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A NOTE FROM THE PRESIDENT

MEGAN MOONEY, PHD
Houston, Texas
TPA President 2020

Dear TPA Friends and Colleagues,

It is hard to believe that this is my last message to you all as President of the Texas Psychological Association (TPA). I almost cannot fathom that we are in December already and yet I am glad to be looking forward to a new year (as I’m sure many of you are, as well!). I hope that this final letter finds each of you and your loved ones safe and healthy.

For those of you who don’t know me well, in my clinical practice, I specialize in treating children and families who have experienced a wide variety of traumas and losses. In particular, I focus on LGBTQ+ youth who are disproportionately at risk for experiencing all forms of trauma. Because of this lens in my clinical work, I talked with the Board of Trustees at our first meeting in 2020 about the principles of Trauma Informed Care:

- Safety
- Trustworthiness & Transparency
- Peer Support
- Collaboration & Mutuality
- Empowerment, Voice, & Choice
- Cultural, Historical, and Gender Issues


These principles are not action items that one checks off as present or not present. They are a way of being and an overall mindset for people and organizations. At the beginning of 2020, TPA was ushering in a new era with our first new Executive Director in over 25 years and significant changes to our profession resulting from legislative changes in 2019. I was hoping that, by highlighting these principles in our leadership of the Association, our Board could help TPA transition into a bright new future. Little did I know at that time what 2020 had in store for us all and how meaningful trauma-informed care would be for not just TPA but for the entire world.

In October 2019, I delivered my first speech as incoming President and reflected upon areas within TPA that I felt we could improve upon. Here is an excerpt of what I said then: “TPA has unfortunately historically excluded many people from our membership or our activities. This may have been intentional or due to implicit biases or negligence. But something that has been clear to me while I’ve been serving as a Board member and Chair of various committees is that we need fresh, new voices and ideas to actively participate in the association… TPA needs to more actively and intentionally invite people who have felt marginalized to participate in every level of the association. I am personally committed to this goal. I would like to invite each of you here to contact me directly if you are ready to find your unique way to contribute to TPA.” Early in the year I had conversations with TPA leadership about reaching out to students, to people of color, and to LGBTQ+ people. We began considering how to look inward to challenge ourselves to address the biases and problems I had seen while we simultaneously considered how to publicly disseminate research and position statements regarding “social justice issues”.

And then COVID-19 struck the country and our world in a way we could never have imagined. The ways in which I sought to include and listen to our membership changed rapidly. The leadership team and I focused quickly on topics related to transitioning to telehealth, insurance coverage and reimbursement, licensure concerns, and overall safety and security for our colleagues and the communities we serve. I jumped head-first into social media and email messages in ways my introverted self never could have imagined. I talked with family, friends, and colleagues about the fears for our personal and professional well-being and about how this might impact people we care about.

Through the first few months of the pandemic, I spoke with members whom I’d never met before and worked hard to make sure they knew we were listening, we cared, and we were doing everything we possibly could to support them. By mid-May we thought we had put out most fires and had a bit of a rhythm going and a system to the work.

And then George Floyd was murdered and the world watched the painful footage, cried and was outraged, and protested. And then the national media told us of the murders of Ahmaud Arbery and Breonna Taylor which had actually occurred months prior. And those of us who hold white-skin privilege needed to truly pause and reflect on these incidents as just the latest injustices that occur on a daily basis to our friends, colleagues, and community members of color. I know that I stopped and took stock of my own thoughts, feelings, and potential biases and how my various privileges helped me to have a life relatively free of trauma and injustice and to be in this particular position of leadership at this moment. I reflected on how, in this role, I could best make a difference. I knew that no one needed another statement that “racism is bad” and have it end there. I realized that these events were simply the next way for me to follow through and enact my theme of inclusion. I formed the Racial Justice Task Force in early June and this dedicated group has continued to meet monthly since that time with subgroups doing additional work in between meetings. The Task Force has identified four priority aims: (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; (4) Acknowledge, describe, and mitigate the systemic barriers within our profession.

Continue on page 4
Welcome to 2021! After the tumultuous year we experienced in 2020, I’m hoping that 2021 brings us better times. I would like to start off by introducing myself to everyone. My name is Nicole Dorsey and I have been the Training Director for the Harris County Juvenile Probation Department in Houston for nearly 12 years. I had recently been contemplating becoming more involved in TPA, when this position became available. I am grateful for the work that TPA does on behalf of our profession and I believe that we are currently at a crucial time in the field of psychology, which is why our involvement in our professional associations is so important. The importance of psychology’s contribution is reflected in several of the articles and columns in this issue, including Dr. Megan Mooney’s final column as TPA President. In our next issue, you will hear from our new President, Dr. Fran Douglas.

I would like to thank Dr. Jennifer Rocket for her guidance as I take over this new role and I intend to continue down the path that she has begun. Our hope is for the Texas Psychologist to be a forum for evidenced-based articles and to address pertinent and timely issues in our field. I would especially like to encourage students, interns, and post-docs to consider submitting an article. Please email me directly with any submissions or questions: Nicole.dorsey@hcjpd.hctx.net. I hope to receive articles addressing a variety of topics, but also articles that are of interest to our broad population of psychologists. Please do not hesitate to reach out to me if you have any ideas or suggestions regarding the Texas Psychologist. This publication is for all of us and I would like to do my best to ensure that it is an email that you all look forward to receiving in your inbox.

Best wishes for a Happy New Year!

Nicole
for trainees and practitioners of color. Much progress has been made and I am dedicated to continuing to participate in this task force even after this year. Fortunately, I know that our next three TPA Presidents are equally committed to these goals and will continue the work.

In October, my next opportunity to focus on the theme of Inclusion presented itself as the Texas State Board of Social Work Examiners voted to change language in their rules that would have allowed discrimination against LGBTQ+ people and people with disabilities. This vote came after “guidance” from the Governor about their Board rules supposedly being out of step with what is in statute. TPA leadership partnered with NASW Texas, APA, and many other groups to adamantly oppose this rule change. I provided comments during a hearing of the Behavioral Health Executive Council (BHEC) on behalf of TPA and we were glad to hear the BHEC vote to reverse the proposed rule change. But we know that this is just foreshadowing of the 2021 legislative session. Bills have already been pre-filed that would label gender-affirming care for transgender children and teens as “child abuse” and many more will be filed that will claim the need to be allowed to discriminate against and even refuse mental health services to LGBTQ+ people. TPA remains committed to ensuring equal rights and access to treatment for all people and will oppose proposed legislative and state policy changes that would harm our fellow Texans.

As this tumultuous year draws to a close, let me talk about future directions and some rays of hope. My hope and belief is that Diversity and Inclusion will be woven throughout the fabric of TPA and will not just be a “topic” or “theme”. They will become our way of being. The full Board has been active throughout this year and most members of the Board are part of the Racial Justice Task Force, The Diversity Division, and/or the Social Justice Division. They are all committed to these initiatives continuing as are the next three Presidents of TPA. We also have an incredible Executive Director, Jessica Magee, and a new Marketing and Communications Manager, Dena Goldstein. We have been fortunate enough to have Jennifer Harris consult with us this year on improving our media contacts and presence and she will be continuing with us into 2021. These amazing women, along with our wonderful Government Relations Consultant, Kevin Stewart, are ready to help TPA be more fresh, modern, and tech-savvy and most importantly, poised to show our expertise as the doctoral level mental health professionals in the state of Texas to the public and the legislature.

Last but not least, I would like to sincerely thank my wife, my family, and my friends for helping me through this year (and all the ones before it!). I also truly appreciate our Executive Committee, Drs. Alice Ann Holland, Fran Douglas, and Alfonso Mercado as well as our full Board of Trustees and the TPA staff. I am so fortunate to have worked alongside such an amazing team and I thank them all for their hard work.

I wish each and every one of you a safe and happy holiday season.

With hopes for a brighter and better 2021,

Megan

Megan A. Mooney, PhD
she/her/hers
2020 TPA President

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A NOTE FROM THE TEXAS PSYCHOLOGICAL FOUNDATION

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

After a successful 2020 virtual Convention and the close of the year, it is timely to review TPF’s efforts and endeavors this year. Megan Mooney, PhD, chose Inclusion as the focus of her presidency. Throughout this year, trying as it has been with the Covid-19 pandemic, the TPF Board of Directors has attempted to provide a more inclusive focus in at least one aspect of its mission in recognizing excellence and achievement in graduate training. In achieving this goal, the TPF Board includes two professors, Drs. Linda Ladd, Texas Women’s University, and Courtney Banks, Sam Houston State University. The Board hopes to extend this focus by including another professor on its Board. We bid farewell to two students who served on the Board for two years before entering their internships in July, Anna Abate and Cassandra Bailey. They are truly dedicated professionals who contributed a lot of vitality to our meetings and mission.

Kyle McCall joined us for the first half of the year and Patrick Stanford-Galloway joined us midway through the year. Each exhibited a high degree of enthusiasm for our profession and contributed to our monthly board meetings. Student members of TPF have an equal vote on issues that surface during our agendas.

With the increased use of technology, our monthly meetings were changed from early morning telephone conferences to early evening Zoom meetings; this allowed for the inclusion of more members to participate such as Dr. Kelly Arnemann who is employed by the VA in San Antonio.

Dr. Jo Vendl, a past TPF president, returned this year to serve as a Board member, bringing with her years of experience in the TPF setting.

Jessica Magee, TPA’s Executive Director, was present at all of our meetings. She serves as Treasurer. We were able to consolidate our assets and funds through her efforts. She also served as our meeting secretary; minutes were typically available for review within twenty-four hours if not after our meetings.

This spring, the Texas Psychological Foundation Board approved an online survey that was designed by board members, Drs. Linda Ladd, Courtney Banks, and Mr. Kyle McCall, which constituted a sub-committee, with the assistance of Jessica Magee. The online survey was sent out to the TPA membership three times between April 2020 and June 2020. The sub-committees recommendations will be used as a framework to construct a strategic TPF five-year plan.

