Audio Transcript for Episode 605: "Therapy Deserts: What Are They? Where Are They? What Needs to Change?"

Please note: This transcript has been lightly edited to remove filler words or sounds.

JOANN DAVIS
If the only therapy center within a 60-mile radius has three white women as their counselor, your men of color are not going to relate to any of those experiences. Your non-English speaking individuals are probably not going to connect very well with therapists who don't speak the same language as them.

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CHAD MOSES
You're listening to the "To Write Love on Her Arms" podcast, a show about mental health and the things that make us human. I'm your host Chad Moses, and in each episode, we'll be talking about the things that can often feel hard to talk about, like depression, addiction, self-injury, and suicide. We'll be sharing stories and exploring big themes like hope, healing, and recovery. If any of the topics we discuss, or the stories we share, feel too heavy for you, know that it's OK to pause, to restart, or to stop altogether. As we discover new stories, we hope to remind you that your story is important.

[music playing]

CHAD
The term therapy deserts is relatively new. Or at least, many people are learning about it for the first time. Because while talking about and even going to therapy has become way less stigmatized over the course of the last three years, there are still places without the resources, necessary infrastructure (like internet access and public transportation), and even the language to be able to access it. Therapy costs money, often a lot of money, but how can you address the financial barrier when there isn't even a counselor within a 60-mile radius of where you live? And to put this number into perspective: There are currently 570 counties in the US without psychologists, psychiatrists, or counselors. That's 17% of counties in the country.

To assist us in answering some questions about therapy deserts like: What are they? Where are they? And what can we do to address them? We're joined by two wonderful folks that are bringing professional and personal experience to the mic.

Our first guest is JoAnn or "Jodi" Davis, who is an MS, LPC, and NCC that currently works at a comprehensive homelessness program in Texas. She holds a Bachelor of Science in Biomedical Sciences from Texas A&M University and a Master of Science in Counseling from the University of North Texas. When not providing therapy or doing advocacy work, Jodi often volunteers at local therapeutic horsemanship programs. Jodi's favorite hobbies include drinking way too much coffee, cruising down backroads, and taking selfies with various dogs and farm animals.

And our second guest is no stranger to this podcast. Bianca Mujica is TWLOHA's Community Care Coordinator, which means her work focuses on finding inclusive and creative ways to connect with supporters online. She is a Mexican-American queer woman from Texas with a background in journalism and a love for language. Outside of work, she can be found eating lots of pasta, cuddling with her dog, and creating colorful pieces of art.

This is an exceptionally important, insightful, and informative conversation and we are so grateful that you've chosen to tune in. So without further ado, I'm your host Chad Moses, let's get started.

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CHAD
We're talking, you know, from two different perspectives about the same theme about the same frustration that so many people have, namely, being therapy deserts. It's a common theme of conversation within the world of mental health to discuss cost as being the biggest barrier. But the reality is, there can be more than just one big barrier as it relates to getting the care you desert. So this conversation is really revolving around not so much when cost is the biggest factor in the equation, but rather, if there's a lack of options for care in your area, that being a therapy desert, Bianca, I think you were actually one of the first people in my life to introduce me to this concept of therapy. So back when I started working for the organization, 15 years ago, that was a conversation piece on my radar. That doesn't mean that it's a new problem, but it's high time that we talk about it. So I guess, from your personal experience, me coming from a very suburban lifestyle, always knowing you know how to get a hold of my neighbors there, we share yards and streets and whatnot, I live in a very cosmopolitan area for the most part. What was your experience? And how people would discuss their more desolate area in terms of care?

BIANCA
So the short answer is that they wouldn't. Therapy was not something that I knew existed for most of my life. Maybe one of the earliest memories I have is watching VeggieTales, with Larry, the cucumber sitting on a chair, talking about something random, and it's a very, like, Freudian image where they're showing like the paintings and what is he looking at. But anytime I saw therapy, it was always that very stereotypical narrow-minded view. And even then it wasn't referred to as therapy, there was no conversations about mental health, and why people may go to therapy. It was just like, oh, this is what people do when they have a thing to talk about. I think part of that is also due to the culture that I grew up in, having grown up on the border, literally, like five minutes from Mexico, there were a lot of people that were undocumented. And so because of that, and also because it is a fairly distant area, or distant relative to other bigger cities, there was not a whole lot of money or representation going into the towns in the general region. So there just wasn't a lot of investment in the community. And mental health isn't really the first thing people invest in anyway. So when you compound that on these demographics, like immigrants, people of color, low income people, they're even lower on the list of priority. So there was, there was really no talk about it. And I didn't go to therapy for the first time until high school. And even then I was against it because of the stigma I had in my head about it. I remember, I was struggling with an eating disorder at the time, and my mom was like, you need to go to therapy. And I was so resistant to it, because, and I remember saying, I don't want some stranger to tell me. I'm crazy. And that's how I felt about it at the time. And eventually, I realized, oh, this is a thing that is actually good. For me, this is helpful. But for a long, long time, it was very stigmatized. And even though I went to that therapist for like two or three years, I never told anybody about it. I never told my friends, my other family other than my parents who knew, I didn't even explain to my grandpa who would drop me off and pick me up, because I just didn't think he would get it.

CHAD
And where geographically were these conversations about your first introduction, your high school introduction to counseling? Were you still living in a more rural community?

