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Unbeknownst to all of us, 2020 quickly became a challenging and controversial year. With the rapid spread of COVID-19 (coronavirus), and the incredible speed at which things were changing around us, the ABPP continually adapted our operations and business so that Specialty Boards and the ABPP could continue to conduct business. Despite these unprecedented times, the American Board of Professional Psychology persevered and continues to be in good standing. The Executive Committee and Central Office Staff had been conducting business remotely for several years. So, this transition was less difficult. Yet, we were still challenged with conducting business with Specialty Boards. The pandemic never deterred our efforts to certify Specialists; Specialty Boards continued to administer oral examinations, albeit remotely. By doing so, the ABPP certified two hundred and twenty-four new Specialists in 2020. Likewise, the ABPP Standards Committee was able to successfully complete three PCRs remotely.

During 2020, mental health clinicians were faced with changing their method of service delivery from providing face-to-face services to using telepsychology. Likewise, Specialty Boards were confronted with pivoting from face-to-face examinations and in-person meetings to some form of remote interaction. Despite the pandemic, candidates continued to pursue board certification. By mid-year 2020, most Specialty Boards were using some form of remote examination while others were exploring ways to do this, and Specialty Boards had changed to remote meetings to conduct business. During the Specialty Board Presidents’ calls, I was genuinely impressed and grateful for the camaraderie exhibited by Specialty Board Presidents who unselfishly assisted other Boards with establishing a remote style of oral examinations that fit their needs. During our December Board of Trustees meeting, Trustees described remote oral examinations as successful and noted the need to continue the option of offering remote examinations post pandemic. Thus, during our Board of Trustees’ December 2020 meeting, the Trustees approved Specialty Boards offering remote evaluation post pandemic, as they see fit. I anticipate that after the pandemic, Specialty Boards will continue offering oral examinations remotely.

The Board of Trustees could not ignore the social unrest in 2020 and authorized the ABPP to make a public statement in response to these social events. Historically, ABPP has not made public statements related to social events. Yet, given the significance of the social unrest in 2020, the ABPP made an exception. The public statement regarding ABPP’s position on the current social unrest was posted on the front page of ABPP’s website and on the ABPP Facebook page. Although the statement has been moved to the Diversity page on our website, the ABPP remains steadfast that the dignity of all people, regardless of age, race, gender identity, ethnicity, political affiliation, or sexual orientation will be respected, and it is the cornerstone of our longstanding commitment to foster all cultures belonging in our organization. In fact, in December, The Specialist published a special issue on diversity.

To date, we have fifteen specialty boards, and one subspecialty. During our December 2020 meeting, the Board of Trustees heard the formal proposal from the Serious Mental Illness (SMI) group. After thoughtful consideration and discussion, the SMI group has been authorized to begin the implementation phase of affiliating with ABPP. Following the 2019 Board of Trustees meeting, we approved the Addictions group for consideration as a specialty.
and this group will be presenting their formal proposal to begin their implementation during the 2021 Mid-Year meeting. Additionally, the Forensic Neuropsychology group submitted a brief proposal to be recognized as a subspecialty, as did the Psychopharmacology group; the Board of Trustees will hear their proposals during the 2021 Mid-Year meeting. Our organization is clearly continuing to grow. Reflecting on my eleven years on the Board of Trustees, I am in awe of the commitment, creativity, and devotion of Trustees, as well as their dedication to their respective specialty boards. Our organization is prepared to positively impact the culture of professional psychology and fulfill ABPP’s mission.

Furthermore, over the past year we made a few changes to improve our organization. Firstly, a webinar task force was created to explore opportunities for ABPP to offer webinars with respect to continuing education credits. A proposal was approved by the Board of Trustees and we are gearing toward offering continuing education material via a webinar. Secondly, to standardize our elections’ process, a task force was developed to explore our current nominating procedures. The task force diligently established procedures for nominations and campaigning for positions on the Executive Committee. Thirdly, the Human Resources Task Force became a standing committee and will assist the Executive Committee with overseeing staff hiring, performance reviews, compensation/bonuses, disciplinary procedures, and other relevant functions identified by the Executive Committee. Next, we recognize that IT is our future. The Executive Committee is exploring ways to continuously monitor and update our IT Platform. Finally, we developed a viability task force to advance criteria in exploring the viability of proposed Specialty Boards, and the sustainability of existing ones.

Of all licensed psychologists, approximately 4% of us are board certified. During my tenure as President, my goal is to increase this percentage. It is my priority to continue reaching out to licensed psychologists eligible for board certification. This incentive includes early career psychologists and clinical directors of psychology programs, internships, and postdoctoral fellowships. We will continue to lean on the ABPP Foundation to disseminate scholarships to individuals applying for board certification. Additionally Dr. Brenda Spiegler (President Elect) and I, are reaching out to Canadian Psychologists to educate them about board certification and assist them in whichever way in their pursuit to become board certified by the American Board of Professional Psychology. Moreover, our Marketing/Outreach committee and the BOT will continue to collaborate with the Reis Group to continue our ongoing marketing initiative by focusing on messaging and target outreach to candidates, employers, and other stakeholders.

I continue to challenge The Board of Trustees and all Specialists to actively participate in planning for the future of our profession by encouraging eligible licensed psychologists to pursue board certification. ABPP’s future is bright, and I am optimistic for this organization.

Respectfully,

Christina Pietz, PhD, ABPP
President, American Board of Professional Psychology
Board Certified in Forensic Psychology
Executive Officer Update
David R. Cox, PhD, ABPP
Spring / Early Summer of 2021

I hope everyone has weathered the winter and is experiencing some joy with the good weather upon us, and the easing of COVID-19 restrictions! It has been an interesting period of time, no doubt. Despite so much shutdown worldwide, ABPP has remained busy and we seem to have adapted relatively well to the changes required to continue our work of credentialing specialists. Indeed, I am certain we will all come out of this experience with some new ways of looking at the world in general, just as we have taken a fresh look at our examination process.

We have a very busy Board of Trustees meeting coming up in June, with presentations by two new specialty boards and one proposed subspecialty. As part of that meeting, we will also be looking at issues of viability and sustainability of specialty and subspecialty boards, reviewing models of examination used during the pandemic, reflecting on our switch to virtual examinations, and discussing how the future looks in anticipation of a post-pandemic world.

Current status of proposed ABPP Specialties & Subspecialties –

At our December 2020 meeting, a group proposed the establishment of a specialty examining board in Serious Mental Illness Psychology (SMI). The ABPP Board of Trustees (BOT) approved the group to proceed to the next phase of affiliation, the implementation phase. Another group, Addiction Psychology was similarly moved ahead and will also be presenting at our June BOT meeting. During this Implementation Phase, the groups will establish, in coordination with ABPP, the process whereby credentials review and examination of applicants will occur. A Forensic Neuropsychology subspecialty proposal is also on the agenda for the upcoming June meeting.

As a reminder, ABPP previously voted to accept specialty recognition by CRSSPP as de facto recognition of that specialty area of training and practice. A CRSSPP-recognized specialty group seeking affiliation with ABPP, will not need to demonstrate to ABPP that the specialty exists. Such specialty groups will need to focus on how they can develop an examination process and board that are fiscally and logistically viable, including sustaining themselves over the long-term. ABPP has not yet deliberated over a similar concept for subspecialties, hence it will need to do so in the coming months. As of now, CRSSPP has not recognized any specific subspecialties, since establishing recognition of the concept of subspecialties is relatively new to CRSSPP.

SMIP is already recognized by the Commission for the Recognition of Specialties and Subspecialties in Professional Psychology (CRSSPP) as a specialty, while Addiction Psychology, currently recognized by CRSSPP as a proficiency, will be seeking specialty recognition through CRSSPP in the future.
**Taxonomy for Psychology**

I believe that one of the most important developments in recent years in Psychology has been the adoption of a taxonomy. Specifically, the establishment of A Taxonomy for Education and Training in the Health Service Specialties in Professional Psychology ([https://www.apa.org/ed/graduate/specialize/taxonomy.pdf](https://www.apa.org/ed/graduate/specialize/taxonomy.pdf)) has provided psychology specialties to clearly articulate what constitutes appropriate labelling of education/training programs as providing an Exposure, Experience, Emphasis, or Major Area of Study in the specialty. Most, if not perhaps all, of the Specialties, have completed documentation which can be viewed on the Council of Specialties web page [https://www.cospp.org/education-and-training-taxonomies](https://www.cospp.org/education-and-training-taxonomies).

The Taxonomy is an important tool for Specialties and programs to use for a variety of reasons. Rather than re-create/repeat the reasons here, I will refer you to APA's site found at [https://www.apa.org/ed/graduate/specialize/understanding-taxonomy](https://www.apa.org/ed/graduate/specialize/understanding-taxonomy). The information on that page and linked FAQs (see the right side of the web page), is the outcome of multiple hours of collaborative work between APA staff members and Specialists who constituted the Outreach and Communications Working Group, developed following the last Inter-organizational Summit on Specialty, Specialization, and Board Certification (4.0). I encourage all to review in detail the page and click through on the FAQ links. A good illustration of how this information may serve the profession- and ABPP specifically, can be found by clicking on “How can I tell if my psychologist is a specialist” on [https://www.apa.org/ed/graduate/specialize/taxonomy-faqs-public](https://www.apa.org/ed/graduate/specialize/taxonomy-faqs-public).

Spreading the word out to the public as well as to the professional field about specialty and board certification, is a key objective of the work that the Summit Outreach Group has embarked and continues. Starting within our own professional circles, getting people to understand and use the Taxonomy will no doubt assist in providing clearer information about levels of education, training, and specialty.

In future iterations of ABPP examination manuals, specialty boards will be encouraged to incorporate the specifics of the specialty's completed Taxonomy- as provided to CoS on the above-mentioned web page.

**Summit Outreach and Planning**

The Planning Committee of the Inter-organizational Summit on Specialty, Specialization, and Board Certification has determined that a future summit (Summit 5.0) will be planned sometime within 2022. Spending 2021, on dissemination and education regarding the Taxonomy was determined to be a high priority (see info [https://www.cospp.org/2021-cos-taxonomy-initiative](https://www.cospp.org/2021-cos-taxonomy-initiative)). Summit 5.0 will likely focus on following up with the integration of the Taxonomy into graduate education and training. This in turn may also lead to a discussion and production of a means whereby the Taxonomy can be applied to the education and training that individual psychologists have had. Presently, the Taxonomy is to be applied to education and training programs, not individuals. Nonetheless, a “translation” for use in reviewing individual education and training is a natural next step.