Survey results targeted funding levels for graduate research, funding research by TPA members, work with TPA to reinstate leadership training for graduate students and early career psychologists, offer local associations the opportunity to apply for the new TPF grants, and provide a platform for graduate students to determine which activities would benefit them for the purpose of supporting students and building student loyalty to the profession of psychology and TPA.

The Foundations Bylaws were updated to include our method of recruiting members to its Board; after being nominated, a potential member is elected to serve a three-year term on the Board and then is ratified by TPA’s Board of Trustees. This year there was an electronic call for nominations that went out to TPA members.

TPF was able to participate in joint efforts by TPA and the Diversity Committee to reach out to students. For example, a presentation by Dr. Andy McGarrahan regarding his and his wife’s initiative to provide semester internships for black students was appreciated and enlightening.

This year was exceptional in students submitting papers for awards as well as 44 submissions in the annual poster competition. Awards and Grant winners are as follows: Roy Scrivner Gay/Lesbian/Bisexual Research Award: Sakina Ali: Eudaimonic Well-Being for Lesbian and Bisexual Women: The Roles of Religion and Social Connectedness; Jennifer Ann Crecente Memorial Grant: Rebekah Urban: Development and Preliminary Validation of the Gender Inclusive Rape Myth Acceptance Scale; and the Graduate Proposal Award: Haley Conroy: Perceived Discrimination and Anxiety among Black Youth.

Honorable Mentions went to Hansong Zhang: Mental Health Outcome of Studying a Course in Miracles (ACIM): A Cross Sectional Analysis, and Andrew Rogers: Development of a Personalized Feedback Intervention Targeting Pain-Related Anxiety for Hazardous Drinkers with Chronic Pain.

Drs. Amanda Venta, University of Houston, and Glenn Sternes, Private Practice, Houston, were nominated and elected to the Board of TPF Directors. A request for ratification by TPA’s BOT will be made at the next meeting.

Dr. Kelly Arnemann was elected President-Elect for 2021 and will serve a President for 2022 and 2023.
The PPF Board is extending its invitation to a graduate student for one seat who would like to serve on its board. A time commitment is not necessary although a year or two is conceivable.

In our final annual meeting in November, we paid tribute and a sad farewell to departing member Dr. Heyward Green who served as a Board member for six years, and two as president. Under his watch, TPF has grown and is stronger because of his leadership. He leaves with the title of Dr. Halloween, remembering his antics and presence at the 2019 convention.

As president I am gratified and honored by the commitment and dedication of the TPF Board members. They personify what is best about our profession.

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Thank you to our Heroes, Friends, and Donors!

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**FROM THE TEXAS PSYCHOLOGICAL FOUNDATION**

2020 Awards and Accomplishments

We're excited to announce the recipients of TPF grants and awards of 2020.

**Graduate Student Research Proposal Grant**

This grant was awarded to Ms. Haley Conroy of the University of Houston for her excellence in a research proposal related to the broad area of psychotherapy. Her research titled Perceived Discrimination and Anxiety Among Black Youth was awarded $1,500 toward the costs of conducting her scholarly research to promote the field of psychology.

**Roy Scrivner Gay/Lesbian/Bisexual Research Award**

This grant was awarded to Ms. Sakina Ali of Texas A&M University for her excellence in a research proposal related to the broad area of psychotherapy. Her research titled Eudaimonic Well-Being for Lesbian and Bisexual Women: The Roles of Religion and Social Connectedness was awarded $1,000 toward the costs of conducting her scholarly research to promote the field of psychology.

**Jennifer Ann Crecente Memorial Grant**

This grant was awarded to Ms. Rebekah Urban of Texas Woman’s University for her excellence in a research proposal related to the broad area of psychotherapy. Her research titled Development and Preliminary Validation of the Gender Inclusive Rape Myth Acceptance Scale was awarded $1,200 toward the costs of conducting her scholarly research to promote the field of psychology.

**First Place Award for Poster Presentation of Research**

This award was presented to Ms. Nabeeha Asim for her scholarly research and professional poster presentation of her topic, Dating Violence in Adolescents with and without Borderline Personality Disorder. The award of $300 goes toward supporting future scholarly research in the field of psychology.

**Second Place Award for Poster Presentation of Research**

This award was presented to Ms. Vanessa Gamboa for her scholarly research and professional poster presentation of her topic, Is there a relation between emotion regulation strategies and COVID-19 related anxiety in LatinX adults? The award of $200 goes toward supporting future scholarly research in the field of psychology.

**Third Place Award for Poster Presentation of Research**

This award was presented to Ms. Jessica Woodford for her scholarly research and professional poster presentation of her topic, Keepers of the Culture. The award of $100 goes toward supporting future scholarly research in the field of psychology.
Each year at TPA’s Annual Convention, awards are presented to psychologists and other individuals who have made significant contributions to professional psychology. This year’s lineup of award recipients is full of outstanding contributors to the profession of psychology and mental health.

- Outstanding Contribution to Public Service
- Outstanding Contribution to Education
- Outstanding Contribution to Science
- Outstanding Legislative Contribution
- Outstanding Media Coverage
- State Advocacy Award
- Psychologist of The Year
- Distinguished Lifetime Achievement

Outstanding Contribution to Public Service
TPA President-Elect Designate Alfonso Mercado, Ph.D., received the Outstanding Contribution to Public Service Award. This award recognizes a psychologist who has made outstanding contributions on behalf of the public. Dr. Mercado is a Licensed Psychologist and an Associate Professor in the Department of Psychological Science and School of Medicine’s Psychiatry and Neurology Department at the University of Texas-Rio Grande Valley. He is the Director of the Multicultural Clinical Lab, which focuses on treatment efficacy with culturally diverse groups, personality and substance abuse research with Latino populations, and examining trauma and resiliency with recent immigrants. He testified in front of Congress this year and completed numerous media interviews in efforts to draw attention to the needs of the vulnerable people he serves.

“Dr. Mercado is a truly amazing person and psychologist who devotes incredible amounts of his personal and professional time advocating for the safety, health, and well-being of immigrant families and the underserved communities at our border,” Dr. Mooney explained. “He gives tirelessly of himself in an effort to use psychology to help the public.”

Outstanding Contribution to Education
Courtney Banks, PhD, earned the Outstanding Contribution to Education Award. This award recognizes a truly distinguished contribution by a psychologist in the area of education. Dr. Banks is an Assistant Professor at Sam Houston State University where she is also the Director of the Creating Optimal Relationships in Educational Settings lab, conducting research surrounding promoting home and school engagement in K-12 schools, parent socialization of education and behavior engagement, and examining ecological factors that influence bullying participant roles. As a member of the Texas Psychological Foundation (TPF) Board, she is committed to TPF’s mission recognizing excellence and achievement in graduate training through grants and awards.

Dr. Banks’ peers describe her as someone who “sets a high bar for bringing psychology topics to life and enthusiastically engaging students at every level of training” and “embodies an attitude of inclusivity and warmth toward students and colleagues, alike. She is an asset to our department and to the field as a whole and in no domain is this clearer than in her contribution to education.”

Outstanding Contribution to Science
Jennifer Callahan, PhD, received the Outstanding Contribution to Science Award. This award recognizes a psychologist who has made a significant contribution in the discovery and development of new information, empirical or otherwise, to the body of psychological knowledge. Dr. Callahan is a Professor of Psychology and the Director of Clinical Training for the doctoral program in Clinical Psychology at the University of North Texas. Her team’s work primarily centers on improving psychological services and client outcomes among under-served and disadvantaged populations. She is a Liaison to the American Psychological Association (APA) Presidential Deep Poverty Initiative and has authored more than 140 publications. She is the Editor-in-Chief for the Journal of Psychotherapy Integration, an Associate Editor for the Training and Education in Professional Psychology, and a Consulting Editor for the American Psychologist and Practice Innovations. Dr. Callahan is truly committed to continuing research that will reduce barriers for individuals from marginalized communities.

“Dr. Callahan’s efforts to conduct research and provide data regarding areas of potential implicit bias in our field make her a true asset to Texas and TPA,” Dr. Mooney said. “She has graciously helped TPA in our efforts throughout the year to advocate for our members and our profession using sound scientific data.”

Outstanding Legislative Contribution
Senator Judith Zaffirini earned the Outstanding Legislative Contribution Award.
This award is given to a legislator, legislative employee, or other individual who has had a major role in initiating advocacy in favor of passing legislation that has a major impact on psychology in Texas. Senator Judith Zaffirini—who is the first Latina elected to the Texas Senate—represents the 21st Senatorial District, which extends from the Rio Grande to the Colorado River and to the Port of Corpus Christi and the Valley.

“Senator Zaffirini has been a great ally in mental health throughout the COVID pandemic,” Dr. Mooney noted. “She has reached out to TPA and psychologists to make sure that she considers information about the mental health needs of the community while hosting town halls for her constituents. She and her staff have worked tirelessly to make sure that they are providing evidence-based information to the community about mental health needs as well as information on coping for families during this unprecedented time.”

Outstanding Media Coverage
TPA’s Public Relations Consultant
Mrs. Jennifer Harris received the Outstanding Media Coverage Award. This award is presented to an individual or organization that has benefited psychology through a media event. Mrs. Harris is the founder of JWH Communications, a full-service strategic communications firm that offers media relations, social media and digital engagement and issue campaign management, among other services. Through her efforts, TPA has had more media contacts in the past six months than in the past six years.

“Jennifer has been a true asset to TPA this year.” Dr. Mooney further explained, “Jennifer has done a tremendous job connecting TPA with various media sources so that psychologists are at the forefront of providing information about mental health to the public.”