BIANCA

So I, born, raised, spent my whole life in McAllen, I spent my whole life up until I left for college at 18, in this town, in this region of towns, on the southernmost border of Texas, anybody who works with me knows that I have a tattoo with a, with a Texas on it. So I'm usually pointing to where I grew up, where I moved, while but I spent my whole life there pretty much and because of how limited it felt at times, because of how just underserved it felt I really wanted to leave, I wanted to go to a place where in my head, things happened, there was diversity, there were new people. But I, what I didn't realize at the time was that wasn't exactly by design, it's because the people here, for the most part, don't have the resources to go anywhere else. They don't have the ability to leave, or there's just not a lot of funding to help it grow in the way that a lot of people need.

CHAD
Jodi, coming from the care provider point of view, when I say therapy desert, what words or pictures or phrases or just diatribes really come to the surface?

JODI
So kind of similar to that, I also grew up in a very small town area in South Texas. Very close to Uvalde. I interchange the cities Hondo and Castroville. They're like a rock skip away on highway 90 from each other. So rural that like I joke, and it's not really a joke, it's accurate, that we in high school, we knew it was time to graduate when you couldn't see the highway because the cornfields were too high. Like that's how rural my high school was. Children of the Corn had a whole different meaning. And so there weren't a lot of mental health providers, in general, growing up. I think Castroville's population is like 3000, Hondo's is like 8000. And they're like, they're real small. And so therapy just kind of didn't exist until I went to school. And when I went to A&M's campus was kind of the first time that I really got involved in oh, this is what therapy is. And so as a provider growing up with that, looking back, it just makes me realize how much our youth here in Texas, a lot of times don't even have access to therapy. Number one in these therapy deserts, where there just aren't providers. A lot of times people don't even know therapy exists. And when they do it sees TV representations of therapy. And most mental health professionals I know, they'll watch a TV show with a therapist and be like that's not right. That's not right. That's really not right. Like I think media has done such a poor job of explaining what therapy is to people where if you don't have a therapist in your town, and that's all you see, you're not going to want to go to therapy. It's like, oh, my therapist is a terrible person. Or it's, I have to be crazy to go to therapy, something has to be wrong with me. And so not only do they not have providers, it's when you get access to them. So look at the rise of teletherapy, assuming you have the internet capacity, which I'm sure we'll get into later, are you even going to find someone that you connect to or want to go see without that stigma associated with it?

CHAD
I love, yeah, the idea that you kind of wind up with two options if you aren't in an area where therapy is normalized. Either, I don't want the thing that I know that I see in media or I don't want the baggage that comes along with what this would look like, you know. In the words of Bianca, I don't want to talk to a cucumber. So getting into the, the numbers getting into the details of what a therapy desert is, there are currently 570 counties in the United States, without any psychologists, any psychiatrists, or any counselors, that's actually 17% of counties in the country. And we all know that not every county is built the same way. We know that as you were moved further west, that these counties cover a larger landmass. So the lack of professional care limits people in these counties are seeking solely digital forms of mental health care. And with that option, there's often a need for a reliable internet connection, which we know can be very costly. And sometimes it's not even possible, and we're referring to specifically rural places. So let's start with Jodi on this, how are these people in places that don't have access to reliable internet, and who is doing the letting down of these people?

JODI

I kind of have a unique perspective on this. So obviously, I grew up in a very rural part of Texas, and then, you know, you kind of joke there, like AOL dial up with like, the fastest form of internet for the longest time, and you would just sit there and I'm like, wow, I really hope this doesn't take the 36 hours to download this mp3 song that it's saying on my computer. Versus in Dallas, like, I could stream an entire movie without it ever buffering. And it's just like, whoa. And so looking at those type of internet capabilities, like if you're trying to do a virtual therapy session, in areas that don't have reliable cell phone service, you know, various providers, you know, I think I have an aunt and uncle and they have to use very specific cell phone provider, it's the only one that provides out there, and it probably drops the call, like 35% of the time anyway. So if you're trying to have a mental health conversation, it can be really detrimental both as the client or as the therapist, I don't want to open up something. And then your therapy, phone call drops, because you're in a dead zone. And now I've left you with this topic open. That's a liability both for me, and it's just also not very nice to you to do either. And then you can also look at it from the perspective of, you know, where I grew up is very close to the Uvalde school shooting that happened at Rob Elementary. And then a couple of weeks ago, the Allen outlet mall shooting is very close to where I currently live. And just watching the differences in services, you know, in Allen, you can walk down the street and probably have access to some sort of therapy center versus Uvalde, one of the kiddos out there is doing EMDR therapy, which is a specialized form of therapy, they're driving over 60 miles each way to San Antonio, for the closest provider, they don't even offer it between those 60 miles, there's not another provider out there. And so I think that number one shows just the geographic location of our therapists, but then also to those internet capacities. Even if you could do some of these virtual therapy options. I don't want the call to drop in the middle, you don't want the call to drop in the middle. And that I think is a failure of our government in the sense that as we become a more technology savvy world, why is this not something that our cities are able to implement? Why are our counties not pushing more for reliable internet services along these ways? Because it gets bigger than therapy. So many jobs, everything's online now applying for a job getting a job doing your job, and that brings lack of resources, lack of jobs to these rural communities, and it's just going to put them farther behind it. So many ways.

CHAD

The internet does not exist for the sake of entertainment. It's supposed to be there for ease of access of information. Now, information can be entertaining. But information can also be life-saving. It can be identity affirming, it can be so many other things before you start talking about music or Netflix or, or what have you. Thank you for sharing, especially just with that young individual that found a care provider, but it's gonna take you an hour if there's no traffic to get there and back, and I'm sure you also have schoolwork to do and man then what this is talking about. Yeah, get gas money, for sure.