**International Project on Competences in Psychology (IPCP)**

ABPP was to have been represented at the (cancelled) International Project on Competences in Psychology (IPCP) meeting in July 2020 in Prague. COVID-19 interfered, resulting in the scheduling of a virtual working group meeting which was held in late May 2021; I will be providing an update in the next newsletter.

**Generic v. Specialty Information in Examination Manuals**

Nothing to report at the present time, however by year-end I will be providing the Standards Committee with a draft manual of the Generic Requirements common to all specialties. The goal will be to have Specialty boards reference that document and no longer need to re-articulate the material in the examination manuals. Thereafter,
each specialty board will simply reference the over-arching ABPP document.

**Central Office and Staff**

As always, great thanks go to our wonderful Central Office Staff – Nancy McDonald, Lanette Melville, Diane Butcher, and Kathy Holland – who provide ongoing service and support to ABPP specialists and specialty boards in a consistent and quality fashion. Thanks, team!

This group of people have worked together for years and I am happy to report that all of them have indicated their intention and desire to remain with ABPP for years to come. They are a great team to work with and I hope you will take the opportunity to thank each and every one of them!

\[\text{Signature}\]
In April 2020, APA scored a seminal achievement for Psychology by expanding access and reimbursement for services provided remotely. Hence, earlier in the year - a good 12 months later, the Specialist placed a call to its readership to have them comment on their experiences as providers, faculty, and supervisors during this time. It gives me true pleasure to announce that you have responded to that call and that the most recent volume (48) of our newsletter has collected a solid compilation of such articles pertaining to: understanding the role of public ethics during a pandemic; delivering remote services to Veterans or the general public - which in turn can provide incredible insights into the future of telehealth; recognizing the value of online learning, while acknowledging its pitfalls; working with trainees to improve their experiences in supervision; understanding and appreciating the pragmatics of distant psychological test administration and interviewing.

The Specialist however, delves into other areas of interest as well. This edition has an intriguing article – reflection on how an established organization can re-invent itself while addressing racism and institutionalism. Furthermore, we have reports of interesting advancements within the realm of service delivery as well as supervision. Please make sure to read the article featuring bibliotherapy in the realm of treatment, and a summary on a new publication on sexual boundaries, trauma and treatment. As always, we are happy to provide you with updates from our President, Dr. Christina Pietz, our Executive Officer, Dr. David Cox, and the numerous colleagues / specialists who are fervently working to promote our profession and provide guidance and support to each and all of us, interested in becoming a specialist.

I am writing this column as we recently celebrated Memorial Day. I would like to stop and showcase one particular submission, the journey of one Dr. Richard Moore on his way to becoming board certified in his specialty field. A gentleman, while stationed in Iraq, focusing on taking the ABCN oral exam - even if he had to rely on his smartphone (!). An incredible story, illustrating the group of amazing and dedicated professionals among us.

The members of the Communications Committee are always on the lookout for great submissions. Please take the opportunity to provide to the Editor and/or the Committee your thoughts on how we can improve our publication and overall media presence. We welcome and encourage your input. This volume would not be possible without the support and guidance I receive from the members of the Communications Committee - Drs. Sharon Bowman, Laura Flashman, Jay Earles & John Watkins. Last, I must not neglect to mention the valued mentorship obtained by Dr. David Cox (Executive Officer), and the incomparable feedback I get from Ms. Nancy McDonald (ABPP Associate Executive Officer) and Lanette Melville (ABPP Information Systems & Marketing).

Respectfully,

Kristine T. Kingsley, PsyD, ABPP Editor, the Specialist
Chair, ABPP Communications Committee
In 2017, the then presidents of the clinical specialties (e.g., Clinical, Group, etc.) established the ABPP Veterans Affairs Initiative, which in turn was recognized by the BOT as the VA Task Force, two years later— in 2019.

Initially the scope of the initiative- and subsequent task force was to: a) determine a mutually beneficial way to promote board certification of VA psychologists; b) provide an opportunity for discussions regarding the pros and cons on becoming board certified; and c) create a forum for continuing advanced training for interns, fellows, and early career psychologists. Recently, the task force expanded and became the "Psychologists in Public Service Task Force" (PPSTF), which represents government psychologists in the VA, Public Health Service, Bureau of Prisons, and Department of Defense. In spite of the expanded scope, the PPSTF carries the same mission across the different sectors, which is the outreach to psychologists in public service in order to inform them of the benefits of ABPP.

Today, we are adding new initiatives as well as continuing many of our ongoing activities.

**Stacey Pollack, PhD joins our task force**-

Dr. Stacey Pollack serves as the National Director of Program Policy Implementation in the VA's Office of Mental Health and Suicide Prevention, and the VA's lead psychologist based in Washington, D.C. Dr. Pollack has joined our task force as the VA Liaison to ABPP's Board of Directors. She carries years of experience and service within the VA, and will be able to advise us on the best ways to work with psychologists in the VA as well as other government agencies. We are hoping for a strong alliance and an ongoing collaboration, which aim to promote standards of excellence across the field of psychology.

**Ambassadors**-

Borrowing from the success of the Ambassadors Program created by the Early Career Psychologists Task Force, we have designated ambassadors of our own. ABPP has an untapped resource across psychologists in public service who are board-certified. Ambassadors are points of contact for psychologists who might be interested in board certification. They share information about ABPP board certification by providing at least one dissemination activity per year (e.g., continuing education presentations, trainee/student seminars, or even informal discussions with colleagues). The goal is to educate colleagues and trainees regarding the board certification process and help
future specialists pursue it. Currently, we have recruited seven ambassadors who serve within the VA, Bureau of Prisons, and Department of Defense facilities across the country. We are currently seeking additional nominations for ambassadors in order to further foster and build this program.

**Webinars**

Webinars are continuing for a second year in a row and are available to all psychologists in public service. Each month we highlight one of ABPP’s specialties and provide critical information about the specialty, eligibility, application process, foundational and functional competencies, benefits, or any other issues. Overall, webinars have been well received and continue to serve as a primary form of outreach.

**Early Career Psychologists**

The Early Career Psychologists (ECPs) represent a cohort of individuals who have demonstrated a significant interest in board certification. We are currently collaborating with ABPP’s ECP Task Force to find ways to engage ECPs in public service, and discuss the value of certification. Given that finances are often a barrier to participation, we have also been exploring ways to provide scholarships to ease some of the financial burden. Furthermore, based on the observations that online oral exams are effective, we support the opportunity to study the value of continuing online exams for ECPs- in an attempt to help further reduce costs.

**Network: Training and Clinical Directors**

Training and clinical directors help interns and postdoctoral fellows think through how they want to approach their career after their formal training is completed. They have opportunities to discuss the value of being board certified over the course of their career. We have created a network of directors at all levels of public service, and encouraged them to discuss the importance of certification, not only for the individual psychologists but for the field of psychology as well. In the end we are building bridges with postdoctoral training programs, which can actively promote board preparation activities and enhance ABPP’s appeal to potential applicants.

**Expanding Our Scope**

Last but not least, to achieve our objectives we need many psychologists across all government agencies who believe in ABPP’s mission—to serve the public by promoting the provision of quality psychological services through the examination and certification of professional psychologists engaged in specialty practice. If you would like to join us or receive additional information, please contact Samuel James, sjames@srjames.com or Leo Caraballo at caraballoleo16@gmail.com.
The ABPP Foundation: A Source of Scholarships for those Seeking Board Certification.

James W. Lichtenberg, PhD, ABPP and Vladimir Nacev, PhD, ABPP

The ABPP Foundation, which was formally recognized in 2010 by the IRS as a charitable 501(c) (3) organization established to provide support for ABPP, became operational in July 2012. Its major purpose is to provide the opportunity to donate in support of continuing professional education and advocacy for board certified psychologists, with the ultimate intent of improving the health and well-being of the public.

The mission of the ABPP Foundation is the promotion of competent specialty practice and specialty board certification, the protection of the public through providing educational opportunities in the form of scholarships and assistance to training programs, and provision of continuing professional development. The Foundation supports educational programs to promote the importance of Psychology and board certification to the public and related professions. In order to achieve this goal, the mission of the Foundation includes raising funds. No earmarked funds can be used for any purpose other than those by which they have been designated.

The ABPP Foundation consists of 13 members, broken in four groups. The executive officers are James W. Lichtenberg, PhD, ABPP (Chair), Linda Maria Garcia-Shelton, PhD, ABPP (Vice Chair), Vladimir Nacev, PhD, ABPP (Treasurer), and Meghna Patel, PhD, ABPP (Secretary). The general board members include Sally Barlow, PhD, ABPP, Sherry Benton, PhD, ABPP, Anne Dobmeyer, PhD, ABPP, Robert Frank, PhD, ABPP, Kathy Hart, PhD, ABPP, and Ted Stachowiak, PhD, ABPP. The Ex-Officio Members are David R. Cox, PhD, ABPP (Executive Officer ABPP) and Joel C. Frost, EdD, ABPP (Representative, ABPP BOT). Lastly, the Foundation’s administrator is Cindy Lynn.

For almost a decade, the ABPP Foundation has steadfastly supported psychologists’ efforts to earn board certification through scholarship programs by reimbursing ABPP candidates for some or all their board certification expenses. More specifically, the Foundation has funded early career psychologists, training directors, and psychologists from diverse backgrounds seeking to earn board certification. The Foundation has also funded micro-grants for activities that encourage or support board certification efforts, supported educational programs for psychologists regarding board certification, and funded continuing education programs for psychologists.

Current ABPP Foundation Programs

1. APPIC/ABPP/ABPP Foundation Training Director Scholarship Program: The ABPP Foundation seeks to expand the number of board certified specialists among highly qualified psychologists in key training positions. Accordingly, awards up to $1,000 are available to defray the costs of the ABPP board certification application process, including costs of travel and lodging to take the exam. This award is available to any current director or co-director of a doctoral training program listed by APPIC as a Doctoral Program Associate (DPA) or an APPIC member internship or post-doctoral residency program in the U.S. or Canada in clinical, counseling, or school psychology. Applicants must also currently meet ABPP criteria (e.g., degree, licensure, experience) to become board certified in the specialization for which they are applying, and they cannot already hold ABPP board certification. This award would be in addition to (and does not include) the waiver of the $125 ABPP application fee. The scholarship reimbursement is given to the recipient upon completion of board certification. Scholarship recipients are expected to complete the application for board certification and achieve certification in their specialty within two years from the date of the award notification. For example, in 2020 there were 21 recipients from a pool of 50 applications.
2. **The National Latina/o Psychological Association, ABPP Foundation, and National Register of Integrated Behavioral Health Scholarship Program:** This scholarship, funded by contributions from Cesar Gonzalez, PhD, ABPP, ABPP-F and the National Register, provides recipients with $1,500 towards the completion of ABPP board certification. Scholarship awards began in 2016 and two scholarships were awarded annually. To be eligible, applicants must be graduate students or early career psychologists and must complete the board certification process within two years of receipt of the scholarship award. Applicants must be NLPA members, English/Spanish bilingual, and express an interest in working with Hispanic populations in integrated health service delivery settings. In 2020, the Foundation awarded two scholarships from a pool of four applicants.