State Advocacy Award
Bonny Gardner, PhD, received the State Advocacy Award. This award is given to a TPA member who passionately and tirelessly demonstrates commitment to the advancement of the profession of psychology at the state regulatory level. Dr. Gardner has devoted most of her career to providing clinical service. An active and long-time TPA member, she has served on several committees and chaired the Business of Practice Committee for more than a decade, where she developed respected relationships with Texas Health and Human Services staff. She also consistently attends TPA Legislative Day and has forged relationships with most of the Austin Delegation. She has served on the PSY-PAC Board for the past three years and helped raise almost $30,000.

“I cannot think of another psychologist in Texas who has dedicated more time in advocating on behalf psychologists in Texas,” Dr. Mooney explained. “Dr. Gardner is truly worthy of recognition for her service.”

Psychologist of The Year
Past TPA President Cheryl Hall, PhD, was named TPA’s Psychologist of The Year. This award is given to a psychologist recognized as having made a significant impact on the field of psychology in Texas. For more than 20 years, Dr. Hall has worked diligently for Texas psychologists, serving as Federal Advocacy Coordinator prior to being elected to the TPA Executive Committee. She routinely travels from Lubbock to Austin to participate in activities promoting psychologists, including TPA Legislative Day. A tireless advocate, she encouraged sponsorships of a prescriptive authority bill for psychologists in 2017, which lead to increased interest and a hearing on similar legislation during the 2019 session.

Dr. Hall was nominated for this award by a number of her peers who describe her as “a fantastic leader in the realm of advocacy” and someone whose “extensive history of legislative involvement at the state and national level is profound. I am energized by her commitment to attending to legislative advocacy across the various roles of being a psychologist, and I am a better Texan in understanding our government through my association with Dr. Hall.”

Distinguished Lifetime Achievement
Lou Ann Todd Mock, PhD, earned the Distinguished Lifetime Achievement Award. This award is generally given to a psychologist who is nearing the end of their career and has a long and distinguished record of exemplary professional accomplishment. Dr. Mock was an associate professor in the Menninger Department of Psychiatry and Behavioral Sciences at Baylor College of Medicine, where she supervised pre-doctoral interns for nearly 40 years prior to her retirement from Baylor. She also held a private practice, focusing on women’s issues, children and families, and recovery from traumatic life experiences. She continues to consult with Casa de Esperanza, an emergency shelter and foster home for abused or neglected children from birth to age three.

“Dr. Mock has dedicated her long career to helping advance and protect the profession of psychology in Texas. She supervised countless interns through the Baylor College of Medicine internship program over decades of her tenure. Many of her interns have gone on to hold a number of important titles and roles within psychology, both in Texas and across the country. LouAnn Mock has truly had a distinguished career and I am so incredibly proud to call her my supervisor, my colleague, and my dear friend,” according to Dr. Mooney.

As a member of the National Child Traumatic Stress Network, Dr. Mock helped develop several curricula that have been used for the past decade to train people in evidence-based trauma-informed care across the country. Dr. Mock also is a member on the Texas State Board of Examiners of Psychologists and serves on committees that oversee the examinations of individuals seeking licensure as well as the committee that oversees complaints against licensed psychologists. The seriousness by which she undertook these roles has helped protect psychology as a profession, but more importantly--the public.
INTRODUCTION
Television screens and social media posts have brought a great deal of attention to race-related issues in this country in recent years. Less has been shared, posted, or tweeted about the wide-reaching implications of race-related stress on individuals long after these heinous, attention grabbing incidents have disappeared from the media news cycles. In reality, when the videos stop trending and the hashtags disappear, the deep and pervasive implications of racial trauma are felt in its survivors. Voicelessness, rage, devaluation, and flashbacks encompass just a few of the many trauma symptoms that proceed from experiences of race-related stress. This form of interpersonal trauma has far reaching implications for the minds and bodies of individuals experiencing, bearing witness to, and hearing about the atrocities of discrimination, racism, and racial oppression. As a clinical community, this calls us to reflect on what we know and where we need to evolve in the realm of traumatic stress, specifically regarding race-related stress. Current times challenge us to expand our conceptual frameworks for understanding, recognizing, and supporting individuals and communities through the provision of culturally sensitive and trauma-informed care.

TRAUMA
When individuals experience atrocious or traumatic events, their entire world and sense of being can be disrupted and devastated. All of the frameworks they once used for making sense of their experiences may no longer feel effective or applicable in their new lived reality post trauma. Many of the patterns that once kept their relationships in sync and safe may be destroyed and displaced, leading to difficulties trusting themselves and others. What constitutes a trauma then is not entirely dependent on the nature of the event but also on the personal and social interpretation of the event and the responses of the affected person, their family and community, as well as the wider society.

By definition, traumatic stressors are “events that violate our existing ways of making sense of our reactions, structuring our perceptions of other people’s behavior, and creating a framework for interacting with the world at large” (McFarlane & De Girolamo, 2007, p. 131). In addition, per the American Psychological Association (APA), “trauma is an emotional response to a terrible event like an accident, rape, or natural disaster” (American Psychological Association, n.d., para. 1). Further, the National Child Traumatic Stress Network (NCTSN) defines a traumatic event as “a frightening, dangerous, or violent event that poses a threat to a child’s life or bodily integrity (NCTSN, n.d.).” Per the NCTSN, children who witness traumatic events that threaten the life or safety of others, specifically loved ones, can also perceive these events as traumatic (NCTSN, n.d.).

These definitions provide us a helpful framework for understanding trauma, but are somewhat confusing and lacking in details. These descriptions call us to consider what exactly qualifies as a “terrible event” or what a “frightening, dangerous, or violent event” looks like. They warrant speculation surrounding how exactly we define what poses a “threat” to another human being and to their “life or bodily integrity.” It can be argued that many events outside of those falling within these broad definitions or defined categories may be considered traumatic to the individual person given that we all have varied and diverse life experiences, as humans we may be traumatized by different experiences or events. This is critical to understanding trauma as it reminds us that while frameworks exist, “What constitutes a trauma then is not entirely dependent on the nature of the event but also on the personal and social interpretation of the event and the responses of the affected person, their family and community, as well as the wider society” (Kirmayer et al, 2010, p. 156).
It is important to provide insight into the historical context and the Black experience in the United States of America that has created and contributed to race-related stress.

Further, research supports the notion that trauma can arise from “three different types of painful learning (Gentry, 2016, p. 8)” or incidents when a “painful or traumatic experience from our past intrudes into our perceptual systems (Gentry, 2016, p. 8)” specifically through primary trauma, secondary trauma, or environmental trauma (Gentry, 2016). In other words, individuals can be traumatized by experiencing events firsthand (i.e. being harmed themselves) or even by witnessing another person be harmed (i.e., watching a parent be beaten, witnessing a friend be assaulted, seeing someone be harmed through your television screen). However, individuals can also become traumatized without experiencing or witnessing trauma (Gentry, 2016). Given this, while it is widely accepted that horrific events can lead to the experience of trauma, the notion of what is classified as traumatic is ever changing.

HISTORICAL AND SOCIOCULTURAL CONTEXT

Before discussing the specifics of race-related stress, it is important to provide insight into the historical context and the Black experience in the United States of America that has created and contributed to race-related stress. In a speech by Barack Obama at the National Constitution Center, he called slavery the United States’ “original sin” (National Constitution Center, 2008), which polluted the progress of the country. The legal institution of human chattel enslavement, more commonly known as slavery, existed from the “origin” of the United States in 1776, as a means of free labor. However, some consider the outset of slavery to the U.S. to have begun in 1619 after The White Lion, a private government owned ship, brought 20 African slaves to Virginia. Slavery continued in the U.S. until 1865 following the passage of the 13th Amendment. Following slavery, institutionalized oppression impacted the lived experience of Black individuals in the United States through laws, policies, and institutions created and imposed to degrade, humiliate, and regulate the Black persons.

Following the abolishment of slavery, Alabama instituted the Convict Lease System in 1846, which used Black persons for another form of free labor. This system led to Black individuals being convicted of crimes, the majority of which were false, and then being leased to plantation owners. While being leased to plantation owners, “convicts” were brutalized, starved, and at times, even sodomized. This practice transpired for over 100 years, ending in the 1950s. The number of individuals that died during this period is still unknown (DeGruy, 2005). Another form of oppression following slavery was the implementation of the Black Codes, a set of laws beginning in 1865 that were established to be imposed upon recently freed slaves to “control their movement and activities” (DeGruy, 2005, p. 81). Although the codes varied from state to state, regulations included the prohibition of Black persons from sitting on juries, voting, and owning land. Regulations also delineated where and with whom Black individuals could travel, where they could work, and even the hours they were allowed to work (DeGruy, 2005). The legacy of slavery and the oppressive systems thereafter affected and continued to effect Black individuals.

DEFINITIONS OF RACISM

While the legal institution of slavery was abolished in 1865, ideologies and belief systems surrounding inferiority and inequality are deeply rooted in American culture, values, and ideologies. While laws have changed and civil rights have progressed, remnants of dark times in American history continue to present themselves and insidiously affect the lives of Black Americans. Racism is one of these remnants that has withstood the bounds of time and has been conceptualized and understood in a variety of ways. Harrell (2000) defines racism as,

“A system of dominance, power, and privilege based on racial group designations . . . where members of the dominant group create or accept their societal privilege by maintaining structures, ideology, values, and behavior that have the intent or effect of leaving nondominant-group members relatively excluded from power, esteem, status, and/or equal access to societal resources. (p. 43)”

Other researchers have delineated that different types of racism exist. More specifically, Jones (1997) identified three forms of racism: individualized racism, institutionalized racism, and cultural racism. Individual racism can encompass acts and attitudes that express an individual’s prejudices toward a specific group. Institutional racism is the process of individual racist beliefs being translated to a larger scale into discriminatory procedures and policies into an institution. Cultural racism is the result of the dominant and privileged group’s power to establish and determine attitudes, values, and beliefs that become expressions of its culture (Jones, 1997). In addition, Carter (2007) highlights “cultural racism,” (p. 88) delineating the lack of recognition, attention and care to the descendants of those directly seized in chains, who endured incalculable amounts of hardship and pain by slavery, segregation, and the denial of access and opportunity. In addition to these varying forms of racism, Sue et al. (2007) describe “everyday racism” which comes in the form of racial microaggressions, which they define as, “brief and commonplace daily verbal, behavioral, and environmental dignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults to the target person or group” (p. 273).