BIANCA

so I think, kind of going off the idea of not having gas money, that also relates to the assumption that you have a car, which, if this is a area with a lot of poverty, it may not be something that is as widely available, or maybe there's not public transportation, or if there is, it's not super reliable. Here in Dallas, we have quite a bit of public transportation, but it can take an hour to get somewhere that it would take 10 minutes to drive to. So it also depends, like, do you have the time in your schedule to lock out who knows how long for a 45-50 minute session. And then on top of that, if you're thinking about a lot of these places that are rural, that they're most likely very impoverished, underserved communities, we know that these kinds of places that have the least amount of resources put into them tend to also be susceptible to natural disasters, and then they don't get the resources to bounce back from those. And so then their internet, their telephone lines, their homes, whatever it may be, is going to be impacted by that. And so even if maybe they had a way to access that therapy, if something happens, and they're not their community isn't getting the investment that it needs to bounce back, then that might knock therapy totally out of the

question. So, and I know that in my hometown, hurricanes would happen every summer, every other summer, it was very common because we were only like an hour away from the beach. And if you're still trying to rebuild your home that flooded a year ago, then you're going to prioritize the mold in the walls over getting internet. it's either be able to live in your home or be able to access therapy that is already not seen as a priority anyway. There's also a cultural aspect of it, in terms of who's doing the letting down. I think in the border towns, where it's a very Hispanic machismo type of culture. There's this idea of not asking for help, not needing help. doing either of those things is a sign of weakness, and self medicating with alcohol, with drugs, with any sort of other coping mechanism other than talking about it. So of course, there is this responsibility on government and public officials to do the investment. But I think there's also a responsibility on the culture that's the air we breathe, to let people know like, Hey, you can talk about this. You can challenge it, it doesn't have to be this way. And we don't have to be okay with it. We don't have to continue to just not question why we don't have access to these things.

CHAD
We also know that another intersection of deserts and rural communities is that includes all BIPOC communities. We also know that Texas is the state with the highest number of counties without mental health care providers. Joanne, kicking it to you in terms of your hometown experience living near Uvalde, living right on the doorstep of the horrific mass shooting at Robb Elementary? How in your work as a counselor, have you seen this intersection at play, in regards to a lack of resources combining with BIPOC communities?

JODI
I think number one, I think representation is so important in therapy, right? You tend to and obviously, it's not gonna be in every scenario, but you tend to connect more with someone that has similar experiences with you. So me, a white cis woman walking into Uvalde that is predominantly Hispanic that isn't going to connect as well, you know, I don't speak Spanish. For a lot of those families, English may not be their first language, and who am I to come in and say, 'Oh, I need you to do therapy, from my white perspective, in English, which is not your first language and still trying to get across the whole point that you're trying to say,' no, that's not gonna be very beneficial and helpful to them. And unfortunately, a lot of times, becoming a therapist is very expensive. My student loan providers will tell you, I owe them a lot of money, they are not wrong. And a lot of the theories that we study are based on predominantly old dead white men. And so with that, a lot of the things that were taught in school, and it's changed in recent years, as this has become more prevalent, just understanding the multicultural aspect of therapy, because who would have thought of that before now, because that's a new topic. But a lot of these things that we are taught in school, first of all, are based from that very white perspective, you know, very westernized, we're not looking at somebody that their cultural values and things. And then on the flip side of that, if you're coming from an impoverished area, you are going to really struggle to become a therapist, just from the cost perspective of it. You know, if you're a first-generation student, first of all, you have to navigate an undergrad degree in the state of Texas, which, as a first-gen student is extremely hard to do, when you don't have that support behind you are just the understanding of how the system works. And then number two, in Texas, you have to have a master's degree to apply for licensure, I don't know if you know, a master's degree, they're also very expensive. And so with that these costs, keep adding up, then you pay for your license, then you pay for your licensure exam, then you pay for continuing education, however many hours per year, do you want another certification, anything you're paying for that. And so it's just very expensive, and a lot of time, not getting paid what you're worth. And especially if you're working in agency-type settings, if you're working somewhere, you know, with some of these rural communities that they can't afford a private practice out of pocket pay, I can't afford a private practice out of pocket paid $125 an hour. You know, if I didn't have health insurance, I would really struggle to see a therapist. And that's not to say we shouldn't pay our therapists. We need to eat. My loans are very expensive, you know,

I have to pay off the education that I have. But the agency type settings which I work in an agency, I don't work in private practice. Right now I work predominantly with homeless individuals. So my salary is paid by the agency. We are not the most well-funded individuals in the mental health community. Because we work for an agency, a lot of agencies are overworked, their staff burns out very quickly, because we have a very high caseload at a very low pay. I'm very fortunate that the agency that I'm at, I absolutely love them, they've done a very good job balancing my mental health, with the work that I'm expected to do. But a lot of times people working an agency are not people of color, because they cannot afford to when you're working paycheck to paycheck, you can't afford to do these types of jobs, you need to go into something that is paying you a little bit more to survive, right. And if that just further creates this disparity between people of color, being able to access multicultural counseling, and then already the therapy deserts that we exist in where some of these counties don't have providers anyway. So if the only therapy center within a 60-mile radius has three white women as their counselor, your men of color are not going to relate to any of those experiences. Your non-English speaking individuals are probably not going to connect very well with therapists who don't speak the same language as them. And so you're looking at all of these issues and you know, I work now in an area outside Dallas, where I work in Collin County, we don't have public transportation, and we're in a pretty wealthy area of Collin County, right outside Dallas and we don't have public transportation. My clients experiencing homelessness struggled to get places because there's no public transit out there. And so when I look back at where I grew up, and it's like, I didn't even know buses existed for like the longest part of my life outside of the school bus. It's like, oh, people actually ride buses places, and it's not the big yellow one to take you to the elementary school like it is. There's just so much disparity there.