3. **The Kaslow Family Fund (KFF) Scholarship Program:** The Kaslow Family Fund was originally established in 2014 to assist psychologists when applying for ABPP board certification in couple and family psychology, to defray expenses incurred in the process. Awards in the amount of $750 are presented to the recipient after successful passage of their exam—generally at the APA annual convention at the ABPP Foundation Reception. As of October 2019, and after consultation with the Kaslow family (Florence Kaslow, PhD, ABPP and Nadine Kaslow, PhD, ABPP), the KFF Scholarship has been expanded to include all ABPP approved specialties, with the proviso that (a) the work sample is about a couple, nuclear family, or extended family and (b) much of the applicant’s professional activity encompasses direct involvement in couples and/or families. Although the criteria for the scholarship eligibility have been modified in consultation with the Kaslow family and with an application deadline extension given, in 2020 only one application was received and unfortunately, the individual was determined to be ineligible for the scholarship at that time.

4. **Eileen Gupton Memorial (EGM) Scholarship Program:** A memorial scholarship fund in honor of the late Dr. Eileen Gupton and through the ABPP Foundation, was established in November 2012 to support specialty certification in Police and Public Safety Psychology and particularly early career psychologists—ECPs (within 10 years of obtaining a doctoral degree). As initially envisioned, ECPs are eligible for an award from the Fund in the amount of $500 upon written notice from ABPP of satisfactorily passing all requirements designed by the American Board of Police & Public Safety Psychology. There were no scholarships awarded in 2020 through the EGM Scholarship.

5. **Walter Katkovsky Scholarship:** The Walter Katkovsky Scholarship was created at the end of 2019 through a generous donation by Walter Katkovsky, PhD, ABPP to encourage and to support health service psychologists, at any point in their professional career and to demonstrate and certify their competencies in their specialty area of practice by supporting them in their pursuit of specialty board certification through ABPP. The Walter Katkovsky Scholarship funds have been dedicated to help defray the costs incurred by psychologists over the course of the certification process (up to $1500) for the following specialty areas: behavioral and cognitive psychology, clinical psychology, clinical health psychology, clinical neuropsychology, clinical, child and adolescent psychology, counseling psychology, couple and family psychology, geropsychology, group psychology, rehabilitation psychology, and school psychology.

In 2020, the Foundation received six applications and awarded four candidates for the scholarship.

6. **Early Career Psychologist (ECP) Scholarship Program:** The Foundation recognizes the importance of promoting and supporting board certification of psychologists who are in the early stage of their careers (with 10 years of postdoctoral experience or less). "Early Career Psychologists” today, represent tomorrow’s educators and leaders. The Foundation is committed to the growth of the future educators and leaders of professional psychology by promoting and financially supporting their path toward board certification in an ABPP recognized specialty as they begin and advance their careers as psychologists. The Foundation awarded 20 applications for this scholarship in 2020.

For many ECPs, the journey to completion of doctoral studies and subsequent licensure requires financial sacrifices,
and is often accompanied by external financial "burden" in the form of educational loans. Discharging acquired financial obligations as related to academic training, quickly becomes a priority for most psychologists, as they begin their careers. Hence, at this early stage of their professional lives, costs associated with becoming board certified may be a deterrent for some otherwise highly qualified ECPs seeking board certification as substantiation of their competencies in an ABPP specialty. The goal of the Foundation’s ECP Scholarship Program is to provide financial support (up to $825) for early career psychologists, meeting criteria for board certification within their chosen area of ABPP specialty.

The Foundation recently received a very gracious contribution to be applied to this scholarship program from CPPSA. It consequently advertised about this program online, to specialty boards/academies, and to relevant APA divisions and their ECP networks.

**Fundraising** The Foundation’s work is financially dependent upon donations from our ABPP specialists, their families, friends, and colleagues. In 2020, the Foundation awarded 34 grants/scholarships to training directors, ECPs and psychologists in specialty specific boards. The scholarships range from $800 to $1500 per person each year. The Foundation receives periodic donations that are made when specialists renew their status with ABPP. The ABPP Foundation reception (and booth) is our major fundraising event, which is held during the APA convention. Sponsors and individual donors contribute to the reception and scholarships. Due to the COVID-19 public health crisis, APA pivoted from an in-person venue to a virtual meeting. With no convention this year, the Foundation is working to increase both individual and corporate donations.

If you share the Foundation’s goals to promote board certification as a part of one’s career development and advance the importance of psychology board certification to the public and related professions, we hope you will donate to the general fund or to a specific fund described in our website. With your generous donations, the ABPP Foundation will be able to double the annual scholarships to many candidates for board certification.

Please make your charitable contribution online at [https://abpp.org/Foundation2/Donate-Now!.aspx](https://abpp.org/Foundation2/Donate-Now!.aspx) or mail your contribution directly to: ABPP Foundation Administrator, 1785 E. 700 Road, Lawrence, KS 66049.
Understanding the Role of Public Health Ethics in COVID-19

John Billig, PhD, ABPP-Clinical Chair, ABPP Ethics Committee**

During public health emergencies such as the COVID-19 pandemic, action on the part of governments or governmental agencies are taken to promote and protect the health of the public. Public health decisions are usually made and enforced by the state and may involve imposing limits on individual liberties for the benefit of the broader population. Government has a duty to protect citizens from harm. In response to a pandemic, this involves actions to minimize illness and death, reduce contagion, preserve an essential workforce, and rebuild the economy and society. Actions taken during the COVID-19 pandemic designed to minimize transmission of the virus, such as mandates for masking, social distancing, school and business closures, stay at home orders, and restrictions on social gatherings, prioritize the health of the community while imposing restrictions on individual liberty. Public health ethics provides a framework based on principles and values to guide decision-making and to justify public health actions. Restrictions imposed on individual liberty may be ethically justifiable if evidence supports that the restrictions will achieve the desired outcome, the harm from the individual liberty infringement is proportional to the public health benefit, and the least restrictive means of liberty infringement is used.

Practicing psychologists have faced various ethical challenges during the COVID-19 pandemic. “How can I continue to provide care to patients while maintaining safety and preventing spread of COVID-19?” “Is it ethically justifiable for me to provide services remotely via teleconferencing if I have never previously done so?” “Are psychological services provided remotely functionally equivalent to face-to-face, in person services?” “How do I balance the fiduciary duty to care for patients while maintaining the safety of myself and my family?” “What are my obligations if my patient does not have internet connectivity to meet virtually, yet declines to wear a mask if meeting face to face?”

Many of these questions can be resolved by following guidance in the APA ethics code, which provides a set of general principles (Beneficence and Non-maleficence, Fidelity and Responsibility, Integrity, Justice, and Respect for People's Rights and Dignity) and enforceable Ethics Standards to guide conduct of individual psychologists. For example, the standards of Competence include requirements regarding Boundaries of Competence (2.01), Providing Services in Emergencies (2.02), and Personal Problems and Conflicts (2.06).

Other ethical challenges during COVID-19 require balancing personal, clinical ethics standards that focus on meeting the needs of individuals, to standards and guidelines that address the needs of the community or population. “How are decisions made to allocate scarce resources during COVID-19, including personal protective equipment such as masks and life sustaining resources such as ventilators and ICU beds?” “As a licensed psychologist, I am eligible for receiving the COVID-19 vaccine, even though I do not see patients face-to-face; should I get the vaccine or forgo it so someone of greater need might receive it?” Public health ethics provides a framework to understand and resolve these issues. Multiple sets of recommendations for equitable allocation of scarce life-saving clinical resources have been developed. For example, the Veterans Health Administration resource, Meeting the
Challenge of Pandemic Influenza: Ethical Guidance for Leaders and Health Care Professionals in the Veterans Health Administration (Veterans Health Administration, 2010), provides guidance to leaders and staff in VA health care organizations for pandemic planning and response. The guidance discusses a leadership decision-making process that is informed and participatory, values-based, beneficial, systems-focused, reasonable, and transparent, as well as norms of health care professionalism such as ethical duty to provide care and non-abandonment, respect for persons, duty to benefit and to prevent harm, and fairness.

Understanding the purpose that underlies public health actions and requirements, that is, of promoting, restoring, and maintaining the health of the population, and knowing that these actions are carried out with consistency, fairness, and transparency, can provide reassurance to psychologists who are concerned about the impact on their clients and themselves. Additionally, understanding the focus of public health ethics can lead to values-based championing of behaviors precisely for their communitarian purposes and beyond simple rules-based or individual-based reasons. Thus, one can choose to wear a mask primarily to benefit the health of the community, rather than simply to protect oneself or because there is a mandate for wearing one. Likewise, getting a COVID-19 vaccination when one is eligible not only provides the individual with protection from the coronavirus, but also contributes to the eventual development of herd immunity in the population. Looking at the various ethical challenges that arise during the COVID-19 pandemic through the lenses of professional ethics codes, person-based individual health care ethics, and population-based public health ethics can provide a balanced view which will optimize ethically justifiable options for the community and individuals.

References


**The views expressed in this article are those of the author and do not necessarily reflect the position or policy of the Department of Veterans Affairs or the United States government."
Boosting Brain Boosters: Implementing the Brain Boosters Program for Veterans and Converting to Telehealth.

Submitted by:
Mary Lu Bushnell, PsyD, ABPP-CN and Nicole A. Roberts, PhD.

Background
Brain Boosters is a psychoeducational group created by Phoenix VA neuropsychologists, Drs. Mary Lu Bushnell and Kathleen Goren in 2007. It was initially developed for OEF/OIF Veterans with mild traumatic brain injury to address reports of cognitive impairment and psychological factors that may underlie cognitive complaints in individuals with a history of mild traumatic brain injury. Brain Boosters quickly grew in popularity, given the opportunity it provided Veterans to learn more about brain health and compensatory strategies in a supportive, strength-based group environment. It has expanded to become a program for Veterans of all eras. The group includes education regarding lifestyle and health factors that have been shown to promote brain health over the lifespan. Participants are Veterans with documented or perceived cognitive impairment or those who simply want to learn more about how to keep the brain healthy. Significant others or other support people are encouraged to participate. Approximately 100 people attend the groups each year at the Phoenix VA (approximately 5-15 participants per group), based on referrals from providers from various disciplines throughout the hospital. Additionally, the program has been manualized and distributed to approximately 70 VA facilities over the past decade.