RACE-RELATED STRESS

Race related stress can derive from a race-based event that causes a traumatic response or emotional reaction, such as being called a racial slur in a grocery store. Research conducted by Harrell (2000) delineated six different types of stress related to individual, institutional, and
The research supports integrating race-related stressors and events into our conceptual framework of what constitutes trauma.

Cultural racism; racism-related life events, vicarious racism experiences, daily racism microstressors, chronic-contextual stress, collective experiences, and transgenerational transmission. Examples of the various stressors include having a family member experience a form of racism, frequent reminders that one’s race matters through acts of exclusions or slight, perceiving ongoing disparities of wealth and power toward one’s own racial group, and the stress associated with racism being transmitted through the generations.

RACE-RELATED STRESS AS TRAUMATIC STRESS

The research supports integrating race-related stressors and events into our conceptual framework of what constitutes trauma. Helms, Nicolas, and Green (2010) identify racism and ethnoviolence as traumatic and describe the experience of ethnoviolence as, "violence and intimation directed at members of ethnic groups that have been marginalized and stigmatized by the dominant or host culture because their inability or unwillingness to assimilate threatens the dominant group’s entitlement to society or community resources" (pg. 54).

Further, Kenneth Hardy (2015) described, “Racial oppression as a “traumatic form of interpersonal violence which can lacerate the spirit, scar the soul, and puncture the psyche” (pg.25). While D’Andrea, Ford, Stolbach, Spinaizolla, and van der Kolk (2012) define the term interpersonal trauma to include things such as: abuse, neglect, assault, witnessing domestic violence, and other forms of maltreatment and serious disruptions in caregiving, researchers in race-related stress identify racism and racial oppression as forms of interpersonal trauma.

Carter (2007) explains that for a race-based event to be considered traumatically stressful, the individual must perceive the race-based event “as negative (emotionally painful), sudden, and uncontrollable” (p. 84), paralleling literature that discusses the importance of individual perception in determining whether an event will be experienced and internalized as traumatic (Carter, 2007). Further, Carter (2007) indicates that the individual must also experience a reaction in the form of intrusion, arousal, or avoidance, for the event to be considered a traumatic event, symptom clusters common to individuals who experience other forms of trauma. More specifically, Carter (2007) identified a variety of emotional reactions that can occur in response to traumatic race-related experiences including trouble concentrating, guilt, nightmares, flashbacks, poor relationships, low self-esteem, vigilance, and withdrawal, reactions paralleling those common in individuals who meet criteria for PTSD according to the DSM-5. Carter (2007) noted the most common emotional responses to an experience of discrimination were feeling angry and disrespected. Direct experiences with racism and discrimination, such as verbal harassment or assaults and being denied access or services, were found to be related with feelings of guilt/shame and anxiety. A hostile work environment was associated with greater hypervigilance and anxiety (Carter & Forsyth, 2010). In addition, it is notable that individuals can also demonstrate responses of activism, empowerment or a commitment to being strong, demonstrating components of responses similar to those endorsing posttraumatic growth or positive change subsequent to experiencing traumatic events (Tedeschi, Park, & Calhoun, 1995).

The research and clinical community have studied the larger impact of trauma through the generations. Intergenerational trauma was first researched and proposed following the observations of emotional and behavior difficulties noted in the children of Holocaust survivors (Rakoff, 1966). The cumulative effect of one’s lineage, parents surviving traumatic experiences, can be passed down and integrate into the offspring of survivors influencing attitudes, beliefs, and behaviors. Through years of research, DeGruy studied this, by exploring the impact of slavery on descendants of slavery and introduced the theory of Post Traumatic Slave Syndrome (PTSS). She defines PTSS as “a condition that exists when a population has experienced multigenerational trauma resulting from centuries of slavery and continues to experience oppression and institutionalized racism today” (DeGruy, 2005, p. 121). DeGruy delineated a facet of PTSS as “a belief (real or imagined) that the benefits of society in which they [Black persons] live are not accessible to them” (p. 121) and outlined three groups of behavior that encompass PTSS: vacant esteem, racist socialization, and ever-present anger. Vacant esteem is defined as “the state of believing oneself to have little or no worth, exacerbated by the group and societal pronouncement of inferiority… the net result of three spheres of influence: society, our community, and our family” (p. 125). Racist Socialization is defined as the “adoption of the slave master’s value system” (p. 134) and the internalization and socialization that things associated with Blackness are seen as inferior, while things associated with Whiteness are superior. DeGruy defines the ever-present anger as deriving from “a reaction to our [Black persons] hopes and dreams being continuously undermined by the institutions which governs us and the racism that permeates American society” (DeGruy, 2005, p. 133). DeGruy’s research on PTSS illustrates and provides a framework for the multigenerational trauma and the continued limited accessibility within the Black community.

DISCUSSION

The impact of intergenerational historical trauma, racism, and race-related stress and trauma is profound and can have significant effects on one’s mental health and well-being. Further, “quality of life, serious psychological distress, and PTSD symptoms are all droplets trickling down from the cloud of racism that is infinitely hanging over the heads of individuals of color in the United States” (McCann, 2018). Racism can
leave hidden wounds and as providers of mental health services it is often our role to help clients make the “invisible visible” in order to experience healing from these scars (Sue, 2004, p. 762). It is our responsibility as clinicians to integrate race-related stress into our framework for understanding ourselves and our clients and their lived experiences in order to provide trauma-informed, culturally responsive care and support. The discussion to follow provides a variety of insights for exploring and engaging in this process. It is intended to provoke curiosity and reflection regarding our own internal dynamics, responsibilities as clinicians, and pathways to improving client care and cultural humility and sensitivity in regard to race-related stress. It is not intended to reflect viewpoints of the entire clinical community. It acknowledges that while for some, integrating these ideas into our frameworks and treatment settings may be novel, and for others, it may be very familiar and integrated into our practice. The following remarks are not intended to set clinical standards but rather to provide beginning ideas and starting points for navigating race-related clinical work in the therapeutic space and beyond.

**THE INNER WORLD AND EXPLORATIONS OF THE THERAPIST IN WORKING WITH RACE-RELATED DYNAMICS**

It has been stated that, “ambivalence is a powerful force. We are always caught between the desire to know and the desire to not know (Charles, p. 26).” To strive toward being a culturally sensitive and responsive therapist, we are called repeatedly to uncover and confront our own discomforts, short-comings, and biases even when we feel ambivalence to do so. We must challenge our beliefs, responses, and sources of information and be open to exploring how facets of our own sense of self influence how we sit with clients in the therapy room. In a time and world filled with such a high degree of polarization and animosity, clinicians may find themselves feeling immobilized and frozen to act out of fear. Fear of being wrong, fear of saying wrong, and fear of doing wrong can stunt growth and lead to inaction. While race-related issues and traumas require careful consideration and immense self-reflection and emotional processing, these issues also require action and movement forward. Even without all of the answers, when providers of care act from a place of genuineness, compassion, sensitivity, and humility, there is opportunity for connection and learning and space for healing and change. As clinicians, we must demonstrate mobility and processes of “working through” just as we encourage our clients to do in the therapeutic encounter when working in the realm of trauma.

In thinking about working with race-related stress, it is necessary to highlight the critical importance of treatment providers working to be aware of their own biases, beliefs, and cultural heritage as they bring these things into the therapeutic space and into interactions with clients consciously and unconsciously. In regard to this, Hays (2008) discusses practical steps to assist clinicians in working toward self-awareness and increased knowledge about oneself and others. She highlights the importance of investigating one’s own cultural heritage - knowing where you come from, what you believe, and what you were taught - because it makes us who we are today. Hays also highlights the need to pay attention to the influence of privilege on our understanding of cultural issues. She calls us to keep in mind our unique identities and experiences which may influence the ways in which we hold privilege in society. Further, she reminds us that exploring our own privilege is ongoing and we must be conscious of how privilege can limit our experiences and knowledge base. Hays also calls clinicians to educate themselves through diverse sources of information “that enable him or her to learn from and with (not simply about) people of diverse cultures (Hays, 2008, p. 61).”

Further, as mental health professionals, it is important for us to consider not only our own internal dynamics and the way these may influence our individual clinical relationships but also the ways in which we can engage in and influence the larger community to address race-related trauma. While a large portion of our work as clinicians can occur inside the therapeutic space, we must recognize that we can stretch our bounds outside of our office, organization, and institution walls into the larger community to promote systemic change.

As clinicians, one of our primary skills is our ability to think critically about people and experiences. In thinking about the applicability of this to the topic of race-related stress, we must of course, think critically about ourselves, our clients, and the larger systems we are involved in. Additionally, we must turn a critical eye to the content and material we are exposed to on a regular basis. Hays (2008) highlights the need for clinicians to constantly think critically and challenge what we read and know. For example, when reading a news article about ethnic minorities, she calls us to ask ourselves the following questions: Am I reading between the lines and thinking about the writer’s personal beliefs or potential political orientations? Am I considering if the article included the opinion of the ethnic minority being written about? Am I aware of how the article may look different if it were written by someone else, specifically an ethnic minority? These questions remind us how essential it is for us as human beings and providers of mental health care to remain open and curious and to challenge what we read and hear. They remind us that it is an ongoing exercise to explore, understand, and challenge our own beliefs and biases and explore and inquire about the perceptions.
and ideologies of others. Regardless of the demands placed on us to learn quickly or the external and internal pressures to do things "right", or the intensity of the social and political climates surrounding our work, we must remember that providing culturally responsive care is not a check box to mark and be completed, but rather a continuous road to navigate, learn, and grow from throughout one's personal and professional journey.