CHAD
So Bianca, Kind of going back, you mentioned your early introduction, and perhaps even belated introduction to therapy. listing a number of different factors that were specific to that, but kind of touching back on that if you would like to share a little bit about the nuances and your experience as a Mexican American queer woman in McAllen, Texas, how have these varying intersections?

BIANCA
When I think about my hometown as being a therapy, desert, and mental health desert, I also think about it as being, in a way a queer desert, not because there weren't queer people there, But because it wasn't a thing that was talked about, it wasn't accepted, it wasn't okay. And the assumption was always that it didn't apply to you the same way that it, the assumption is like, you're not struggling with depression, and you don't have anxiety, Not my kiid, not in my backyard type of mentality. It's the same thing with queerness, people don't think that it's going to be applicable to them until it is, and then they don't have the resources and the systems in place anyway, so then they just continue to not talk about it. For most of my life, I never heard anything about being not straight, I honestly didn't really even hear that much about being straight, because you didn't need to talk about something that was already assumed, you know, like, you don't need to say, hey, don't forget to breathe, people are just going to do it because that's what comes natural to them. So everybody is assuming that what comes natural to you, in terms of your sexuality is this very narrow idea. And we hear stories about queer people who are like I always knew, and I didn't always know, because I had no way of there was nothing for me to measure it against. I had no way of, of no standard, no metric, nothing to compare to, again, no representation. So when I was going to counseling, when I was talking about my mental health, there was a whole side of me that was completely repressed and wanting to come out that just could not, could not even be acknowledged. And when you're struggling with your mental health, and you're like, why am I why do I feel so distant from myself? Why do I feel like I can't get in touch with my emotions? Why do I feel like I can't really be honest about the things I'm struggling with? You know, the parts of your identity that you're not allowed to acknowledge, are going to be heavily intertwined with that. And I, as far as I know, the first counselor I

went to was not clear. She was also not the best counselor I've ever had, but again, that's what was, what was available at the time. And now looking back on it, now having counsel that is very affirming that I specifically looked for based on common identities, I can see the drastic difference, and being able to say, Hey, I'm struggling with this thing. And then my therapist being like, Yeah, that's actually really common with people who've gone through this before. And here's an example of it. Here's a term that you can look into here is some reading, if you want to learn more about it, being able to hear from somebody who has had that personal experience and has the education and the professional knowledge to tell me like, Hey, you're not alone. That has done wonders for me. But I don't know that that would have ever been possible. Back home, at least not when I was growing up.

[music playing]

BECKY EBERT: Hi there, it's Becky Ebert, TWLOHA's editor and producer. I want to talk to you for a moment about something specific: T-shirts. To Write Love on Her Arms has always sold t-shirts as a way to help fund our mission—the mission of hope and help. But the products we sell in our store do so much more than help us financially. Each piece of merchandise is a conversation starter. It spreads the TWLOHA message to someone who may not have found out about us otherwise. So whether you wear our shirts, hats, hoodies, or rain jackets, we want to thank you for bringing a message of hope and help wherever you go. To see our latest designs, head to store.twloha.com now and use the promo code PODCAST20 to receive 20% off your entire order.

[music playing]

CHAD
So, Jodi, you were, I think knocking on this door on the last question. But we know that talking about therapy deserts is not just a theoretical exercise, but there are real stakes involved in having a lack of care, not altogether different from from physical health ailments, that if something goes unchecked, if you don't have access to a medical doctor, something's going to get worse if addressed. So we know that an inability to access treatment for mental health leads people's challenges to get worse, and eventually, resulting in someone needing more intensive support. And we know that again, if you live in an isolated culture, or society or geography, that if you're getting more specific care, that is also going to be a less accessible option for you. So again, coming from the professional's perspective, can we go a little bit more in-depth on the importance of preventative and also just regular maintenance of care for people in terms of how to see the therapist and psychologist, or psychiatrist?

JODI
One of the things that has been really important to me as a therapist is, so I work with individuals who are mandated to come to therapy as part of our program, so they don't always want to be there. But if they like keeping their bed in our shelter, they come to therapy. It's a great trade-off. And so they normally come up, and sometimes they want to be there and sometimes they don't know a very good normalizer for me with them, is I told them, 'Well, hey, I go to therapy too.' And I tell them that number one I'm like, I wouldn't pay somebody, first of all, if this didn't help me. But number two, I'm not going to ask you to do something that I'm not also willing to do. And slight theoretical thing, I don't know if you guys are familiar, there's a concept called Maslow's Hierarchy of Needs. And Maslow talks about how the very fundamental pyramid, it's a pyramid shape, the very fundamental basis of this is like food, water, shelter, safety, you have to have all that first. And that's usually where I first meet people is down there. Like they're just coming into shelter, they finally have some stability. And they're like, I don't need therapy. And they're probably right because in that moment, that is not their priority. And so as we get more time together, and we get to spend time, actually talking about things, one of the biggest things that they tell me is, 'oh, I can