Group Content and Format
Brain Boosters is an innovative and interactive 8-week program that covers a different topic each week. Groups combine psychoeducation and experiential activities. Participants are provided with manuals and optional homework or “opportunities for growth.” Guest speakers from within the VA also are an important component of the program. These guest presentations vary in length and include topics such as insomnia, nutrition, PTSD, medications and cognition, and the VA’s Whole Health program. In addition to education, the speakers also highlight related VA resources and programs.

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Sleep – The relationship between sleep and brain health is discussed. Insomnia is explained and sleep hygiene tips are reviewed. Participants are also introduced to the treatment, Cognitive Behavioral Therapy for Insomnia (CBT-I).

Medication, Neuroanatomy and Attention – Medications and cognition are discussed by a member of the pharmacy team. Basic neuroanatomy is reviewed. The role of attention and how attention can be impacted by various factors (e.g., pain) is presented. Strategies to improve attention are also discussed.

Memory & Memory Strategies – Different types of memory are discussed. There is also a review of memory compensatory strategies.

Executive Functioning – Executive functioning is explained as well as a discussion of what occurs when executive functioning is disrupted. Goal setting and the importance of routine and habits are presented.

Post-Traumatic Stress Disorder – This presentation discusses the symptoms of PTSD and how PTSD can impact cognitive functioning. PTSD treatments are also discussed with the group.

Emotions, Communication Skills & Wrap Up – The final week discusses emotions and emotional regulation. Communication skills are also reviewed. Finally, we review what was discussed over the prior 7 weeks and discuss plans for continued activities that group members can engage in to promote lifetime brain health.

Psychoeducation can be an important key to change (Lukens & McFarlane, 2004) and Brain Boosters is a non-threatening and non-stigmatizing opportunity for Veterans to learn about the potential impact of comorbid mental health conditions and mental health services. The group format is especially beneficial because of the sharing of ideas, group discussion, support and encouragement offered by the group members. The group format also enables participants to realize that others are experiencing similar challenges and to know that they are not alone.

Preliminary exploratory research findings have revealed that the Brain Boosters program is not only feasible to implement in a heterogeneous Veteran population, but also is associated with improvements pre- to post-treatment in perceived memory functioning for younger Veterans, and in attention and depression symptoms for Veterans across age groups (Roberts et al., 2020).

Transition to Telehealth-
The most recent, and biggest, update to the program occurred in 2020 in response to the COVID-19 pandemic. All groups were transitioned to telehealth via the VA Video Connect platform. The exercises and materials were modified...
and adapted to be used and distributed virtually (e.g., PDF handouts and website links are sent electronically via the chat feature and My HealtheVet Secure Messaging). While the group was converted to telehealth to ensure Veteran safety during the pandemic, it resulted in several unanticipated positive consequences. First, while Brain Boosters has always been a popular group, converting to a virtual format has significantly increased the numbers of interested Veterans. To meet this demand, we have added an additional (third) Brain Boosters group each week. Geographic distance, childcare responsibilities, and transportation limitations are no longer barriers preventing individuals from attending. Veterans have repeatedly expressed appreciation for being able to attend the group remotely. We have also seen fewer no-shows and cancellations and an increase in significant other/family member participation with the virtual groups. Second, the connection among group members, albeit virtually, has been especially strong during the COVID-19 pandemic. Participants are exchanging phone numbers, words of support, and heartfelt appreciation of shared experiences. While this type of sharing also occurred during face-to-face groups, it appears that the connection and support among group members has been even stronger in these virtual groups offered during the COVID-19 pandemic. Whether it is due to higher numbers of individuals feeling socially isolated, increased stressors, greater comfort with an online medium, and/or other factors, this connection has been a strength of the virtual program. Third, as typical routines have been disrupted as the result of the COVID-19 pandemic, this has proven to be an especially important time to review and discuss ways to incorporate healthy lifestyle behaviors (healthy diet, exercise, stress reduction, etc.). The shared stories of how people are creating new exercise routines or implementing relaxation strategies have been beneficial and encouraging to other participants.

Lessons Learned
Over the past year we have learned several lessons about facilitating a virtual group. Two group leaders are imperative so that one can assist individual patients with technology as needed. A smaller group size (5-8 people) is optimal to enhance discussion and increase connection. It has also been helpful to contact the patients individually prior to the group to orient them to the process, answer questions and ensure they have access to and understand the technology required to participate. We have also found that it is important to set clear expectations at the beginning of the group (e.g., muting the microphone when not speaking, arriving on time, not engaging in other activities during group, etc.) to ensure a smoother and more enjoyable group experience for all. While we encourage participants to keep the camera on to facilitate more social interaction, group members have shared that they also appreciate having the option to turn off the camera when needed and still be able to passively participate in the group.

There are, of course, limitations to the virtual group. Some participants cannot participate due to technology limitations, cognitive limitations, or both. Other participants have declined the virtual format outright, opting to wait for the face-to-face option. Technology has its own inherent limitations and at times patients and providers encounter technical difficulties. We have used this as an opportunity to teach problem solving skills (and on occasion stress management skills) in order to overcome these challenges.

Future Directions
Given the popularity of this new format, Brain Boosters is expected to be offered virtually as well as face-to-face going forward. We look forward to conducting research on the virtual Brain Boosters program as part of multi-site study. For clinicians or researchers interested in learning more, contact Mary Lu Bushnell, PsyD, ABPP-CN, at mary.bushnell@va.gov.
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About the Authors:

Mary Lu Bushnell, PhD, ABPP-CN, is the Director of Training for Neuropsychology Fellowship Program and is board certified in clinical neuropsychology and a practice sample reviewer for the American Board of Clinical Neuropsychology. She provides consultation to the post-deployment clinical team and TBI Clinic and conducts outpatient neuropsychological evaluations. Dr. Bushnell co-developed and leads the Brain Boosters cognitive enhancement group. Prior to joining the VA in 2007, Dr. Bushnell worked at a community agency where she conducted neuropsychological evaluations, cognitive rehabilitation and psychotherapy with individuals with brain injury. She has provided education regarding traumatic brain injury to organizations such as the Phoenix and Mesa Police departments, National Guard Medical Command, court system, and vocational rehabilitation. Dr. Bushnell serves as a member of the Arizona Division 18, Psychologists in Public Service Governor’s Council on Spinal and Head Injuries and has served as the treasurer/secretary for APA. Finally, Dr. Bushnell is currently working on a study researching TBI clinics.

Nicole A. Roberts, PhD received her doctorate in clinical psychology from the University of California, Berkeley in 2003 and completed her clinical internship and postdoctoral training at the Northern California Veterans Administration Health Care System and University of California, Davis Department of Psychiatry. Prior to joining Arizona State University in 2006, she was an assistant professor in the Department of Psychology at the University of Wisconsin-Milwaukee.

Dr. Roberts’ research focuses on the study of emotion and on the cultural and biological forces that shape emotional responses. For example, this research investigates how ethnicity and culture influence emotional displays and experiences; how the daily hassles of life, such as job stress and sleep deprivation, impact emotion regulation among individuals and couples; and how the emotion system breaks down in patients with psychopathology (e.g., post-traumatic stress disorder) or neurological dysfunction (e.g., seizure disorders). Roberts uses both observational and psychophysiological measures in her work. Her research has been published in the Journal of Marriage and the Family, Journal of Cognitive, Affective, and Behavioral Neuroscience, and Emotion. Her areas of teaching specialization include abnormal psychology, multicultural issues in clinical psychology, emotion, and supervision of undergraduate and graduate research and practicum experiences.
Online Seminars for Trainees During COVID-19: What Have We Learned?

Many board certified psychologists are actively involved in internship and postdoctoral training programs where we participate in designing, coordinating, and delivering clinical seminars for trainees. When the COVID-19 pandemic began and physical distancing requirements led our trainees to begin delivering services remotely, we made a rapid pivot to online learning in order to bring our trainees together from their various locations. Like so many other meetings, we began holding seminars on Zoom or other teleconferencing platforms. This was just one of the many accommodations that psychology training programs across the country made to offer flexibility and maintain educational experiences despite the disruption to our usual formats and training procedures.

Now that we can see hope on the horizon for returning to on-site service delivery and training, we have the opportunity to evaluate how well our accommodations have worked. In a recent article summarizing the massive shifts in psychology training across the U.S. during the pandemic, Bell et al (2020) notes that the quick and substantial changes to our programs may represent a “watershed moment” for psychologists to consider our identity and the way we implement our training programs. They pose the question of whether the movement to distance learning will be considered a temporary stop gap measure or a long-term approach that remains as a viable mode of training. The authors point out that the flexibility offered by online learning could lead to expanded opportunities for collaboration across training programs that could enrich our trainees’ educational experience. Likewise, a review of changes in Canadian psychology training programs during the pandemic concludes that the transition to online formats could lead to increased access to offerings that promote greater equity in training opportunities (Goghari, et al., 2020). On the other hand, it may be wise to ask if there are significant costs associated with the delivery of our training seminars in an online format.
In our roles as faculty in a psychology internship and a postdoctoral training program this past year, we are glad to report that our trainees have experienced a program that has been as close to business as usual as might be imagined. However, we do note that it has been a struggle to maintain the usual level of energy and engagement in our weekly seminars that are now virtual. Similar to what we observe when we participate in synchronous online continuing educational offerings, we find that trainees are tempted to multi-task when they are not in the same room with the presenter. Other tasks and responsibilities compete for their attention, and it is easier for them to pull back and function under the radar when they do not have the accountability of face-to-face interactions. Will this become the new norm? Indeed, we have noticed some of our colleagues multi-tasking during online meetings and conferences we have attended over the past year, and some not even turning on their cameras. Do we need to establish explicit expectations for participation in online training seminars or can we assume that adult learners will take responsibility for their learning without providing this kind of structure and direction? How can we assure that our trainees are learning all that we hope for them to learn during these seminars? It also speaks to the issue of professionalism and the unspoken expectations about behavior, which are much easier to define when we are in person.

Learning is a two-way street. Clearly, as educators, we have a responsibility to design our seminars in a way that maximizes active engagement. When the pandemic suddenly descended, we scrambled to shift our seminars online, with many of us likely assuming that our previous content and methods would translate easily or without much modification to the new format. However, like our colleagues in other academic settings, we have found that the online environment calls for alterations in our approaches. In a recent article reviewing psychology professors’ experiences with transferring their courses online during the pandemic, many report working harder than ever during the past year to make the transition (Abramson, 2021). To keep students engaged during online synchronous classes, professors are using creative approaches such as polling students and embedding quiz questions and bite-sized videos into their lectures. Others use the chat feature to encourage participants to weigh in with questions and comments. Anticipating that Zoom fatigue may detract from the participants’ energy, educators may need to go the extra mile to create interactive exercises to draw trainees into the discussion. The payoff for this time investment may be higher quality, more engaging seminars when we return to face-to-face interactions.

