive outcomes. Before considering mental health treatment, practitioners must educate themselves and the communities they serve about pertinent struggles and treatment factors. Practitioners will need to perform self-evaluation and be honest about biases, both conscious and unconscious, and explore negative perceptions they have of Black American women and how that may create a barrier in care (Constantine & Sue 2006).

Practitioners should make themselves aware of individual differences and specific hurdles Black American women face in their lives and in seeking care. The following are areas that psychologist should take into consideration:

INCREASING AUTONOMY

Practitioners should not start sessions with a preconceived notion that problems of the Black American community need to be “fixed.” Instead, when working with Black women, practitioners should focus on finding tools that may better empower them to reduce effects of daily stressors on their
overall health. For example, practitioners can implement stepped care, where in the first step clients receive less invasive forms of treatment (self-help books and guides) and then if needed, more traditional forms of treatment, such as psychological assessments and therapy are made available for those who do not respond to the first step (Tonlin et al. 2005). Also, when analyzing this population closer, across the United States, approximately 30 percent of African American households are headed by a woman with no husband present, compared with about 9% of white households (U.S. Census Bureau, 2015). Thus, practices and assessment centers can offer child-care as an option for mothers who have no place to leave their children. Another overlooked plan of action is helping the client to identify supports that they currently have access to within their community that they might maximize on and use in addition to therapy and counseling (faith, family and social communities) as a part of their treatment plan.

COMMUNITY OUTREACH

A clinician may also find it best to meet potential clients where they are, in their communities. Perhaps establishing relationships with area churches, community outreach centers and other programs. This could also be in the form of free talks or attending discussions and townhalls. This setting could help Black women feel a sense of community, connection, and comfortability as they are educated and share personal stories which in turn may help to remove stigma from the experience of mental health difficulties. These partnerships could be used to help educate the public on mental health disparities, what they are and what they are not. This could be the time to normalize seeking treatment and demystify the process of involuntary commitment and hospitalization further reducing fear.

JOINING IN THE PROCESS

A pre-conceived notion that the client could have is that in this process they will be told what to do. As Black women experience the “daily grind”, some as over-worked, under-appreciated, often discriminated against, resilient women, they may seek to be more empowered and trusted with their own future, not simply given orders on what to do with their lives. This may be a daily struggle for them as they may feel they have no control in their lives currently. Clinicians should work hard to ensure this is a joint process. Allow clients to invest in the process, relay their fears and become more strengthened in the alliance. This could lead to higher levels of self-esteem and locus of control in the Black women client, which will lead to better mental health outcomes.

SUMMARY

More than 500 thousand Texans are eligible for, but not receiving community-based mental health services (NAMI, 2019). Out of these Texans, the Black population, and especially women, are continuously shown to be underserved by mental health professional. Thus, it is important to confront challenges that arise when learning about Black women, their needs, cultural differences and best practices in providing them with high levels of care. If practitioners know such unique factors and treat them as relevant, they can begin to implement treatments that help to positively build a relationship with Black American women clients, which in turn, may add to more appealing and positive therapeutic outcome for clients with such gender and racial characteristics.
REFERENCES


Substance Abuse and Mental Health Services Administration. Improving Cultural Competence. Treatment Improvement Protocol (TIP) Series No.


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 4/16 for the spring issue.
An Interview with Jessica Magee,
TPA Executive Director

Conducted by Kyle A. McCall, MA
TPA Board of Trustees Student Representative

TELL ME HOW YOU BECAME INVOLVED WITH TPA.

I applied for this job because of TPA’s Report from the Strategic Planning Committee, or what I think of as an as-is assessment. It was a very honest assessment of the state of the association, and a broader assessment of the state of psychology. (There is a joke here about leaving it to psychologists to provide an honest assessment of something.)

I have had unique opportunities in my career that have allowed me to be creative and innovative in my approach to both governance and management. I saw a need for that at TPA and responded to the call.

TELL ME MORE ABOUT YOUR EDUCATION AND EXPERIENCE.

My first job out of law school was with the Texas Supreme Court Children’s Commission, assessing the quality of legal representation in child protective cases. That report was part of broader efforts of reform at DFPS.

The Supreme Court is right next to the Capitol. When my contract had expired, naturally, I walked next door.