just come talk to you about whatever, and it makes me feel good.' It's like, yeah, you want to tell me about how bad your sports teams are doing, I get it. I'm a Denver Broncos fan, we're bad. And so just having that person to talk to on a regular basis about something that's important to them, often makes such a big difference, right? And we're not talking about trauma, we're not talking about, you know, some of the big things that people will say, 'Oh, that's what therapy is for, I have to be sick, I have to have a disorder, I have to have gone through something traumatic.' And I think just putting that seed there that yes, a lot of these individuals have experienced trauma. And sometimes when I work with them longer they get safe enough to talk about that with me. But that doesn't have to be with therapy, therapy can be that. That's what our training does. It teaches us how to prepare for, you know, some of these more significant mental health concerns. But it also teaches us that the basis of any good therapy is going to be the relationship, which is why multicultural counseling is so important, right? Because of the basis of therapy, the basis of what is success is the relationship. You can't do preventative work, if you don't show up, it's hard to do preventative care at the doctor's office, if you only go to the emergency room when your appendix ruptures, you know, you're not getting that preventative care. So if you aren't going until something's wrong, that creates some of this disparity here. And I think that's where therapy is seen. If you only go to therapy when you're sick, you only go to therapy when something's wrong, because that's what's on, that's what's on media. That's kind of what's talked about, it's that oh, well, we don't go to therapy, because only crazy people go to therapy. Now normal people like you and I and everyone else can go to therapy. And I think with that, just that normalization of it. But then also it comes back to the therapy deserts, how are you supposed to get preventative care when the preventative care provider is 100 miles away, and you can't take time off work to go out there because you're working whatever shifts you can pick up, you know, there's no public transit, you don't want to put 200 miles on your car once a week to drive all the way out there. And I think that's where the nuance of preventative care versus reactive care comes into play. And it's also really expensive. I know, we've kind of danced on this topic. And it's, it's an interesting topic to dance around. Because as a mental health professional, I need to get paid, I need to also pay my bills. But you know, you'll get insurance payouts, insurance does not pay out at fair rates for mental health therapists, I'm gonna go ahead and put that out there right now. I don't even take insurance. And I'm going to put this out there, right? And so why would a therapist take a full caseload of insurance patients, when they can take private pay clients, because they're gonna get paid so much more for that, normally, they'll balance it out and do a little bit of both. And then the flip side of that is you want therapy to be affordable, you want people to have access to therapy, and it's finding that very nuanced balance of it, which is hard to do when insurance companies are always looking for a profit. Anytime mental health is going to become a profitable industry, you're going to find that struggle, because, again, why would insurance pay out a full rate? And so then why the therapist? Would I accept the full caseload of insurance clients, when I know that's probably who needs to come see me? When it's like, oh, well, Joe down the street can pay me $130 an hour? Why would I take Bob's insurance and get paid $95 for the same hour that I'm providing therapy? And so it comes back to all these nuances of how can it be preventative when there's so many barriers to receiving services. And I think unfortunately, that's where a lot of our issue lies is until things start to change. therapy itself will always, maybe always use a strong word. Therapy will continue in the path we are where it's a very reactive, so often it's a reactive, oh, something's wrong, I need to go to therapy, until we normalize it more and make it more accessible.

CHAD
I mean, like, even colloquially, like we hear it all the time. So and so needs therapy. Like, you know, you have and you're just talking about, you know, Maslow's hierarchy like well, our needs are relational, are nutritional, arestructural. And yeah, we build up from there, but even just framing the conversation this person needs it's obvious that they need it. We can all benefit from counseling. Wellness-wise. Yeah. Bianca thoughts on that?

BIANCA
Oh, boy, I don't know if you've seen Parks and Rec, but there's just one episode where where Leslie's like no, I don't have an opinion. And Ben's like, No, you have an opinion on everything, you have an opinion on pockets. That's how I feel I have an opinion on everything. So working at TWLOHA,, especially in the comms team, where I respond to a lot of people on our various platforms, a lot of what we've seen is people saying, like, even if I could afford it, I wouldn't know where to go. Or if I knew where to go, I couldn't afford it. Or I have nobody to take me because I'm 13, or whatever it is. There's a lot a lot of areas. I think that some of the ones that we don't talk about, aside from the geographical physical locations of therapy deserts, is like you brought up the cultural barriers. And for me, something that really sticks out, in my experience, is thinking about growing up in a predominantly Mexican American area where Spanish was the primary language. And if you didn't know Spanish, you would be very limited in the interactions you could have. And despite that, there still were not any Spanish terms that I ever heard growing up regarding mental health. There was never any talk about that. And whether that's because people didn't talk about it, or because the words didn't exist, there's probably some gray areas to that. But when I think about, like, hearing the Spanish translation, for certain words, like the depresión, ansiedad, suicidio,those are saying depression, anxiety, suicide in a Spanish accent. So what that tells me is that, this vocabulary, the language is something that, that we have adopted, as we keep up with the world, as we realize that we need to have these conversations to stay relevant to be able to support people in the current landscape that we're in. But I also think that if we're hearing a kind of borrowed version of words, if we're hearing only the Spanish version of an English word, and that's inevitably going to come with the connotation that it's for people in those communities, it's, if it's an English word, it's for white people, or at least it's not for us. And you already feel that all the time as a person of color in an immigrant, impoverished, distant community anyway. So I think there's just one very specific example of how the cultural barriers have been lagging behind, and then if you can't talk about because you don't have the language, you don't have the cultural understanding of it, how can you expect to get funding to get preventative care to get any sort of understanding on a wider scale? I, I think, for me, it does kind of feel like it's at a standstill, because I literally do not know the words to talk about it a lot of the time. I, if I think about maybe, say depression, for example. I don't know if when I say that in Spanish, if the interpretation that somebody has of it, whose first language is Spanish, if they're going to take it literally is like, you're depressed, like you have a medical condition, or if they're going to take it as the stigmatized version, or they just don't know what it means. So there's definitely a lot of, a lot of disconnect in how we're able to communicate within even our own communities. Because we don't, those bridges aren't being built. And it definitely does feel like it's just kind of expanding the desert. It's expanding the vast nothingness in terms of having these conversations.