**BEING WITH AND HOLDING RACE-RELATED STRESS**

In working with all clients, the words of Donald W. Winnicott ring true, "be before do (Winnicott, 1986, p. 42)." As mental health professionals we are inundated with theories and frameworks for how to work with and "treat" those who come to us for help. We learn different skills and strategies for addressing particular issues and needs and sometimes, we may get lost in the templates and techniques and the need to "do," to "fix," or "change." When working with clients, particularly those managing race-related stress, one can argue that the most important thing we can do is "be." While we can use our knowledge and theories to conceptualize and strive toward understanding, we can ultimately strive to "encounter the moment and try to learn something from it (Charles, p. 13)" and recognize that racism is largely complex, dynamic, and insidiously haunting in the lives of Black people.

We can refrain from diving in with what we think we already know about how individuals experience their world, and instead place our focus on being present in the moment to truly and genuinely bear witness to our client's experiences. We can bring our warmth, presence, and compassion to the space and acknowledge our own reactions, missteps, and short-comings. We can strive toward creating a sense of holding, containment, and safety in the therapeutic space through our words, actions, humility, and openness. As clinicians, we can of course continue to grow, learn, and train on topics related to identity, race, trauma, diversity, etc. all while remembering that "we inevitably begin a treatment in the dark (Charles, p. 12)" and sometimes, "not knowing can also be seen as a mark of respect for the task that lies ahead (Charles, p. 12)." Given this, it is critical that we remain humble and ask questions of our clients with genuine curiosity, empathy, and openness.

Additionally, it is important for us as providers of care, to be mindful and carefully consider what we ask our clients to share and how we ask our questions. Specifically, we are called to reflect on our current interview protocols and routines and ensure we are asking about racism and race-related stress to not only gain a better understanding of the individual client but also to let them know that this topic is not "off-limits" or out of the scope of the therapy space. As a clinical community, the topic of race-related stress and racial trauma calls us to reconsider the ways we commonly assess for traumatic experiences and the inclusion or exclusion of race-related dynamics from these measures, assessments, and screening tools. For example, in looking at the widely accepted and highly valuable Adverse Childhood Experiences tool, we may consider if and where adverse race-related experiences or traumas in childhood may have a place in this measure and other related trauma assessment tools (Felitti et al., 1998).

It is our clinical responsibility to provide those we serve and treat with a safe space to share any and all experiences that they would like to without judgement or bias radiating from our chairs. It is critical for clinicians to bring an honest acceptance of both our own and our client's experience. We must strive to remember that our clients are the experts of their own lived experience and that intrapsychically, our clients possess all they need for growth and healing. As we work toward holding and containing the various emotions, dynamics, responses, and experiences associated with race-related stress for our clients, it is equally important that we find healthy, effective ways to hold all of these things for ourselves. There is an intensity and heaviness that can come from "being with" others managing trauma and we must be mindful of the occupational hazards of secondary traumatic stress and/or vicarious traumatization that can unconsciously transpire (Figley, 1995; Pearlman & Saakvitne, 1995).

**DIAGNOSING AND LABELING RACE-RELATED STRESS**

Human beings have a tremendous capacity for resilience and adaptation to adverse experiences. However, on occasion, traumatic experiences can lead to significant internal distress and development of psychological symptoms and syndromes. When it comes to diagnosing trauma the American Psychiatric Associations, Diagnostic and Statistical Manual of Mental Disorders is frequently utilized. Within the DSM-V, lies a section entitled, Trauma- and Stressor- Related Disorders, which includes Posttraumatic Stress Disorder (American Psychiatric Association, 2013). When thinking about working with clients who have experienced race-related stress, it is important for clinicians to recognize that while individuals may experience symptoms that map onto our diagnostic labeling system and they may not. While we must keep this in mind when assessing for symptoms, we must also keep this in mind when considering what constitutes a traumatic event. For example, individuals may not only exhibit direct experiences of racism that can lead to traumatic stress responses but may also be vicariously impacted or traumatized in other ways such as through television or social media. More specifically, current technologies provide a variety of platforms and channels for individuals to be inundated repeatedly with distressing race-related content and traumatic scenes of individuals within one's own ethnic group being harmed. Overall, as previously stated, working with clients who have experienced race-related stress, requires clinicians to acknowledge race-related stress and trauma as a legitimate form of traumatic stress.
Further, it is critical to keep in mind that individuals are impacted on a daily basis by the larger systems in which they are a part of. When thinking about racial oppression and race-related stress, as clinicians we can remain cognizant of the systematic oppression and institutionalized racism which exists across systems and institutions including criminal justice, education, and healthcare. We can more deeply understand the lived experiences of our clients by acknowledging the oppressive systems in which they may function and exist, all of which may influence clinical presentation and client rationales for seeking support and therapeutic services. As clinicians, it is critical that while we remain deeply present and engaged in the therapy room, we never lose sight of the bigger systems and contexts in which our clients exist from their individual microsystem through the larger societal macrosystem (Bronfenbrenner, 1979).

Given all of this, it is a challenging dialectic for clinicians to both allow clients to be the definers of their own experiences and internalized perceptions of events, and assist the client in recognizing that traumatic responses they are experiencing may be relevant to race-related stress, racism, oppression, and intergenerational transmission of trauma. It is important for clinicians to keep frameworks of PTSD as well as PTSS in mind while attempting to conceptualize, formulate, and give words to the client’s experience and clinical presentation. As a mental health community, it is important to remember that “Our need to find anchors - and signposts to guide our way - can make us jump too quickly on “meanings” as saturated elements that leave little room for growth. ..We do this with diagnoses, for example, forgetting that these labels are merely metaphors, a way of “marking the spot (Charles, 14).” When sitting with clients who have experienced race-related stress, we must keep in mind that rage, disavowal, guilt, vigilance, and flashbacks are merely “marking the spot” for areas of excavation into deep and often hidden wounds inflicted by the munitions of racial oppression and racial trauma.

...work toward creating a safe space and communicating our openness as clinicians to discussing race and the client’s experiences.

HEALING RACE-RELATED STRESS: EXISTING FRAMEWORKS AND BEYOND

In working with individuals who have experienced race-related stress, we can lean on our understanding of trauma and modern-day conceptualizations of the stages of recovery for healing from adversity. More specifically, we can remember that regardless of approach, orientation, training, or clinical presentation, the basic ingredients of trauma treatment include establishing relationship and safety, “remembrance and mourning,” or retelling the story of the traumatic event and reconnecting with self and others (Herman, 1992). However, Hardy (2015) can provide us with clarifying insights and helpful places to begin when discussing race-related stress and racial oppression specifically. Hardy (2015) reminds us that one must approach our work in a similar manner described above, beginning with understanding, moving to addressing, and ultimately working toward healing. We must first acknowledge that the implications of race-related stress, like all traumatic experiences, may be apparent on the surface and hidden deep within the psyche. For example, individuals may endorse symptoms of PTSD, however, they may also deeply experience internalized voicelessness, assaulted sense of self, internalized devaluation, and rage (Hardy, 2015). These wounds Hardy discusses may not manifest as direct clinical symptoms of diagnostic criteria; however, they are not any less debilitating or impeding to healthy functioning.

Given this, Hardy encourages us to implement an interrelated, stepwise process to our work with race-related stress beginning with acknowledgement and affirmation of race as an intricate part of society. He encourages us to then work toward creating a safe space and communicating our openness as clinicians to discussing race and the client’s experiences. In step three, Hardy encourages us to invite the client to share personal stories of racial experiences” (p. 27), allowing the individual to use his or her own voice and begin to think critically about his or her experiences. The next step is validation, which is used for “counteracting devaluation and an assaulted sense of self” (p. 27) and provides a sense of substantiation and merit to the youth’s perspective and experience. Hardy goes on to further state that, “there is an untapped hero within that has been overshadowed by stereotyping, pathologizing, demonizing, and criminalizing” (p. 28) and we have a role in working to bring up this hero within the individual that has been invalidated and diminished. Step five focuses on helping individuals to reestablish their voice through “The Process of Naming”, which consists of labeling and using words and language to describe one’s racially based experiences. The next step focuses on recognizing that incidents of disrespect or attacks on one’s dignity do not diminish one’s self-worth and helping the client to externalize devaluation. The seventh step aligns with this as it focuses on counteracting devaluation by offering a variety of resources that assist in developing strengths and protective factors against future attacks on one’s sense of self, self-blame, shame, and guilt. The eighth and final step in healing the hidden wounds of racial trauma is rechanneling rage, by helping individuals become aware of it, take charge of it, and redirect it without eliminating this powerful and critically important emotion (Hardy, 2015). Discussed above are just a few frameworks that may be helpful in understanding and working with clients managing race-related stress and associated symptoms. However, many more may be applicable and the clinical community can benefit from continued research in this extremely important area of clinical practice.

CONCLUSION

It has been said that, “The study of psychological trauma has an “underground” history. Like traumatized people, we have been cut off from the knowledge of our past. Like traumatized people, we need to understand the past in order to reclaim
the present and future. Therefore, an understanding of psychological trauma begins with rediscovering history.” (Herman, 1992, p. 2).