My third session at the Capitol I worked for a freshman member of the Texas House of Representatives. Not only was he a freshman, but his district was created as a result of redistricting. This meant we had no historical data on the district. For freshmen offices, your first day on the job is essentially the first day of session. At the same time we were being inundated with meeting requests from lobbyists, we were opening our district office and trying to pass important pieces of legislation, like a liability bill that provides immunity for persons or businesses providing assistance during disasters or expanding CTE (career and technical education) programs for students. And then my boss was assigned to Appropriations (the House committee that writes the budget), which is a rare honor for a freshman.

Six months later, we passed more pieces of legislation than any other freshman that session (there were 26).

Following that, I served as the first Policy Director of the Texas House Republican Caucus. In that role I established principles by which the 16 legislators on the Policy Committee would make voting recommendations on over 1,200 bills. I created the process by which 30+ Capitol offices assisted in analyzing over 2,000 bills that session. I also drafted a policy and procedure manual for Capitol offices.

My most recent job was with the government relations team at the HHS Office of Inspector General. Coming off a rocky few years of scandal, our team help re-build the reputation of the office. Our current IG was nominated and approved by the Texas Senate this year.

I cannot imagine taking a job and doing the status quo.

WHAT HAS SURPRISED YOU MOST ABOUT WORKING WITH TPA?

I do not know where some of you get your energy from! I am grateful and appreciative of so many members who have welcomed me, offered support, and given their time to the association. All of this while balancing other responsibilities—work, family, school. Your eagerness to help is a motivator to perform.

TELL ME ABOUT SOME OF THE PEOPLE YOU HAVE MET SO FAR WORKING IN TPA.

I think when the average person thinks of a psychologist, they often associate that word with therapist. And for a major of practitioners, that is accurate. But I also work with professors, deans, forensic psychologists, neuropsychologists, clinical psychologists—there are so many sub-fields. This, of course, does not surprise you. But it did me.

Continued on next page
Folks keep asking me how they can help. Educate me. Teach me about what you do so I can be a better advocate for you.

WHAT WOULD YOU TELL SOMEONE WHO IS THINKING ABOUT JOINING TPA OR DONATING TO TPF?

If you are a psychologist in Texas, TPA is your number one resource. We monitor all licensing and regulatory activities and put out calls to action and aggressively protect the practice of psychology at the Legislature. If you want to support TPA's work at the Capitol, donate to the PAC.

TPF has some exciting things on the horizon. You will see award amounts increase and student participation encouraged by TPA's student liaison and current interviewer, Kyle McCall. Following a great Halloween party at last year's conference, TPF is already planning the next one.

IN LIGHT OF YOUR PAST EXPERIENCE, WHERE DO PSYCHOLOGISTS GENERALLY STAND IN THE LEGISLATURE AND WHAT CAN WE BE DOING NOW TO CULTIVATE MEANINGFUL AND LASTING RELATIONSHIPS TO ACCOMPLISH OUR POLICY GOALS?

Mental health and behavioral health have been two of the biggest topics addressed by the legislature in last three sessions, and, to be frank, TPA has not had a seat at the table. TPA had a hard-fought Sunset battle for two of those sessions and we lost momentum elsewhere.

TPA staff are meeting with legislators on both sides of the aisle during the interim. Without a returning speaker of the House and a possible red-to-blue flip, it is important that TPA built a solid network of members it can work with who trust us. If any of you have relationships with members of the legislature or candidates, let us know. We always need grassroots support and we would like to know what you are hearing in your area. Or if you want to be involved locally, let us help you schedule a meeting with your legislator or introduce you to your LAS.

TPA also needs more representation on state/agency boards. We can alert you to openings and help you apply. If you already sit on a board, let us know and we can incorporate that work into our messaging.

Speaking of messaging—we have to get our message out there. It was suggested TPA create a press packet for the media so they know when they can come to TPA for responses to current issues. If you want to be part of delivering that message, join our speakers bureau.

Do not have time for any of that? Come to TPA Day at the Capitol! It is one day every two years. We can receive recognition from both chambers and have legislators talk about how to advocate effectively and the impact you can have on the legislative process. Finally, we match you with your legislator for an opportunity to advocate for your profession.

SPEAKING OF, WHAT IS NEXT AT THE LEGISLATURE FOR TPA?

We will be advocating for issues you are hopefully already familiar with: guardianship, immunity from civil liability, RxP, and balancing the standards of practice for psychologists in licensed sex offender treatment programs (LSOTP).

The Legislative Committee, which makes recommendations to the Board, will continue its work as other issues are identified either by you or in interim committee hearings or task forces, etc.

WHAT DOES A TYPICAL DAY LOOK LIKE FOR YOU?