CHAD
I mean, it makes sense, you know, heaping shame upon shame and isolation upon isolation.

JODI
So something from the, from the clinical perspective, I'm gonna throw some acronyms around the DSM, which think of it as like the therapist Bible for like diagnosis, right, like every diagnosis that we have come up with, it keeps getting bigger, in each new edition. And with that, there is a very, very tight, I wish I had mine with me, it's in my office. But there is a very, very teeny tiny couple of pages called cultural considerations. We have this entire, you know, hundreds of pages in this book, and there's like six of them diagnosed to quote unquote, cultural considerations. And this is what every therapist, insurance company, at cetera, et cetera, is using for diagnosis, like even the language that we are diagnosing mental health disorders, the language that we are using in just a therapy setting in and of itself is written from an English speaking white, predominant way, even in just the way that we're looking at, oh, this is how we figure out whether clinically, someone has clinical depression, clinical anxiety, and just even that aspect of it, and

that's something that every therapist is using. And so when we're looking at, oh, well, you know, the language translation of it is going to be such a problem, you know, that relates back to the multicultural piece that we were just talking about. Because even in our you know, diagnostic criteria, we don't have words in languages other than English is minuses those like six pages of like, oh, here are some considerations if you're working with a multicultural client, when really especially as intersectionality becomes so much bigger in our world. And as we work to combat some of these therapy, deserts and really bring services to some of these areas that we as providers are going to have to start addressing, you know, when we're revamping the DSM, they just came out with a new version, this year, last year, I don't remember. As we're starting to really look at some of these diagnoses for the next version like we need to put more on a provider standpoint, we need to put more emphasis on this because we are never going to connect to some of these cultures until we do, and I think that's a shame.

CHAD
And the idea that what you're reading in that book has been aggregated from people that have been able to undergo critical observation,

JODI
Right, the ones who can afford to go to therapy

CHAD
So, jeez louise, while we're, you know, kind of in the professional lens, right now. Lastly, we know that another piece of this conversation is that there's simply not enough mental health professionals to meet the soaring needs of people when it comes to the care they deserve. So let's take a moment to talk about two things. So one, the hurdles required for someone to pursue a career in mental health. And you kind of touched on that a little bit earlier. But point two being how difficult it can be for someone to find a therapist that is not just culturally aware, but perhaps even having a shared cultural background.

JODI
Number one did, it's expensive. And I also think with it, I think the hardest part of a graduate school and getting a Master's in Counseling was how much it makes you look at yourself in the process. Because to be a good mental health provider, you need to be aware of your own biases, you know, I'm not going to sit here and say, oh, I'm an unbiased person, like, no, okay, we all have our biases, and we all have to work to address them. And I think that is one of the hardest parts of grad school was looking at those aspects of yourself. And also like, oh, I should maybe deal with some of my own trauma before I start working with someone else's. And so number one, just that aspect of it, too. It's expensive, just straight simple. And, you know, I really think with it, too, it's hard to convince somebody who doesn't believe in therapy or the usefulness of therapy to become a therapist. Because if you don't even believe that therapy works, why are you going to dedicate your life career to that? And so I think that's where we go back to, we need more representation in the field, which creates this really vicious cycle of there's not enough representation and because there's not enough representation, it's hard to draw people into this field. That in itself is a whole vicious cycle outside of the cultural context that Bianca has already talked about, right? Like, there's so many aspects of that's such a layered cake that I don't want to open that cake right now. And, you know, I think also with that, so as we've all kind of seen in the last couple of years with COVID, in one way, it's really cool. Seeing how therapy has become more normalized, I think some of the younger generation has done a really good job of pitching mental health and therapy. In making this more normalized. You know, you can hear people say, Oh, here's what I learned about in therapy today. Whereas like, 20 years ago, people were like, I'm in therapy, don't tell anybody. The flip side of that is, you have to be really careful with your mental health providers that you don't burn them out. Because it is such a taxing field. You know, people joke and say, “Oh, well, you sit at your desk and talk to people all