The aforementioned discussion of race-related stress calls us as a clinical community to do just this. As providers of healing services, we must be willing to deeply explore our own personal, cultural, and generational histories. We must be open to stretching our bounds of vulnerability and self-reflection as clinicians and be open to challenging our conceptual understandings of traumatic stress and trauma-informed services. Working with race-related stress in the therapeutic space and beyond calls us to rethink our ways of asking about adversity and intervening with suffering individuals. It demands that we look beyond the walls of our treatment facilities, offices, institutions, or research centers and recognize that racial injustice pervades across individuals, organizations, societies, and the globe and demands our attention and intervention. Most importantly, as stewards of hope, healing, and transformation we must recognize our role in providing our clients with safe, culturally attuned, and supportive spaces inside of the therapy office and in the larger systems of our society so that they may “complete the process of moving in, through, and out of “immobility” or “freezing” (Levine, 1997, p. 20)” and find true healing.

REFERENCES


School Support Advocacy for Students with Disabilities: A Medical-Legal Partnership in a Developmental Clinic

By Caroline Turner, LMSW, Meredith Brinster, PhD, Sheri Ravenscroft, MD, Lucille D Wood, JD, Jake Herrel, Jeff Shahidullah, PhD

Medical-legal partnerships (MLPs) integrate the expertise of lawyers within healthcare delivery systems to support families in accessing services made difficult by civil legal barriers or community health disparities (Cohen et al., 2010). Given the numerous social determinants that affect child health and wellness, such as living in poverty, having inadequate access to habitable housing, health insurance, and nutrition (Marmot & Wilkinson, 2005), MLPs can serve to ameliorate some of those issues. Promoting access to needed and equitable legal services also allows for advocacy within the educational system for students with disabilities.

Advocacy and partnership may promote awareness of basic legal and educational rights for children with a range of disabilities from medical conditions to emotional-behavioral disorders, learning disabilities or multiple co-occurring disabilities (Burke, 2013). If barriers to needed and equitable services are apparent, families can receive free advice, advocacy, and supportive representation quickly when an MLP is established. MLPs often prioritize the needs of low-income and other vulnerable populations where structural inequities have perpetuated medical, developmental, and educational disparities (Regenstein, Trott, Williamson, & Theiss, 2018).

With regard to educational disparities, all families of children with disabilities should have equitable access to school support services as federal and state laws provide certain services free of charge to preschool and school-age children (Yell & Bateman 2017). This process begins with a multidisciplinary evaluation within 90 days of referral. Eligible children can qualify for an Individualized Education Program (IEP) through Special Education or support through a 504 Plan. These services fall within the framework of the Least Restrictive Environment (LRE) and mandate that all children with disabilities are entitled to a Free and Appropriate Public Education (FAPE) (Lipkin & Okamoto, 2015). Eligibility categories for school support services include specific learning disability (e.g., dyslexia), autism spectrum disorder, other health impairment (e.g., ADHD), emotional disturbance (e.g., anxiety, depression), speech or language impairment, visual impairment (including blindness), deafness, hearing impairment, deaf-blindness, orthopedic impairment, intellectual disability, traumatic brain injury, and multiple disabilities (Yell, Katsiyannis, & Bradley, 2011).

When working with an MLP, families can gain access to a wide array of support for their educational rights they may not have been aware of before.

When working with an MLP, families can gain access to a wide array of support for their educational rights they may not have been aware of before (Cohen et al., 2010). MLPs can provide basic support like education on the law to more one-on-one advocacy such as attending IEP meetings with the family. If necessary, an MLP can even assist a family in mediation if they feel the school district refuses to support their child with free and appropriate education (Ryan, Kutob, Suther, Hansen, & Sandel, 2012). This support allows for a wraparound service approach encouraging many multidisciplinary professionals to be in agreement on the services the child is receiving in multiple locations (Eber, Hyde, & Suter, 2011).

DELL CHILDREN’S/UNIVERSITY OF TEXAS SCHOOL OF LAW PARTNERSHIP

The Developmental Behavioral Pediatrics clinic of Dell Children’s Medical Group is an interdisciplinary clinic that provides medical, developmental, educational, and behavioral care to children and families to greater Austin and surrounding areas. A majority of the children meet criteria for medical diagnoses (e.g., autism spectrum disorder, attention-deficit/hyperactivity disorder, global developmental delay). Patients and families experience unique challenges related to educational achievement, including qualifying for educational eligibility as a student with a disability, accessing appropriate academic supports and interventions, as well as navigating state-mandated testing. Moreover, the jargon and abbreviated terminology often used by medical and educational professionals alike can burden parents to learn a new “language” in order to advocate for their child. Not surprisingly, caregivers of children with disabilities, particularly those who are non-English speaking, experience stress and report feeling marginalized in navigating across systems.

The INCLUDE Project at Texas Law, housed within The Richard and Ginni Mithoff Pro Bono Program, hosts ongoing disability-related pro bono projects, allowing law students to hone their legal skills while providing needed services to the community. In order to support students with disabilities in education, INCLUDE offers two targeted pro bono projects: SPEAK (Supporting Parents’ Education, Advocacy and Knowledge) and the Special Education Advocacy Project. SPEAK takes the form of law-student-led workshops, which are held throughout Austin with the goal of educating parents on the special education system and empowering them to advocate within it. These SPEAK workshops are especially useful for the
parents of recently diagnosed or previously undiagnosed children, who are unfamiliar with the landscape of the special education system.

INCLUDE’s Special Education Advocacy Project steps in when parents of a student with disabilities need individualized legal assistance to improve special education services or accommodations. The Advocacy Project assigns a team of law students, under the guidance and supervision of a licensed attorney, to serve as counsel for the family and represent them in interactions with the school district. Most often, advocacy teams represent the family at IEP meetings or informal hearings within the school, but the representation can also involve mediation or due process hearings. Both of these pro bono programs seek to support families and students in navigating the complexities of the special education system while educating law students on how best to advocate for students being denied access to a free and appropriate public education.

EARLY LESSONS LEARNED AND FUTURE DIRECTIONS

One of the most common barriers some families seem to face is simply a lack of understanding around what school services and supports they can ask for and what is appropriate. Working with an MLP, families can receive not only a diagnosis, but at the same time, they can also learn what services could be available through their school district. Early knowledge of this would allow for more expedient intervention in the school and better outcomes for students with disabilities overall.

As more families are connected to our growing MLP, we hope to streamline access to wraparound services in a way that is equitable across diverse backgrounds and needs. As such, there is a need for more systematic tracking of families after referral, including data collection regarding outcomes, as well as soliciting feedback on ways to improve the service in the future. Moving forward, burgeoning needs include addressing the unique challenges inherent to families receiving school-based services in light of widespread COVID-19 related school closures. MLP may prove an integral resource as educators, families, and medical providers attempt to partner in navigating uncertain times.

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Barbara Abrams
Laurence Abrams
Robert Adelman
Benjamin Albritton
Kay Allensworth
Carinne Alvarez-Sanders
Judith Andrews
Paul Andrews
Kelly Amann
Kim Arredondo
Kyle Babick
Laurie Baldwin
Lisa Balick
Shalini Batra
Matthew Baysden
Connie Benfield
Linda Boone
James Bray
Josh Briley
Gail Brothers
Robin Burks
Sam Buser
Aleha Cantu
Michael Carey
Mark Cartwright
Cynthia Cavazos-Gonzalez
Kasey Claborn
Frankie Clark
Steven Coats
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KAHLER V. KANSAS

In 2009, after he and his wife separated, James Kahler broke into the house of his wife’s grandmother through the back door and killed his wife, her grandmother, and the couple’s two daughters. During the trial, his attorney raised the question of sanity, introducing expert testimony that Kahler was experiencing symptoms of mental disease or defect that interfered with his ability to control his compulsions to kill his family (Kahler v. Kansas, 2020).

Due to changes in Kansas’ insanity defense statute in 1996, the jury was instructed to consider strictly whether Kahler had the intention (or mens rea) to kill on that day. During the trial, the defendant’s attorney asserted that Kansas’ changes to the insanity statute (Kan. Stat. Ann. § 21-5209, 2011) were unconstitutional, as the jury was not permitted to consider whether, due to mental disease or defect, Kahler was unable to know right from wrong at the time of the offense. The motion was denied and Kahler was convicted of the charges and sentenced to death. Kahler appealed to the Supreme Court of Kansas and the lower court’s ruling was upheld. The higher court stated, “The affirmative insanity defense is a creature of the 19th century and is not so ingrained in our legal system to constitute a fundamental principle of law,” (Kahler v. Kansas, pg. 6).

Kahler then appealed to the Supreme Court of the United States. He asserted that Kansas’ version of the insanity defense violates his constitutional rights under the Eighth (cruel and unusual punishment) and Fourteenth (due process) amendments, because he was incapable of knowing right from wrong at the time of the offenses but was barred from presenting this evidence during trial (Kahler v. Kansas, 2020). Kahler argued that Kansas effectively abolished the insanity defense (Kahler v. Kansas, 2020).

Instead, the defendant must prove that, due to mental disease or defect, they did not have the adequate capacity to formulate the intention to commit the act; “evidence of a mentally ill defendant’s moral incapacity – or indeed, of anything except his cognitive inability to form the needed mens rea – can play no role in determining guilt” (Kansas v. Kahler, 2020, pg. 4). Once a defendant has been convicted, the defense is then permitted to present “wide latitude to raise his mental illness as a reason to judge him not fully culpable and so to lessen his punishment” (Kansas v. Kahler, 2020, pg. 4).

Further, the majority opinion argued that it is inappropriate to impose a constitutional doctrine for insanity defense standards, and that due to the complexity and evolving science related to mental health, states should be permitted to decide such standards. More specifically, the majority opinion concluded that, although insanity pleas are considered a fundamental principle of law, the M’Naghten test (i.e., nature and quality, and wrongfulness) is not so ingrained in law as to be considered fundamental. Thus, Kansas’ lack of adherence to the M’Naghten test as means of evaluating insanity does not pose a constitutional violation.