As for the learner’s perspective, we are continuing to discover that although the online format offers convenience, it may not live up to the in-person experience. In a nationwide study of undergraduate students who transitioned to online courses mid-semester during the onset of the COVID-19 pandemic, student evaluations showed that they rated their classes as less enjoyable, less interesting, instilling less learning, holding less attention, motivating less effort, and including less cultural content/considerations after the transition. Of course, these findings may reflect the unique disruption of teaching methods mid-semester, which did not allow for careful planning and triggered a disappointing change in expectations for course delivery. The findings are also based on undergraduate experiences, unlike those of our trainees who are presumably more motivated to hone their craft. When the new training years began last summer for our internships and post-doctoral programs, our trainees came in with the expectation of remote learning and we had more time to adjust the design of our seminars. Nevertheless, we need to acknowledge that the online format may not be the preferred or optimal format for our trainees, even if they enjoy the convenience. We may need to be more active in holding them accountable for their learning when they meet online and setting norms for active participation. The same expectation also needs to be held for our peers during online meetings so as to set a professional example for our trainees. We also need to acknowledge that the reduced contact between our trainees in other settings throughout their training programs due to the pandemic has likely impacted levels of group cohesion in their cohorts, perhaps contributing to less connection of when they meet for seminars. This raises larger questions about how we can retain a sense of community, solidarity, and
camaraderie within our programs if we continue to utilize remote learning platforms (Goghari, et al., 2020).

The changes we have made over the past year in response to the pandemic offer us an opportunity to revisit what is important to us in our training programs. We encourage other psychologists who are involved in training to voice their opinions on this issue, and we hope that regulatory bodies, such as the Association of Psychology Postdoctoral and Internship Centers (APPIC) and the Council of Chairs of Training Councils (CCTC) examine and consider these issues carefully as we move beyond the pandemic and continue to improve our programs.

References:


Prospective ABCN specialists often dread the oral examination the most, out of the four steps required to achieve board certification in clinical neuropsychology. However, few of them have had experiences like the following: (1) infantry service in the US Marine Corps during the Iraq War (2003) with specialization in shoulder-fired rockets and explosives, (2) training in urban, jungle, and desert warfare, (3) leading a Maritime Special Purpose Force Squad, and (4) service as a military psychologist in Afghanistan. With these experiences and many more comprising his vast skill set, Dr. Rich Moore completed his two-year postdoctoral fellowship at Walter Reed National Military Medical Center in June 2019 and immediately embarked on pursuit of board certification in clinical neuropsychology.

“The day I received my certificate of completion [from his postdoctoral fellowship] was the day that I submitted my materials for the credential review,” said Dr. Moore, who is currently deployed to Iraq with the US Army and holds the rank of Major. “The day that I learned my credentials were accepted was the day that I registered for the written exam.” Notably, he was stationed in Germany at Landstuhl Regional Medical Center and managed to find a testing center about one hour away that was affiliated with PSI, the company with which ABCN is currently contracted to administer the written exam. After passing the written exam, he submitted his practice samples immediately. “The further you get away from your fellowship, stuff is less fresh,” he said. “The people I talked to who recently went through the process made it clear that it was really important not to delay.”

Dr. Moore's practice samples were then accepted, but then the COVID-19 pandemic hit the globe hard. Like the other specialty boards, ABCN was forced to postpone all in-person examination activities. Dr. Moore's rapid acceleration toward board certification seemed to hit a snag. Ms. Annunciata Porterfield, ABCN's Executive Assistant, informed him that plans were underway for an online oral exam, and that people would be offered registration slots in the order that their practice samples were accepted. He waited, while hoping for the best, and continued to prepare. “I was preparing as if I was going to do it in November,” he said. His deployment to Iraq had been unexpected, which led him to leave behind test manuals and many other reference sources in Germany. “I did the best I could with three textbooks,” he said. “I had to study with a flashlight because my roommate was sleeping.” His housing arrangement consisted of a metal container (similar to a shipping container) that was converted to a sleeping space with bunk beds. In military jargon, these are referred to as containerized housing units (CHUs). He very much hoped to complete the oral examination during his deployment since it afforded him time to study that he would not have enjoyed back in Germany. “I haven't seen my family in four and a half months,” he said. “There was no way I would be able to study in Germany like I can here [in Iraq].”

He then received an email indicating that all of the November 2020 oral exam slots were taken. Dr. Moore replied to Ms. Porterfield and stated that if a spot happened to become available that he would gladly take it. Two weeks later, he received the good news that a spot had opened up and that he was now scheduled for the oral exam in November 2020.
Iraq is in the Arabian Time Zone, which is eight hours ahead of Eastern Time. Furthermore, due to restrictions, Dr. Moore was not able to use his employer-provided computer. Instead, he had to rely entirely on his Android smartphone. Hence, here was a gentleman not even 18 months out of fellowship, stationed in Iraq, and wanting to take the ABCN oral exam on a smartphone (!). For those who are not aware, the ABCN oral exam requires not only communicating over a secure audio-visual link with examiners, but it also requires viewing and discussing an ethics vignette and examining data from a clinical case. Dr. Moore sought to take the oral exam with only what was in the palm of his hand. The relatively small screen size was clearly not an advantage, but he was determined.

The ABCN exam co-chairs, Dr. Bernice Marcopulos and Dr. John Lucas, only became aware of the issue with Dr. Moore's limited technological setup two days before the exam. There was a serious debate about whether he should be asked to postpone his exam and take it once he was back in the USA. It was hard to imagine someone being able to take the ABCN oral exam with only a smartphone as the medium of communication. I had to inform Dr. Moore of this possibility. When I did so, he practically begged for the chance to take the exam. “What can I do to give them the confidence that I can pull this off?” he wondered. I did a test run by connecting to him using Google Meet, which is the platform being used for the ABCN online oral exam. I was able to see and hear him clearly and vice versa. I showed him some hypothetical data and a document approximating an ethical vignette. He had to scroll across his screen to see everything clearly but managed to do so. I then reported the results of the test back to the exam co-chairs.

Although there were serious reservations about the adequacy of Dr. Moore’s setup, the ABCN exam co-chairs allowed him to proceed. “They were just really bending over backwards to accommodate me,” he said appreciatively. And so it happened that Dr. Moore completed the ABCN oral exam in Iraq on a smartphone inside his containerized housing unit. And he passed under perhaps the most unique of circumstances in ABCN’s history. What does the future hold for Dr. Moore? “A lot of faculty jobs are requiring board certification,” he said. “Being a supervisor/teacher interests me. I’m going to keep trying to practice good Neuropsychology and hopefully I can end up on a faculty. I want to pay it forward.”
Tele-supervision: Lessons Learned from a One Year “Clinical Trial”

By Lindsay A. Phillips, PsyD, ABPP & David Mather, PhD, ABPP

In response to the COVID-19 pandemic, much training in health service psychology has made a remarkable pivot to telepsychology services and telepsychology supervision. For the majority of supervisors and supervisees, this has been “new territory,” often without significant prior training or experience in telepsychology. This article is intended to convey a number of lessons learned after a full year of telesupervision in clinical psychology, as well as challenges to consider as we move forward with telesupervision in psychology training.

Telesupervision is described as, “supervision of psychological services through a synchronous audio and video format, where the supervisor is not in the same physical facility as the trainee” (APA's Commission on Accreditation's Standards of Accreditation for Health Service Psychology, 2015, p. 27). Past research on telesupervision focused predominantly on trainees’ perspectives, and trainees are likely to find telesupervision helpful. Inman et al. (2019) analyzed 35 empirical studies from 25 journals and one book chapter published between 1990 and 2016 (content was not found prior to 1990), finding that trainees typically perceived telesupervision as equally effective as in-person supervision, particularly when live and using audiovisual programs. Similarly, Martin et al. (2018) analyzed 11 papers, identifying eight themes that contribute to effective and high-quality telesupervision. Themes identified included trainee characteristics, supervisor characteristics, supervision characteristics, supervisory relationship, communication strategies, prior face-to-face contact, environmental factors, and technological considerations. The first five of these themes are cited as essential to effective face to face supervision (e.g., Falender & Shafranske, 2004; Norcross & Popple, 2017), while the final three are more specific to telesupervision. More recent studies examining trainees’ perspectives (Jordan & Shearer, 2019; Tarlow et al., 2020) indicate that trainees find telesupervision comparable to in-person supervision, including ability to form a supervisory alliance.

Based on this limited research, trainees tend to perceive telesupervision as favorable – or almost as favorable – as in-person supervision. Yet, research should continue. Diversity considerations are unfortunately under-addressed in the current research (Jordan & Shearer, 2019; Falender et al., 2014). We are also limited in our understanding of how telesupervision may promote competence development and if telesupervision affects how supervisors evaluate competencies.

How has it worked this year?

We reached out to several colleagues with Board Certification in Clinical Psychology who have been providing telesupervision over the past year, as well as doctoral students and doctoral interns being supervised by the authors. We simply asked for their impressions after delivering or receiving telesupervision for a year, including what seemed to be going well, and what seemed to be more challenging or frustrating.

Our Board Certified colleagues, our supervisees, and we agreed that telesupervision has become easier and more effective as we have all become more expert with the virtual platforms utilized, including agreement on which platforms available in our programs are most conducive to supervision. Included in this increased expertise is...
accepting that electronic challenges sometimes “just happen” – frozen screens, different capabilities of different computers, tablets, phones, and wireless routers, forgetting to bring the phone charger, etc. As these have been accepted as “normal, expectable” occurrences, they seem to have less impact on the flow of supervision and, therefore, less potential impact on supervisory alliance.

**Advantages**-

Somewhat unexpectedly, we all have found that telesupervision has a few clear advantages over face-to-face supervision. First, a host of commuting and parking issues – activities away from main hospital or university campus, challenging weather, inadequate hospital or campus parking, etc. – are not challenges faced by trainees or supervisors with telesupervision, so regular supervision schedules have proven to be more consistent and less often rescheduled. Second, it is easier to arrange impromptu meetings, particularly at the group level, as space availability is not a concern. Third, supervision sessions can be easily recorded if needed, with no requirement for additional equipment or infrastructure. Fourth, for group supervision in particular, it is far easier to share recordings or documents with the entire group, compared to in person group supervision without large screen video capability. Lastly, direct observation by supervisors, of both clinical care and supervision of supervision, is less intrusive than when the supervisor is in the room, behind a one way mirror, etc. This is particularly true if the supervisors turn off their cameras and are “blank spots” or initials on the supervisees’ screens. Several supervisees emphasized that they believe they are much more “themselves” in clinical service or supervision delivery when direct observation is virtual.