day long. How hard is that?" I don't know when the last time you tried to have an hour-long conversation without getting distracted looking at your phone being like man did I remember to go pee in the 10 minutes between sessions like, it's hard to do, especially when it's something very heavy. And with that, as we have this push for more therapy, it's also balancing the needs of our providers with a population that is rising, and how much therapy that they're wanting access to where we've kind of stagnated our mental health professionals, just and I think a big piece of that is money. It's not a very lucrative career. It can be I should refer to like, if you're into the whole private practice charging $125-130 hour session, then you can, you have the clientele that can pay that it can be a lucrative thing. But really, at the agency setting, which is where a lot of my focus is in mental health is that agency community aspect of therapy, where the clients are paying either a subsidized cost, you know, part of the agency fees or whatever, or there is no cost, you know, the clients I see they don't pay anything for therapy there. They just show up, all they have to show up. So the agency pays for my salary and because I work in that non-profit setting, I'm not making bank right, like I'm paying my bills and I'm just praying that my savings account is solid. And so with that, you know, if I ever had some unfortunate tragedy in my life, I'm looking at, "Can I afford to stay at the agency? Can I afford to stay in this career that I have spent so much money on?" Before I need to take my degree elsewhere to make a survivable living wage, and that, unfortunately, kind of, I think, can limit the access to therapy because we burn our agency therapists out so quickly. So I've been very blessed where I work. You know, you hear these horror stories of therapists of, oh, I have 120 clients on my caseload. Right, you're like, how do you see 120 people a month, let alone in two weeks? It still brings me back to the school shooting, right? And everyone's like, oh, well, we need more mental health care for are youth. Texas ranked 51st. Like Puerto Rico's there, we rank 51st. On like, accessibility of therapy to youth in this, in this state. Like, we're 51st in everything. And it's just, it hurts to hear from that government perspective. Oh, you just, we just need to provide more therapy? Who's paying for this therapy? Who is taking care of our mental health providers? Who is creating the access to this? It's very easy to say, oh, the fix is more mental health. But what are we doing about it? You know, and I think for me, as a therapist, that's one of the hardest things when tragedies like this happen in communities, and it was like, Oh, well, we just need more mental health, like stop making that your rally cry. Where is the legislation? Where's the funding? Where are the boots on the ground to actually help these individuals? You know, it's funny, I go places, and I have to stop answering this question. People ask me what I do for a living. And I'm like, I'm a therapist, in a homeless shelter, I have to pick a better answer than that. Because everyone's like, oh, that's so great, you know, blah, blah, blah. And then you'll have, will change subjects, they'll be like, but you know, student loan forgiveness is such a terrible thing, and I'm like, I'm working in a non-profit, I'm banking on some of these, you know, public service loan forgiveness programs, because otherwise, I will have to pick a new career field 20 years down the road, if I still haven't paid off my student loans. Like you can't tell me "Oh, it's so commendable what you do, but you can't access the services, because that makes you a lazy person." And it's just that aspect of it. I know, I got way off topic for whatever we were talking about. That's my soap box.

CHAD
No, you're still there. Like, there's so much truth to that, like, where you put your dollar that points to your values. And to whatever extent we, we make mental health you said rallying cry, but honestly, sometimes it's a punchline, right? That's the easiest, most accessible scapegoat to this, and you can only blame the same thing for so long until you actually do something about it.

JODI
And also you look at these mass tragedies, and you know, less than 3% of mass tragedies are actually caused by people with significant mental health problems. So like, are we even addressing the issue with more mental health and that aspect of it, like stop using that as your rallying cry for mass tragedy? Not, not even close. But I do agree, we need more mental health care access in this state. But yeah, where is

the action behind the words? Because until we change that, they're just empty words. You know, that would be like, you know, TWLOHA saying, like, oh, well, people need other people, and then not having an agency to actually go out and meet people where they are and do the work that you guys do, right, like that empty tagline doesn't actually solve or do anything. And so I think that is such a big piece of put your money where your mouth is, if you're going to start talking about these concepts, and actually make a difference, because otherwise we're stuck in the same breath that we're in right now.

CHAD
So Bianca taking, taking that energy and moving it over to conversation of intersectionality. With culture, with race, how do we go about addressing that?

BIANCA
You have to be in the community. You have to understand you can't just go in and be like, Hey, we're gonna give you money. We're going to give you therapists all that stuff, and then think it's gonna get better. You have to understand and be a part of these communities and integrate yourself to really have a good idea of what these people actually need. So in Hispanic communities, for example, where there's going to be certain addictions that are really prevalent, like alcoholism, you can't just go in and say, “Hey, we're going to give you some recovery programs,” without also thinking about why those things are prevalent, what are the cultural factors that got us to this point. So you have to think about the context that all of this is happening with and use that as your baseline. But I also think that we have to understand that, what was mentioned earlier, is that you can't just say, I'm going to find a therapist, and it's all fine and dandy. My first therapist was a Hispanic woman or Latina, and I didn't feel like she really related to me, because perhaps it was the generational difference. But we have to remember that simply getting BIPOC people to be able to become therapists is not enough. Like you also have to, like Jodi said, give them the chance to address their own traumas and healing and, and work on themselves as well because then you're just going to be perpetuating the cycle of generational trauma, where we can't talk about it, and when we do it in a way that doesn't actually address the problem. I think in addition to that, we also have to have empathy for why people don't pursue it, even if they want to, for example, my family is very close, very tight knit. And the idea of leaving home, moving somewhere else, especially to another region where there aren't more family members is not a common thing. My grandpa's always asked me like when you're going to move back home, maybe there's a job for you back here. And I know that it's out of love, it's out of like wanting the family to be together. But if you have to leave to go four or five hours away for school, because that's the closest place that has a therapy counseling program, then you're going to constantly be guilted into making that choice. And growing up when you're always hearing that family is the most important thing, and that like we understand you, you know, there's this othering it's really, really hard to leave this community, even if you intend on coming back, which then also may not be an option, because of the limited resources, maybe you have this education, but you can't use it because there's nowhere for you to work back home. So there has to be a lot of understanding about all of these barriers, and then the patience and the persistence to address all of those things, as opposed to just these easy, like, okay, let's give me some money so that you can have a therapy practice, because we know it doesn't work like that.

CHAD
That's awesome. You really laid out, kind of, there needs to be, I don't know if it's balancing the scales or getting a proper mixture and the mixing bowl about it, but in my mind, what's batting around is this idea of paying out for services and also a buying in to the communities that we're hoping.