*Acknowledgement: We would like to thank Dr. Mary Alice Conroy, ABPP (forensic), for her insightful remarks and analysis of our article during the drafting process.
The dissenting opinion agreed with Kahler that Kansas indeed abolished the insanity defense. They argued that although states should have the right to create their own doctrines for the test of insanity, they should include the essential portions of the M’Naghten test. They reasoned that the M’Naghten test is, in fact, an engrained standard in the American legal system, representing a minimum standard that states should have the ability to expand upon but not to contract in scope (Kahler v. Kansas, 2020). By considering only a “narrow modern notion of mens rea” (Kahler v. Kansas, 2020, pg. 12), Kansas was contracting the scope of M’Naghten. Since the Court opinion, case law analyses have detailed the understanding that prior to the advent of the Model Penal Code in the 1960s, the term “mens rea” referred to an “evil meaning mind,” which reflects that the mind knows it is doing evil, rather than that the mind simply knows what it is doing (Dressler, 2020; Meyer, 2020).

Additionally, the dissenting argument stated, “But our tradition demands that an insane defendant should not be found guilty in the first place. Moreover, the relief that Kansas offers, in the form of sentencing discretion and the possibility of commitment in lieu of incarceration, is a matter of judicial discretion, not of right,” (Kahler v. Kansas, 2020, pg.23). Legal scholars have since questioned whether states might be within constitutional boundaries to effectively eliminate the mens rea prong, as here the majority of the Court makes “significant” note that because evidence is permitted during the sentencing phase, Kansas has not abolished the insanity defense. Said another way, how soon might it be before a given state bars any presentation of mental illness evidence during the trial phase, and only permit such evidence post-conviction at the sentencing phase, as the Court established such alternatives as constitutional (Dressler, 2020; Kirkpatrick, 2020)?

The U.S. Supreme Court’s ruling sets a new precedent for mental health law in the context of insanity defenses and represents new standards for the intersection of psychology and law. First, although upholding the lower court’s ruling, the majority opinion stated that insanity defenses are indeed ingrained in the American legal system and, as such, represent a fundamental right and should be considered so constitutionally. Second, this decision affirmed that there is no single constitutional doctrine for insanity standards. Third, it is not a violation of constitutional rights if state standards for insanity contract the scope of the M’Naghten test. Fourth, it is not a violation of constitutional rights to delay until post-conviction the presentation of evidence related to lack of appreciation of wrongfulness due to mental disease or defect.

**TEXAS AND INSANITY**

In Texas, a defendant is considered insane at the time of the offense if, as a result of mental disease or defect, the defendant did not know that his conduct was wrong (Tex. Penal Code § 8.01(a) (1994)). Although legal and mental health scholars debate the interpretation of Bigby v. State (1994), the court ruled on the meaning of wrongfulness, stating that focusing on the defendant’s “morality” is “misplaced,” and going on to state, “By accepting and acknowledging his action was ‘illegal’ by societal standards, he understood that others believed his conduct was ‘wrong,’” (Bigby v. State, 1994, pg.10). This was further affirmed in McAfee v. Texas (2015): “If the accused knows that his conduct is ‘illegal’ by societal standards, then he understands that his conduct is wrong, even if, due to a mental disease or defect, he thinks his conduct is morally justified,” (pg. 10). Texas case law was relied upon as evidence to support the argument that Kansas’ standard of mens rea for insanity threshold does not violate constitutional rights. Specifically, Texas’ standards were cited by the U.S. Supreme Court as “exclude[ing] from the ranks of the insane those who knew an act was criminal but still thought it right,” (Kahler v. Kansas, 2020, pg. 21).

The use of Texas’ case law to support as the standard of insanity a sole requirement of mens rea, disregarding a defendant’s understanding of right and wrong, calls into question whether Texas case law or criminal procedure may more directly follow suit. That is, as the Kahler v. Kansas (2020) opinion was supported by Texas case law, might Texas use the Kahler v. Kansas (2020) case as evidence to support changes to its own insanity standard, codifying the strict use of mens rea rather than wrongfulness?

As stated in the amicus curiae brief submitted by the American Psychiatric and American Psychological Associations in support of Kahler, the use of mens rea as the insanity standard is inherently flawed. It is the official stance of the American Psychological Association that due process rights are infringed upon by blocking mentally ill defendants from presenting a “traditional insanity defense” (American Psychological Association, 2020). Mental illness rarely impairs one’s ability to intend an action (Kahler v. Kansas, 2020); rather, mental illness is more likely to motivate the intention to act, however irrational, such as when experiencing command auditory hallucinations (Peterson et al., 2014). As one legal scholar noted, “In the majority of cases where the insanity defense is asserted, the defendant is aware of and intends his conduct” (Kirkpatrick, 2020).

**AS STUDENTS**

As students in Sam Houston State University’s doctoral program in clinical psychology, with its known emphasis in forensic assessment, we were intrigued by this petition to the Supreme Court. Faculty board certified in forensic psychology have instilled in us the foundational importance of mental health case law in guiding our clinical work and opinions. This has been further engrained by attendance at presentations by well-known professionals in the field of forensic psychology. We had an opportunity to watch the abstract concept of case law unfold in front of us in real-time, and with a case that was bound to have a ripple effect on the forensic psychology community. For almost a year, we kept a pulse on the issue, enthusiastically reading new analyses of potential arguments as they emerged.

By the time the Court heard arguments for the petitioner and respondent in October 2019, we were deeply invested in learning what inquiries the Justices might have regarding the case. Much to our dismay, the questions asked by the Justices highlighted a fundamental misunderstanding of the process of criminal responsibility.
evaluations. For example, an inquiry was made by Justice Gorsuch regarding whether one could enter an insanity defense for any felony charge or just some of them (An insanity defense may be raised for any charge, misdemeanor or felony; Howe, 2019). Meanwhile, Justice Alito made statements suggesting a lack of understanding of the rate bases of insanity pleas, stating, “It has been calculated that one in five people in the United States has some mental disorder,” and thus believing the Kahler case would subsequently lead to a rise in attempted insanity defenses (Howe, 2019). With new apprehension, we continued to monitor the SCOTUS blog for any developments in the case. When the opinion was handed down in March 2020, we were left curious and dissatisfied, even after reading the full text of both the majority opinion and the dissent.

Since March, we have scoured journals and online resources for case law reviews on the final opinion. Of note, the Kahler case has likely been overshadowed by the current state of the country in response to the COVID-19 pandemic. Additionally, the lack of attention to the decision may be due to it having affirmed the lower court’s ruling, as cases that overrule tend to signal a more important Supreme Court decision (Fowler & Jon, 2008). Even so, we might expect a number of case law reviews following a Supreme Court decision. However, only four reviews surfaced, each of which are critical of the majority opinion and in agreement with the dissenting opinion. In one such review, Kirkpatrick (2020) pointed out, “the Court set forth an optimistic vision of state legislatures as policy making laboratories, carefully considering the difficult choices involved in formulating the insanity standard...In reality, attempts to narrow or repeal the insanity defense are more commonly the result of ‘get tough on crime’ initiatives rather than deliberative and reasoned legislative debate” (pg. 3). In fact, Kansas’ repeal of its former M’Naghten-styled insanity statute was in response to mounting public outcry after the NGRI finding in the John Hinkley, Jr. case (Larkin & Canaparo, 2020).

Texas is known as a “tough on crime” state, ranking first in the nation for total incarceration and second for incarceration per capita (Gershowitz, 2012). Further, a new legislative session begins January 2021 and, in light of the Kahler decision, could bring with it attempts to narrow the current scope of Texas’ insanity defense statute. The student authors have historically been involved in state-level legislation, for example advocating for data-driven mental health regulations on Legislative Day on behalf of the Texas Psychological Association, as well as active engagement with the Sam Houston Area Psychological Association. Partaking in such professional service as student clinicians is formative, as it provides us insights into the decision-making process of the bodies that regulate our profession. With regard to the insanity defense, it feels necessary for psychological professionals to advocate for the most up-to-date and practical conceptualizations of the intersection of mental and behavioral health and the law, and the student authors enthusiastically share the stance of the APA in this matter. As such, the Kahler case has generated much interest and even more questions and uncertainties for us regarding the implementation of such statutes.

On the other hand, a balance between legislative policy action and clinical work must be struck. As students, we grow concerned about the potential that our advocating might be held against us while fulfilling our duties as expert witnesses in future sanity cases. As such, we will continue to comb through the literature for scholarly analyses of the Kahler opinion in an effort to arm ourselves with knowledge in the event that we engage in a discussion on relevant sanity policies from a forensic clinician’s perspective. And for now, with regard to the level of advocacy within caselaw implementation, we will ponder a question posed by Gowensmith (2019): in our profession, have we “emphasized ‘good’ work, but not ‘just’ work”?

REFERENCES


Texas Penal Code § 8.01(a) (1994).
A Texas Take on Socratic Questioning

By Scott Waltman, PsyD, ABPP
Private Practice, San Antonio, TX

When I first moved to Texas from Philadelphia, I was in major culture shock. People were so much more friendly and life moved at a more leisurely pace. I remember the first time I saw traffic come to a complete stop to let someone make a left turn. Texas really is a place like no other. Similarly, Texans are unique, and often require a different approach than might be used in other regions. For example, Albert Ellis, the originator or Rational Emotive Therapy, was famously confrontational. In my experience this type of approach tends to make Texans dig the heels of their boots into the ground. We are the Alamo state. Alternatively, Texans respond well to collaborative approaches such as the use of Socratic Questioning.

Consider the following examples. Paul is a middle-aged professional who has been dealing with depression for years. When he gets more depressed, he tends to have low energy and to spend most of his free time in bed. As his therapist, you could simply tell Paul to get out of bed and to get moving. You could tell him that he’ll feel better if he spends less time in bed. What happens when you try that is Paul looks at you like you have no idea what depression is and explains he is too tired to do anything. The more Socratic approach would be to collaboratively evaluate the assumptions that underlie his behavior. In this case, Paul had an idea that he was tired and needed to rest. So, we looked at how long he had been tired and how much time he spent resting and found that resting in bed didn’t make him less tired. This made for an easier transition into behavioral activation and building momentum.