**Breaking Even**-

Consistent with past research (Jordan & Shearer, 2019; Tarlow et al., 2020), none of us found a major negative impact on supervisory alliance in individual telesupervision. Most supervisees agreed that they prefer in person supervision, primarily because of telesupervision’s periodic loss of voice tone and decreased nonverbal cues. None, however, identified these factors as seriously decreasing supervisory alliance or quality of supervision. Supervisees perceived no difference in supervisors’ responsiveness to questions and concerns raised by supervisees, sustained focus of telesupervision on supervisees individualized growth and training needs, delivery of both support and challenge, or ability to appropriately shift focus between clinical training vs professional mentoring.

One caveat in this assessment of equivalence – there was universal agreement that synchronous visual and auditory telesupervision is vastly preferable over telephone supervision. (Telephone supervision had been briefly used before we had videoconferencing programs readily available in some programs.) Supervisees and supervisors readily agreed that everyone is more distractible when utilizing telephone only. This is consistent with previous research (Inman et al., 2019).

**Challenges to Consider**-

Our supervisees raised a few areas of concern with telesupervision which we recommend all supervisors consider. First is a perception raised by some supervisees of feeling more “on their own” with urgent or emergent situations. These supervisees made it very clear that they had never had difficulty immediately reaching any supervisors by phone or text, and that supervisors were just as available as when supervision was in person rather than virtual. Rather, they attributed their feeling to the loss of physical proximity to trusted supervisors in potential crisis situations.

Second, there is a clear and detailed perception that group telesupervision may be less effective than individual telesupervision. Supervisees noted the loss of opportunities for training group cohesion, with the loss of time together as a training cohort both before and after group supervision. Both the group supervisees and supervisors
struggle with the awkward nature of group give and take on virtual platforms, with people needing to talk more sequentially and individually as opposed to a free flowing give and take. Related to this is the inability to clearly see everyone in a larger group simultaneously on the screen, and the associated significant loss of non-verbal cues, much more so than with individual telesupervision. Most notably, for many supervisees this produces decreased feelings of safety in vulnerable discussions in group supervision, as they are far less able to gauge the nonverbal communications of both colleagues and supervisors. This was cited as most notable related to sense of safety in vulnerable discussions of diversity consideration.

Finally, supervisees noted a potential concern related to self-care and the use of telepsychology broadly and telesupervision specifically. Without the need to physically move around to different “events” throughout the workday – classes, patient care, supervision, etc. in different rooms or different buildings – there is less built in “break” between work events, and a tendency to let everything run together and not take moments to reflect and relax. Combined with activity restrictions associated with COVID, this contributes to a blurring of the boundaries between “at work” and “off work,” making self-care more challenging. Telesupervision was not seen as causative in this regard, but was certainly seen as an example.

**Ongoing Considerations**

In this article, we have provided a brief overview of past research on telesupervision, as well as a summary of how some trainees and colleagues with Board Certification in Clinical Psychology have navigated the year, including what has been helpful in telesupervision, and areas we should monitor. Overall, telesupervision has several benefits with past research support, but we could encourage further research in this area well beyond our informal sample and discussion of the lessons we have learned over the past year of increased time in telesupervision.

**Lindsay A. Phillips, PsyD, ABPP** is a practicing licensed psychologist in Pennsylvania, and is board certified in Clinical Psychology. She has received several national accolades, including the 2012 Judy E. Hall, Ph.D., Early Career Psychologist Award from the National Register of Health Service Psychologists and a 2018 Teaching Resource Prize from the Society for the Psychological Study of Social Issues. Lindsay served as Vice President and Northeast Regional Coordinator for the American Board of Clinical Psychology.

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Practical Guidance for Remote Psychological Test Administration and Interviewing

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Abstract

With the advent of the COVID-19 pandemic and subsequent declaration of a national emergency on March 13, 2020, many psychologists’ assessment practices became immediately impractical overnight. The need to protect against COVID transmission by limiting in-person close physical interaction superseded a long-standing professional practice that psychological test administration must be proctored in-person, and the constraints also accelerated the adoption of telemedicine which had been slowly developing. Necessity forced the abrupt adoption of video teleconference technology for both the interview and proctored testing of psychological examinees, despite a lack...
of accepted procedures or studies investigating psychometric validity. This article is intended to provide practical
suggestions on how to offer remote psychological test proctoring and interviewing in the context of forensic adult
assessments, based on the extensive experience of Public Safety Psychological Services prior to, and during the
COVID pandemic, as well as empirical data supporting the validity of video-based psychological interviews and
test proctoring.

On February 29, 2020, the first death in the United States attributed to the novel coronavirus COVID-19 was
reported to have occurred in Kirkland, Washington1, and a state of emergency was announced in Washington State.
While the rest of the country was not yet fully aware of the significance of this event, psychologists in Washington were
beginning to understand the potential implications of the virus and its’ impact on business operations. By March
13, 2020, a national emergency was declared in the United States as a result of the rapid spread of the COVID19
(SARS-CoV-2) virus. Within two weeks, nearly every state was under a “stay home order” and the option to
perform business as usual was suddenly and substantially limited.

Due to the stay home orders, as well as to staff and psychologists’ own concerns about becoming ill or becoming
asymptomatic carriers and then transmitting the virus to their families or patients many psychologists shuttered
their practices and began to ponder the practicality of staying at home “for a few weeks” with the hope that the
pandemic would be short lived. When it became apparent that the pandemic was very likely to cause longer-term
disruptions, the use of video teleconferencing technology, which had seen low but growing usage in telehealth or
teletherapy services, began to look like a necessary alternative to conventional practices.

Prior to the COVID-19 pandemic, a handful of psychologists had utilized remote psychological interviewing to
provide culturally competent counseling services to underserved populations, e.g. the senior author in remote
parts of Alaska, Washington State, and Native American tribal regions within the U.S. However, the vast majority
of psychological interviews, both therapeutic and forensic were conducted in a more traditional in-person office
setting (Pierce, B. S., et al., 2021).

With the advent of the COVID-19 pandemic stay at home orders, a transition to using video teleconferencing
technology (such as Zoom or Google Meet) to complete psychological interviews became a necessary option
for several reasons. First, many interviewees coming from out of state were unable to travel due to logistical
considerations including mandatory quarantines and flight cancellations. Second, psychologists, their office staff,
and, at times, the interviewees fell into what had been defined as a “high risk” group and were advised to stay at
home and to avoid unnecessary contact. Third, many psychologists’ offices were not equipped to follow the rapidly
changing social distancing and infection control guidance from various regulatory agencies. Last, while some
interviewees were able to have their interviews conducted at an institutional setting, e.g., a public safety agency or
a social security disability office, a large majority of these government agencies started limiting facility access to
current employees only. Soon after initial restrictions on access these agencies were compelled to consider the risk
of having interviewees, and, in some cases, psychologists, come into their facilities. These changes occurred very
quickly and psychologists soon found themselves with limited options to continue their work involving testing and
psychological interviews, despite the fact that many potential questions and concerns were yet to be addressed.

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1 The first death is now thought to have occurred in February 6, 2020 in Santa Clara county in California.
Common Concerns about Remote Psychological Interviews

The abrupt transition to video-based interviewing raised a number of issues including the effects on validity of the psychological interview, jurisdictional and licensure issues, and others concerns about best practices in this new era.

Validity of Remote Psychological Interviews

A literature search revealed very little guidance on the practice of remote psychological interviewing. The minimal evidence available suggests results from remote versus in person interviews are similar. Lexcen, et al (2006) examined interrater reliability for two interview-based assessment instruments, the Brief Psychiatric Rating Scale-Anchored Version and the MacArthur Competence Assessment Tool-Criminal Adjudication when administered either in person or remotely to 72 forensic inpatients. Results suggested that clinical information obtained via remote interviewing was similar to that obtained by in-person interview. An analysis of psychological suitability ratings (suitable or unsuitable for public safety employment) comparing pass rates prior to and following a transition to video interviews corroborates these findings within a public safety applicant sample. At a large West Coast police department 356 applicants were screened in 2019 – pre COVID - utilizing face-to-face interviews with an 81.5% pass rate. By comparison, 67 applicants to the same agency were screened using video interviews between May 2020 and February 2021 resulting in a 77.6% pass rate. A chi-square analysis indicates that there is no statistically significant association between pass rate and interview type in this sample (p=.463). Thus, empirical data appear to support the hypothesis that high level information and determinations are equivalent to those obtained from video-based psychological interviews.

Notwithstanding the overall validity of the video interview process, some client agencies and psychologists have also expressed concern about the effect of the video process on the interview at a more granular level.

Video and the subtlety of interpersonal communication

One of the primary objections of psychologists to video interviewing is that the interviewee will provide less information, both physically and verbally, than they would obtain during a face-to-face interview. There is currently no available research that compares the degree of self-disclosure in a remote psychological interview when compared to an in-office interview. Research conducted on video-based psychological treatment, where the subtlety of communication is of the utmost importance, suggests that this concern is unfounded. Wierwille, JL, et. al. (2016) examined the use of telehealth services for treating veterans for PTSD. Their results suggested that veterans receiving treatment via both outpatient (face-to-face) and via telehealth both achieved clinically significant improvements in their reported levels of symptoms. Although the quality of communication produced during psychological treatment is not necessarily equal to the quality of communication in the assessment context, this research does suggest that at a minimum, remote psychological interviewing is likely to be as effective as an in-office interviewing.

Utilizing both in-person and remote video interviews: A case of unequal treatment?

A concern related to unequal treatment stems from the potential legal liability that may result from utilizing different standards for candidates within the same application pool. Historically, this has occurred when different candidates are evaluated by assessors with different subjective standards or interview questions, or where some
applicants are administered a different objective measure than other applications within the pool (e.g., MMPI versus PAI). In the context of this discussion, an applicant who was seen for a video psychological interview and not subsequently hired could make the claim that they were treated unfairly when compared to another applicant who was interviewed by a psychologist in-person. While such a claim may be made in theory, the literature on remote assessment and the empirical data presented above suggests that the allegation of a systematic difference between the processes of an in-person versus video-based psychological interview is unfounded.

Despite the evidence that systematic differences in these interview procedures do not exist, caution must be exercised to ensure the experience is similar across all video interviews as well as between video and in-person interviews. This concept is not unique to video interviews and applies equally to in-person interviews which can be affected by non-standard conditions such as external noises, glare from the sun, or the presence of distractions such as pets. However, as video interviews present as a new format, we discuss below optimal video interview procedures, which will help ensure valid and reliable interview data.