BIANCA

I think it is so important in this, in this aspect, because it, we're talking about therapy deserts, people that don't have reliable internet access, people that don't have public transportation, things like that. We can give them all the resources they want, and they still may not know that they exist, because they can't just open up Instagram and see, therapy for black girls has a whole database because they have no idea that that exists. So there has to be in addition to making these things available, there has to be that physical presence that like active community building, and the willingness to go to those places, which is why you have to invest in the people that are there, that people that are already integrated, because they have the trust, they have those relationships, they have the awareness, and they're going to know the best way to reach out. I'm not going to go to a community that I'm not a part of, and try to tell them how to heal, because I don't know. But if I went back home, I would have that understanding. And I'd be able to say, Hey, I think these are some things that could work and be able to make that institutional change.

CHAD
Yeah, I guess parting thoughts on where do we go? How do we make a difference? And maybe where have you seen signs of hope?

JODI
So I promise what I'm about to say ties back in, it's gonna sound off first. So I think my favorite part about working with people who are mandated to come to therapy, right, is I in some ways have a blank slate or what therapy is for them. Right, because they've seen me, a representation, but most of them have never been to therapy before. And one thing that was really hard for me when I was doing my student internship because unpaid internships are part of becoming a therapist. Let's not talk about that yet. So when I was doing my student internship here, and you know, we were talking, my supervisor and I, and a very key thing that she told me was you are not going to see the same changes you see here that you see with someone who's paying to be in therapy, because their motives are very different. Right? That person wants change in their life. They're paying for change. They're ready for change. Usually. Mandated clients are different. They may not be at a state of change. Sometimes you're just planting the seed of what therapy is and what changes. And I think this point I cast on therapy desert is that seed, maybe this is the first time somebody's heard about therapy desert, maybe it's the first time some of these communities are seeing representation on their communities on a national platform like this, you're not gonna grow the tree tomorrow, you're not gonna grow the tree next week. But maybe you planted that seed. And so people can see, hey, here's where some of the issues are. Here's where I can make change. Here's where I can't make change. One thing that I said in our, I'm on some networking stuff with some other mental health providers, and therapists and stuff. And when this tragedy in Uvalde happened, you know, my thing was, I cannot go provide services to them, I am not the right representation for them. There are better providers out there. And if I go out there, I'm just adding noise to this community that needs healing. That's not helpful to them. And I think we as professionals need to recognize where our roles are. And that comes with just knowing your own biases and your own identities, what is your intersectionality as a provider, and as an individual, and sometimes just planting that seed of saying, hey, I can push this out there, push these topics out there, and just let it be known where the struggles and issues are. So that we just become more familiar with it, recognizing these cultures, meeting them where they are, meeting some of these people who've never even heard of therapy, the soft introduction, plant that seed, and I think that's where the hope is, right? And if you can even just get started talking about this topic, making it more day-to-day conversation, versus some of these big news moments that are out there, you know, just make it more normal, normalizing that. Again, I think that for me, is where the hope is right,

BIANCA
Yeah, I, I love all of that. Retweet. I think in terms of what gives me hope, and what we can do going forward. I just really want to hammer in the earlier point about being in these communities, because we

can talk about it all we want. But if these places don't have access to these conversations, then this conversation isn't going to do anything because the people affected aren't a part of it. So I think it's really, really important when you are learning about therapy deserts and trying to do something about it, that you think, okay, where's this most applicable? Who are the people affected? Who are advocates and people working in these places to make change? Who are the people that are standing up for others? And how can we get them involved? I don't think that it's possible to make any long-lasting, sustainable institutional change, without involving the people that are most impacted by it, because they're going to be the ones that have to carry that forward. So you can't just go in and give them a whole bunch of like guidelines and resources, and then expect them to know how to use it if they've never had that before. So investing in education, and having conversations about mental health, and also being willing to meet people where they're at. Because there's a lot of these communities are not going to know how to talk about mental health, they're not going to know how to provide support for each other and for themselves. So I think it's just really important to think about the little things that can be done that are going to be a part of the larger snowball effect. And when I think about what can actually be done in those spaces, I know from my experience back home, that there are people like that working day and night to see that change happen. There are community organizers and people running for office and people like, joining school boards and becoming teachers because they want to be a part of that change. So I think that's what gives me hope is knowing that there's people like that everywhere. It's more about whether or not they have the support and they have the backing and the knowledge that they're not in that fight alone.

[music playing]

CHAD
I truly cannot thank Jodi or Bianca enough for imparting their wisdom on this conversation. A big part of the work we do at TWLOHA includes informing ourselves and our audience about topics that are nuanced and not widely known or understood, and with your help, we were able to do that.

To you, our listeners, please know how grateful everyone at To Write Love is for your time, concern, and attention. It’s a special thing to learn and grow alongside you all—especially knowing that we all have a common goal in mind: making hope, help, and the possibility of healing possible for as many people as possible.

[music playing]

CHAD
We hope this episode has been a reminder, that your story is important, you matter, and that you’re not alone.

If you’re struggling right now, know that it's OK to reach out, and that there are people who want to help. Part of our mission is to connect people to the help they need and deserve. You can find local mental health resources on our website twloha.com. That’s T-W-L-O-H-A.com. And Click FIND HELP at the top of the page.

If you’re in the US or Canada, and need to talk to someone right now, you can always text our friends at Crisis Text Line. Simply text the word TWLOHA— again, that’s T W L O H A—to 741741. You’ll be connected to a crisis counselor. It’s free, confidential, and available 24/7. For a list of crisis support resources for listeners living outside of the United States, please visit TWLOHA.com and click on the International Resources tab.

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A big thank you to our friends at Copeland for the original music on this episode. The To Write Love on Her Arms podcast is produced by Rebecca Ebert. Music assistance was provided by James Likeness and Ben Tichenor. And again, I'm Chad Moses, thank you so much for listening. We're glad you're here.