Another example was Maria who had a fear of public speaking and had been promoted at work to a position that required periodically giving presentations. As her therapist, you could offer reassurances and tell her that she will probably do fine and not to worry about it, but she definitely won’t believe you. The more Socratic approach would be to test her fear out. In this case, Maria had a fear that she would look very anxious and everyone would notice. So, we dug out old footage of her giving presentations and watched it together. What she found was that she actually did okay. This helped her see that her fear was disproportionate to the situation and she really believed it because through our collaborative discovery, she was able to come to this new conclusion on her own.

Anyone who has been doing therapy for a while can tell you that if you simply give your client the answer, you’ll be giving them the same answer week after week after week, because it won’t really sink in.

In the cognitive and behavioral therapies, guided discovery and collaborative empiricism are parallel terms that describes the process of using collaborative strategies to join with the client in applying scientific curiosity to their thought and behavior patterns (Tee & Kazantzis, 2011). Socratic questioning (also called Socratic dialogue) is a way to engage in a collaborative empiricism with your clients. The use of Socratic processes is thought to lead to a deeper level of learning and change (see Beck, 2011). Though, previous research on Socratic Questioning has been limited by the lack of treatment integrity measures specific to this strategy (see Padesky, 2019). One study has demonstrated that the use of Socratic questioning in the treatment of depression is predictive of decreases in depressive symptoms; further, this relationship holds even after controlling for the relationship (Braun, Strunk, Sasso, & Cooper, 2015). Certainly, further research is warranted, and measures have been developed to aid in that research (see Waltman, Cod, McFarr, & Moore, 2020).

COMMON PITFALLS AND STUCK POINTS IN LEARNING SOCRATIC QUESTIONING

While Socratic Questioning is a transtheoretical psychotherapeutic process, there is some evidence that learning to artfully and competently use Socratic strategies in session is among the hardest skills for a psychotherapist to learn (Waltman, Hall, McFarr, Beck, & Creed, 2017). A common pitfall to Socratic questioning is something called provided discovery (as opposed to guided discovery), this is where a therapist tries to tell the client the conclusions they should be reaching. Many thought records and attempts at cognitive restructuring focus on trying to show the client why their thinking is distorted (see Waltman, Frankel, Hall, Williston, Jager-Hyman, 2019)—this can be counter collaboration.

Additionally, many therapists fall into the trap of trying to convince the client to see things from their point of view or to guide them to what they think is the right answer. This often results in non-collaborative encounters with therapists telling clients how things “really are.” Anyone who has been doing therapy for a while can tell you that if you simply give your client the answer, you’ll be giving them the same answer week after week after week, because it won’t really sink in.

A FRAMEWORK FOR SOCRATIC QUESTIONING

It can be helpful for clinicians to have a framework for thinking about collaborative empiricism and Socratic strategies. In conjunction with the largest public mental health CBT training initiative in the United States, we have refined our method for teaching Socratic questioning to therapists (see Waltman et al., 2020). This framework is a reversal of these mentioned pitfalls, instead of trying to get the client to see it from our perspective, we instead focus on trying to see it from their perspective and then focus on expanding that perspective together.
STEP 1: FOCUSING
The first step in applying Socratic strategies is to identify the targets for these strategies. In a practical sense, we simply do not have time to address every thought that we think might be distorted. We want to target the thoughts that are central to their problems and related to their core difficulties and underlying beliefs. Often some delving and sifting is required to find the optimal cognition to focus on. This skill requires patience and conceptual skills on the part of the therapist.

STEP 2: PHENOMENOLOGICAL UNDERSTANDING
Phenomenology refers to understanding something in both subjective and objective terms. The task of this step is to understand the client and the target cognition. The guiding principle is that people come by their beliefs honestly and we want to come to understand how it makes complete sense that they came to think that way. This early emphasis on validation is also strategic in that it is relationship enhancing and can be regulating for the client. Many Texans are also deeply religious. A purely rational approach can be invalidating for these people. In our experience, people are more willing to have an open mind to alternatives when they feel like you have truly and sincerely listened to them.

STEP 3: COLLABORATIVE CURIOSITY
While this is functionally the disconfirming evidence step, curiosity is key to this process. Now that we see it from their point of view, we can work to expand that view together. We ask ourselves: “What are they missing?” Functionally, there are two kinds of blind spots: things you don’t see and things you don’t know. We need to figure out what are they not attending to due to attentional filters as well as the gaps in their experiences that developed because of their avoidance patterns. Many great questions and lines of inquiry can often be found from evaluating elements from the previous steps. People tend to twist information to fit into their pre-existing assumptions and beliefs. So, we want to help them mentally take a step back and look at both context and the big picture.

STEP 4: SUMMARY AND SYNTHESIS
There can also be a pull for the therapist to try and pick a purely positive thought because they might feel better. The trouble with purely positive thoughts or thoughts that are only based on the disconfirming evidence is that they can be brittle if they do not fit the reality of the client’s life. Therefore, we are looking to develop new thoughts that are balanced and adaptive. This process involves summarizing both sides of the story, and helping the client develop a new more balanced thought that captures both sides. The question we want to ask is whether the new thought is believable. Once we have a summary statement, we want to help them synthesize that with their previous statements and assumptions. How does the new conclusion compare to the initial assumption? And their underlying beliefs? How do they reconcile their previous assumptions and this new evidence? We also want to help solidify these gains by helping the client translate the cognitive shift into behavior change. So, we ask them how they want to put the new thought into practice in the coming week or how they want to test it out in the coming week.

SUMMARY
Meaningful cognitive change is often a process that takes time and effort. There are no shortcuts or “silver bullet” questions a therapist can ask to disprove any and every belief that might come up in therapy. Instead focusing on taking it slow, being curious and trying to really understand your client will get you pretty far as a therapist. Change is often incremental.

REFERENCES

Election Update

Kevin Stewart
TPA Government Relations

The election results are finally in. This was an extremely unusual election year, and there was certainly no shortage of surprises. While the Governor and the Lieutenant Governor were not on the ballot this time around, many expected Democrats to make some serious gains in the House and Senate—some even considered Texas a battleground state. While the Democrats did pick up a key Senate seat, the House was a different story.

TEXAS SENATE
Taking over the Texas Senate was never really in play for the Democrats, but there was a very important election in that chamber. In order to bring a bill to the floor of the Senate, there needs to be a three-fifths supermajority of Senators voting in favor of doing so. Last session, Republicans had the exact number of senators that they needed to meet that threshold. In this round of elections, though, Republican Senator Pete Flores lost his seat. This could have a significant impact on how the Senate operates. Essentially, Republicans will have to either work across the aisle or change the rules to get around the three-fifths threshold requirement. That will certainly be a big part of the discussions next session, and it’s worth keeping an eye on.

TEXAS HOUSE
Unlike the Senate, Democrats were extremely hopeful that they could take over the majority in the House. Polling showed that Democrats had a real shot at flipping the nine seats they needed. However, as was the case in other states, polling did not paint a full picture of how Texans would ultimately vote. Democrats managed to flip one House seat, replacing Sarah Davis with challenger Ann Johnson. However, Republicans also flipped a seat, as Mike Schofield took his seat back from Representative Gina Calanni. In other words, the election was a wash in the Texas House.

SPEAKER OF THE HOUSE
The other major news that came as a result of this election is that Representative Dade Phelan announced he has the necessary votes he needs to become the next Speaker of the House. The formal vote cannot take place until the legislature convenes in January, so nothing is set in stone, but at this point it seems very likely that he will be taking over for Speaker Bonnen in January. We will certainly keep everyone in the loop as we know more—so stay tuned!

TPA DIVERSITY STATEMENT

The Texas Psychological Association (TPA) firmly upholds values that support its diverse members and the clients served by the TPA membership. TPA will establish and sustain policies that promote understanding of the intersectionality of social, political, economic, and environmental practices and race, ethnicity, gender identity and expression, sexual orientation, disability, and religion. All members are encouraged to strive for competence in understanding how these factors affect our communities.

It is the mission of TPA to promote knowledge, awareness, and competence not only within its organization but also throughout the state of Texas. TPA will establish initiatives that will increase the cultural sensitivity and competence of both its leaders and members, build and sustain relationships with other professional organizations, and encourage diversity within TPA’s membership and leadership.

It is TPA’s goal to promote and apply the knowledge of psychology to issues related to diversity including race, ethnicity, gender identity and expression, sexual orientation, disability, and religion. TPA’s specific objectives include: 1) encouraging culturally sensitive research on traditionally marginalized groups and culturally sensitive and responsive treatment; 2) promoting standards of practice that are culturally and linguistically affirming; 3) promoting legislative initiatives that further the training, research, and practice of psychology with marginalized groups and advance culturally competent care; 4) providing a forum for communication and consultation among psychologists in the state of Texas who are committed to developing culturally and linguistically appropriate skills and practices; and 5) promoting the highest standards of ethical and culturally competent practice among practitioners, consistent with those espoused by the American Psychological Association (APA) including but not limited to the Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality (2017) and Organizational Change for Psychologists of the APA.
Case Management Referrals

When your clients with special needs have Medicaid, refer them to case management for help finding services.

Our case managers are licensed social workers or RNs. They understand your clients' complex needs and can help access medical, behavioral health, educational and other services.

Children enrolled in Medicaid (Traditional Fee-for-Service and STAR) may be eligible. Clients enrolled in STAR Kids and STAR Health should first be referred to their health plan.

To refer your client, call Texas Health Steps at 1-877-THSteps (1-877-847-8377) or visit https://hhs.texas.gov/case-management-provider.