Jurisdictional Issues Related to Telehealth

While many states have laws or regulations regarding the practice of telehealth or teletherapy, remote psychological interviewing for forensic reasons is not addressed by these regulations and is complicated by the fact that the person to be interviewed is almost always not the client. Telehealth as discussed by the American Psychological Association (APA) Guidelines for the Practice of Telepsychology (2013) is focused on the typical therapist-client relationship. The typical case of a public safety psychological assessment is more complicated. In many cases, the psychologist has been retained by a public safety agency to conduct the remote psychological interview. In these cases, the psychologist may be in one state, the agency in a second state and the interviewee in yet a third state. The laws in many states require the psychologist be licensed in the state where the “client” is located, as well as where the psychologist is located. However, when the client is the agency, the question of whether the psychologist must be licensed where the interviewee resides at the time of their interview becomes more complex.

The state where the interviewee resides clearly has an interest in regulating the conduct of a psychologist who has the potential to harm one of its inhabitants, but implementing a three-state licensure requirement quickly becomes unattainable, if agencies routinely recruit from a nationwide pool. This kind of problem with state licensing laws has led to efforts to increase license portability or to promote license reciprocity. For example, PsyPact and associated legislative efforts have made progress toward this goal and are surely more likely to do so post-COVID.

This dilemma is not limited to the practice of psychology. For example the legal profession has also had jurisdictional practice problems that have resulted in litigation and ultimately were addressed by an ABA Commission on Multijurisdictional Practice that produced Model Rule 5.5 which was adopted by most states (Theriot, 2016). Model Rule 5.5 permits temporary practice of law within other states and clearly defines temporary practice with five safe harbors and one catch-all exception where work is "reasonably related to the attorney’s home state work" based on several balancing factors (Theriot, 2016). The creation of such a model rule for the interstate practice of psychology that could be adopted by other states and that would also be adaptable to unique situations and technological innovation is well worth considering within our profession.

While a definitive answer to the question of multi-jurisdictional practice does not currently exist, this ambiguity is a source of potential liability and we encourage our readers to work with their regulators at the state and professional level to make them aware that modern clinical practice – particularly since COVID – has evolved, and the regulations must reflect the new reality.
Recommended Guidelines for Conducting Video-Based Interviews

Faced with the necessity of moving to remote interviewing, many psychologists encountered various difficulties in adapting to the new virtual platform. The lead author has had experience conducting remote psychological interviews in Alaska since 2017, at the request of the client agency, and has conducted approximately 3,500 remote interviews to date. Based on her experience, we offer the following suggestions as best practices.

Before Beginning a Remote Psychological Interview- Practice:

Make sure you are very comfortable using the video conference technology software you have chosen to use. Practice using it on different devices (e.g., Chromebook, desktop computer, tablet, and phone) with your office staff, family or friends before you begin using it with clients.

Adjust your lighting and environment so that the client can clearly see you. Be mindful of what is in the background behind you. You may want to stage your office setting, for example hanging your framed license on a wall behind you, etc.

Ensure that you have chosen a platform (e.g., Zoom, Google Meet) which is HIPAA compliant and confirm that you have a Business Associate Agreement (BAA) agreement in place.

Consider any licensure issues that may arise in the jurisdiction(s) of your practice.

Attend a CEU related to offering telepsychology services.

Verify that your professional liability insurance covers telehealth services.

Ensure adequate screen space on your computer, or use a second screen to allow you to keep the client in full screen view- while simultaneously typing in a document, giving you better visibility of the client’s facial expressions.

Be prepared for technology glitches. If video works but not audio, switch to a hybrid solution using audio via a cell phone call to the interviewee. Know how to make your phone number show up as “unknown” if you wish to do so. Consider what you will do if you lose internet service during the evaluation. Having a back-up “hotspot” device is a potential solution to this dilemma. Be familiar with how to switch to the hotspot.

Prior to the Scheduled Remote Psychological Interview:

Send the applicant new waiver documents to gain consent from the interviewee for remote psychological interviewing.

Send the examinee instructions on how to access the video teleconference link including what devices can and cannot be used for the remote psychological interview. Instruct them to test these devices using the designated video teleconferencing platform prior to the day of their interview.

Include information on what to do if the applicant has difficulties connecting on the day of their interview.

Ensure that you and the applicant are logged out of all other programs on the computers being used for videoconferencing to avoid distractions and the sounds of notifications from an open programs.

At the Start of the Remote Psychological Interview:
Confirm the interviewee's identity (e.g., have him/her/them show you a photo ID)

Ensure the applicant is in a private space. If possible, ask them to move their device with the camera around so you can verify they are in an appropriate location.²

Remind the interviewee that they cannot attempt to record the session and cannot take screenshots of the interview or take any notes during the session.

Remind them not to use their device for anything else during their interview (e.g., clicking on notifications that pop up, etc.)

Ensure that you can see the applicant clearly. If they are sitting with a window behind them, often the glare from the window will make it difficult to see them. Ask them to close the window or re-orient their device so you can best see them. If they are unable to move their device, rescheduling the interview is advised.

Obtain a phone number and/or email address from the interviewee in case of a lost connection.

When conducting certain types of evaluations, you may want to obtain an emergency contact information in the event that the interviewee makes any statements that indicate they may be a danger to themselves and or others.

**During the Interview:**

Avoid making initial assumptions about eye contact. When using various devices, the camera angle may make it appear that the applicant is avoiding eye contact, when it may be that their device is oriented in such a way that it precludes direct eye contact. If you suspect this is the issue, ask the applicant to maneuver the device so you can have better face-to-face eye contact.

Be aware of any personal reaction you have regarding items you may view in the interviewee's setting. Monitor yourself for the presence of any biases that may arise within you when viewing these items.

Do not assign meaning to pauses that seem longer than you might expect. While most video conference platforms allow for nearly real time communication, there can be a slight delay which can feel like a person pausing longer than you would expect to answer. If the source of the delay is due to the technology, employ backup strategies discussed above.

Practice a script for the ending of the interview so it does not seem abrupt. Model as closely as you can any closing statements or information that you would provide during an in-office interview.

**Common Concerns about Remote Proctoring of Psychological Tests.**

The COVID-induced shift to video interviewing was a sea change in the practice of public safety psychologists, but the impact on the profession's view of in-person test proctoring was even greater. Prior to COVID, the requirement that psychological tests such as the MMPI, PAI, or CPI must be proctored in-person was seen as an inviolable professional standard. This professional standard was adhered to partially out of historical inertia, but

² Note: When the COVID19 pandemic stay at home orders were put into place, nearly all interviewees were interviewed from their homes and were sometimes in their closets, spare rooms, and occasionally in their parked cars. As long as their environment met the criterion of being a private space, the interviews were conducted.
also as a result of legitimate concerns about test security and the validity of test results taken under unorthodox conditions (Bartram, 2008). Despite these concerns, remote video-based proctoring of psychological tests has become standard during the COVID-19 pandemic and will likely remain in use after restrictions are lifted to address specific situations such as applicants being recruited out of state, or serving agencies in remote regions. This forced experiment has resulted in the propagation of several services to meet the need for competent remote proctoring. For example, services such as ProctorU (www.proctoru.com) and WeProctor3 (www.weproctor.net) now offer video-based proctoring conducted in a structured and secure manner that upholds test security and validity.

Common concerns expressed regarding tests administered without in-person proctoring echo these threats:

Applicants may copy test questions

In a video proctored test administration the medium used to administer the psychological tests (booklet, computer) is no longer in the control of the test proctor. Instead, the applicant may utilize a computer with a webcam at a client agency, or more likely due to COVID constraints, their personal computer while sitting in their own home. The lack of control of the device used to deliver the test material in the video proctored session raises the possibility that the applicant could print, download, or screenshot test questions and distribute them to the public. It is impossible to fully eliminate this risk, but it may be mitigated through procedures and appropriate technological measures.

The applicant must be made fully aware of the requirements of the remote testing process including the prohibition on engaging in any of the above behavior. To this end, our firm has developed a Remote Administration Agreement (RAA), which test takers are required to sign and return stating that they will not use other devices, will not attempt to record information, will not look up item statements, etc. Additionally, they are required to turn off their phone and place it out of their reach. Finally, the test administrator should use all available technological means from the test publisher to limit access to test materials to applicants and only for the limited time of the test session. Different publishers utilize different means of controlling test access and it is important to become acquainted with them and know how to use them. One example of this is the use of a random, time-limited cycling password by the JRA testing platform. By using a cycling password that is active for only a short period of time and only given to applicants at the time of their testing appointment, the risk of the applicant accessing materials outside of the test session or distributing information that would allow others to do so is minimized. Other publishers utilize means of restricting access to test materials as well, such as Pearson’s use of a one-time password for QGlobal testing access.

The potential to “cheat” by consulting others or other materials

Another concern is that applicants may “cheat” the process by consulting with others or accessing unauthorized materials during the testing process. This threat could take the form of another individual claiming to be an applicant when they are not, or having another individual in the room but out of the video frame, or referencing materials out of the video frame or on the device that they are using to take the assessment.

To ensure the integrity of the testing process, psychologists or their test proctors are encouraged to ask the test takers to show the proctor identification in real time as well as their physical environment by rotating their device.

Applicants’ test results may be affected by technological problems

A common concern related to test validity is the threat from technological problems. Permitting applicants to take

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3 WeProctor is a service offered by Public Safety Psychological Services.
psychological tests on their own devices raises the concern that the testing platform will not work smoothly, or at all, on the platform they choose. This is a particular concern with cognitive measures where resolution, website speed, and method of cursor control could greatly affect test scores.

In developing our standardized test protocol, we validated our test battery on various devices. We were able to ensure that even the most basic computer or device could access our online site and we allowed test takers to use their phones solely for the interview video platform.

Applicants may respond differently to tests administered without an in-person proctor

In addition to the concerns noted above, there is also a fundamental psychometric concern related to the altered testing situation. While studies have shown that psychological tests such as the MMPI, PAI and CPI that are taken by computer generate results that are equivalent to a pencil and paper administration (Bartram, 2008; Forbey & Ben-Porath, 2007), the same does not necessarily hold for computer-based administration without the typical in-person proctor.