The work of an association is constant—it reminds me of stepping onto an escalator. The escalator is not going to stop and wait for you to get onboard. You have to just take that step and go.

I am a very early riser. I start my day at 5am. I make a to-do list, first, and respond to overnight emails. (Sorry to those who are the recipients of those early emails!) Then I hit the gym, make a green smoothie, and get dressed. TPA staff work remotely, and structure is an important part of productivity. Our business hours are 9am-5pm.

Nothing is typical yet. Last week I attended the second meeting of BHEC, drove to Plano for a Saturday meeting to discuss EPPP-2, planned the next Board meeting, met with several TPA members and heard their ideas on next steps for TPA, attended a legislative summit for allied health care professionals, and had several introductory meetings with association colleagues.

WHAT WAS YOUR FIRST DAY LIKE?

We are in the process of selling the TPA office. On my first day I simultaneously emptied the office attic of historical files for archiving and edited a letter to HHS regarding proposed rules for OCR. With a small staff you wear every hat.

WHAT ARE YOU CURRENTLY WORKING ON?

There are big things coming to TPA! We are already planning this year's conference, learning from and improving upon previous conferences. TPA's President, Dr. Megan Mooney, wants attendees to have fun. Conferences cannot strictly be about obtaining PD credit. The 2020 presidential theme is Inclusion—of all people including students, professionals, members, non-members, and individuals of all races, ethnicities, gender identities and expressions, sexual orientations, and ages. TPA should represent all of these voices.

I am also exploring our use of technology and options to update our website. TPA will experience some growing pains during this process, but it is important for membership retention and growth that we “get with the times,” so to speak. Information about TPA
activities and opportunities for involvement should be readily available to members and I am not sure that has always been the case.

WHAT ADVICE WOULD YOU GIVE TO STUDENT AND EARLY CAREER PSYCHOLOGISTS WHO ARE THINKING ABOUT GETTING INVOLVED IN TPA?

I am going to flip this and ask that student and early career psychologists give TPA advice on how it can better serve them. Reach out to me, Dr. Mooney, or Kyle. Tell us what we are doing right, tell us what we are doing wrong, tell us what we are not doing but should be. If you want an active role in this process, let’s create one. TPA must support its next generation of psychologists.

WHAT IS SOMETHING PERSONAL ABOUT YOU.

I was diagnosed with two different types of alopecia last year. Ironically, I have a Siberian cat who sheds more hair than I have ever had. Life is funny that way.

WHAT IS YOUR MOTTO OR PERSONAL MANTRA?

Rome was not built in a day.

LEGISLATIVE UPDATE

Legislative Update

Kevin Stewart, Esq.
TPA Government Relations

With the Bonnen controversy out of the way (for the most part), the House and Senate have gotten back to work. Each interim, the Lieutenant Governor and the Speaker provide a list of charges to the committees in their chamber. These charges are composed of subjects that leadership wants the committees to monitor, research, or make recommendations on to prepare for the next session.

In the Senate, Lt. Governor Patrick had a number of charges focused on health care generally and mental health specifically. The Health and Human Services Committee will be researching broad topics like rural health and substance abuse; Finance will also be looking at substance abuse and will be discussing ways to reduce waitlists for mental health services; Education will be focused on special education and alternative education. All three of these committees are charged with monitoring SB 11, which created the Texas Mental Health Consortium. Finally, Veteran Affairs will be looking specifically at mental health services for veterans.

Speaker Bonnen’s charges seemed relatively timid, which is understandable given that he has announced retirement. Many of the charges were to simply monitor significant legislation from last session. There were a few charges focused specifically on mental health, though. County Affairs will be examining the frequency of arrests and incarceration of persons with behavioral health needs. Like their Senate counterpart, the Defense and Veterans’ Affairs Committee will be studying mental health treatment options for veterans. The Human Services and Public Health committees will be doing a lot of monitoring of last session’s legislation, much of which relates to mental health, but Public Health will also be reviewing behavioral health capacity in the state.

A common theme in both chambers will be health care costs. In the Senate, both the Business & Commerce Committee and the Health & Human Services Committee have charges related to health care costs. In the House, the Speaker announced the creation of the House Select Committee on Statewide Health Care Costs. All of these charges, including those provided to the select committee, are quite broad, but we will be looking for opportunities to discuss our agenda.

TPA will continue to provide updates on interim discussions. Meetings will likely pick up after the March primary, and it appears that there will be ample opportunity for members to discuss current issues impacting the practice of psychology. Please stay tuned, and contact us if you have any interest in testifying.
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