Research conducted in similar high-stakes testing environments, but with different psychological test measures, suggests that differences in test results between the two environments should be minimal (Bartram, 2008). In order to specifically address the situation of high-stakes testing in the context of pre-employment public safety assessment, we performed an analysis comparing CPI and PAI data obtained in a pre-COVID, in-person proctored setting and a COVID, remotely video proctored setting (See Tables 1 and 2).
Table 1

*Proctoring Condition Comparisons of CPI-260-PPSR Scales and Risk Statements*

<table>
<thead>
<tr>
<th>Scale/Risk Statement</th>
<th>Mean Difference</th>
<th>t (Cohen’s d)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk Statements</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Involuntary Departure</td>
<td>-0.2</td>
<td>-0.79 (.04)</td>
</tr>
<tr>
<td>Poorly Suited</td>
<td>-0.02</td>
<td>-0.03 (.00)</td>
</tr>
<tr>
<td>Drug Abuse</td>
<td>-0.2</td>
<td>-0.43 (.02)</td>
</tr>
<tr>
<td>Drug Problems</td>
<td>-0.3</td>
<td>-1.15 (.06)</td>
</tr>
<tr>
<td>Alcohol Problems</td>
<td>0.1</td>
<td>0.20 (.01)</td>
</tr>
<tr>
<td>Anger Problems</td>
<td>-0.3</td>
<td>-1.05 (.06)</td>
</tr>
<tr>
<td>Job Problems</td>
<td>-0.6</td>
<td>-1.05 (.06)</td>
</tr>
<tr>
<td><strong>Folk Scales</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dominance</td>
<td>-0.2</td>
<td>-0.53 (.03)</td>
</tr>
<tr>
<td>Capacity for Status</td>
<td>-0.7</td>
<td>-2.04 (-.11)*</td>
</tr>
<tr>
<td>Sociability</td>
<td>-0.4</td>
<td>-1.34 (.07)</td>
</tr>
<tr>
<td>Social Presence</td>
<td>0.1</td>
<td>0.46 (.03)</td>
</tr>
<tr>
<td>Self-Acceptance</td>
<td>0.1</td>
<td>0.28 (.02)</td>
</tr>
<tr>
<td>Independence</td>
<td>-0.1</td>
<td>-0.41 (.02)</td>
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<tr>
<td>Empathy</td>
<td>-1.4</td>
<td>-3.73 (-.20)*</td>
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<tr>
<td>Responsibility</td>
<td>-0.6</td>
<td>-1.85 (-.1)</td>
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<tr>
<td>Socialization</td>
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<td>0.36 (.02)</td>
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<td>Self-Control</td>
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<td>Good Impression</td>
<td>0.0</td>
<td>0.04 (.00)</td>
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<tr>
<td>Communality</td>
<td>0.8</td>
<td>2.28 (.12)*</td>
</tr>
<tr>
<td>Well-Being</td>
<td>-0.1</td>
<td>-0.50 (.03)</td>
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<tr>
<td></td>
<td>Value</td>
<td>z-score</td>
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<tr>
<td>--------------------------</td>
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<tr>
<td>Tolerance</td>
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<td>-1.49</td>
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<td>Achievement-via-Independence</td>
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<td>Conceptual Fluency</td>
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<td>Insightfulness</td>
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<td>-1.21</td>
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<tr>
<td>Flexibility</td>
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<td>-1.10</td>
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**Vector Scales**

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<tr>
<th></th>
<th>Value</th>
<th>z-score</th>
<th>p-value</th>
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<tbody>
<tr>
<td>Internality/Externality</td>
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<td>0.09</td>
<td>0.01</td>
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<tr>
<td>Rule and Norm Violating/Following</td>
<td>-0.1</td>
<td>-0.47</td>
<td>0.03</td>
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<tr>
<td>Ego Integration</td>
<td>-0.7</td>
<td>-0.68</td>
<td>0.04</td>
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**Special Purpose and Research Scales**

<table>
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<tr>
<th></th>
<th>Value</th>
<th>z-score</th>
<th>p-value</th>
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<tr>
<td>Integrity</td>
<td>0.0</td>
<td>-0.11</td>
<td>0.01</td>
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<td>Work Orientation</td>
<td>-0.4</td>
<td>-1.47</td>
<td>0.08</td>
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<td>Managerial Potential</td>
<td>-0.6</td>
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<td>Leadership</td>
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<td>-1.78</td>
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<tr>
<td>Law Enforcement Orientation</td>
<td>0.8</td>
<td>2.24</td>
<td>0.12*</td>
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<tr>
<td>Amicability</td>
<td>-0.6</td>
<td>-2.07</td>
<td>0.11*</td>
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<tr>
<td>Narcissism</td>
<td>0.3</td>
<td>0.64</td>
<td>0.03</td>
</tr>
<tr>
<td>Hostility</td>
<td>0.5</td>
<td>1.24</td>
<td>0.07</td>
</tr>
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</table>

*Note. Values displayed for the risk statements, v1, v2, and v3 are raw values. * denotes statistical significance at the p < .05 level.*
### Table 2

**Proctoring Condition Comparisons of PAI-PPSR Scales and Risk Statements**

<table>
<thead>
<tr>
<th>Scale/Risk Statement</th>
<th>Mean Difference</th>
<th>t (Cohen’s d)</th>
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</thead>
<tbody>
<tr>
<td><strong>Risk Statements</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poorly Suited</td>
<td>-1.1</td>
<td>-1.38 (-0.07)</td>
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<tr>
<td>Drug Abuse</td>
<td>-0.9</td>
<td>-1.09 (-0.06)</td>
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<tr>
<td>Drug Problems</td>
<td>-0.4</td>
<td>-0.85 (-0.05)</td>
</tr>
<tr>
<td>Alcohol Problems</td>
<td>-0.6</td>
<td>-0.85 (-0.05)</td>
</tr>
<tr>
<td>Anger Problems</td>
<td>-0.5</td>
<td>-0.64 (-0.03)</td>
</tr>
<tr>
<td>Integrity Problems</td>
<td>-1.6</td>
<td>-1.41 (-0.08)</td>
</tr>
<tr>
<td>Job Problems</td>
<td>-0.1</td>
<td>-0.22 (-0.01)</td>
</tr>
<tr>
<td><strong>Folk Scales</strong></td>
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<tr>
<td>Inconsistency (Icn)</td>
<td>0.1</td>
<td>0.25 (0.01)</td>
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<tr>
<td>Infrequency (Inf)</td>
<td>-0.9</td>
<td>-1.86 (-0.1)</td>
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<td>Negative Impression (Nim)</td>
<td>0.1</td>
<td>0.55 (0.03)</td>
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<td>Positive Impression (Pim)</td>
<td>-0.2</td>
<td>-0.46 (-0.02)</td>
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<td>Somatic Complaint (Som)</td>
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<td>-0.72 (-0.04)</td>
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<td>Anxiety (Anx)</td>
<td>-0.1</td>
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<td>Anxiety-Related Disorders (Ard)</td>
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<td>Depression (Dep)</td>
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<td>Mania (Man)</td>
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<td>Paranoia (Par)</td>
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<td>0.71 (0.04)</td>
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<tr>
<td>Schizophrenia (Scz)</td>
<td>0.0</td>
<td>0.07 (0)</td>
</tr>
<tr>
<td>Borderline Features (Bor)</td>
<td>-0.2</td>
<td>-0.68 (-0.04)</td>
</tr>
<tr>
<td>Antisocial Features (Ant)</td>
<td>0.0</td>
<td>-0.02 (0)</td>
</tr>
<tr>
<td>Alcohol Problems (Alc)</td>
<td>-0.2</td>
<td>-0.64 (-0.04)</td>
</tr>
<tr>
<td>Scale / Risk Statement</td>
<td>Mean Difference</td>
<td>T(Cohen's d)</td>
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<tr>
<td>------------------------</td>
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<td>Aggression (Agg)</td>
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<td>1.49 (0.08)</td>
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<td>Suicidal Ideation (Sui)</td>
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<td>-0.64 (-0.03)</td>
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<td>Stress (Str)</td>
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<td>0.29 (0.02)</td>
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<td>Nonsupport (Non)</td>
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<td>-0.8 (-0.04)</td>
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**Subscales**

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<td>-2.41 (-0.13)*</td>
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<td>0.66 (0.04)</td>
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<td>Value 2</td>
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<td>Ant-Stimulus-Seeking (Ant_S)</td>
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<tr>
<td>Agg-Aggressive Attitude (Agg_A)</td>
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<td>0.44</td>
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<td>Agg-Verbal Aggression (Agg_V)</td>
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<td>Agg-Physical Aggression (Agg_P)</td>
<td>-0.1</td>
<td>-0.72</td>
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</table>

Note. Values displayed for the risk statements are raw values. * denotes statistical significance at the p < .05 level.

T-tests assessing the difference between the two conditions for the CPI were run in a sample of 689 locally proctored and x remotely proctored applicants and the PAI was run in a sample of 677 locally proctored and x remotely proctored applicants. The t-test results for both instruments show that only 5-6 scales on each measure produced statistically significant correlations and that for those that did, the mean difference was less than 1 T score point for all but the Empathy scale on the CPI (Mean Difference = 1.4 T). Importantly, the results show no meaningful difference in results between the two conditions that would have any clinical significance or impact on a personnel decision.

As with video interviewing, the threats to test security and test validity in the remote proctored administration of psychological tests are of different magnitudes depending on the specific conditions of test administration. The potential testing conditions range from completely un-proctored "take-home" administrations, to access-controlled test sessions with minimal supervising such as identity verification, to video-based administration with a high level of remote supervision (Bartram, 2008; Lawrence & Quist, 2009). To minimize the threats to test security and to test validity, and to achieve valid tests results as we done in our process, we recommend implementing processes and procedures to mimic to the greatest extent possible, the controls typically seen in an in-person proctored environment.
Recommended guidelines for Remotely Administering Psychological Testing via Video.

Prior to the Scheduled Remote Psychological Assessment Session:

Develop a technology plan for your test proctor staff to standardize their equipment. As some staff are working from home, consider having a security plan to ensure that their machines and home networks are secure. For staff working from home, consider an additional stipend or expense for their using their home internet service and/or cell phone.

Ensure that test takers have returned all required documents, e.g. informed consent documents, any remote administration agreement, and a copy of their photo ID.

Develop a “proctor” script to ensure that all test proctors are giving test takers the same information and instructions. Ensure you have a backup plan in case a test proctor’s computer goes down.

During the Remote Psychological Assessment Session

Ensure that each applicant shows ID upon admittance to the video teleconference room.

Develop a standard protocol for allowing test takers to take breaks.

Monitor test takers for any “odd” behavior, e.g. turning off their camera frequently, leaving the room for more than what is a reasonable time frame; constantly looking away from their computer screen, etc.

Noting any odd behavior and/or failure to follow instructions and passing that information along to the interviewing psychologist.

Closing Comments

While many psychologists are likely to return to the practice of in-office testing and in-person interviews when the immediate COVID-19 pandemic situation is resolved, it is almost certain that both remote psychological test administration and remote interviews, when done ethically and with appropriate safeguards in place, will continue. Psychologists may find that being able to serve clients in remote areas where there are a lack of culturally competent psychologists requires the continued practice of remote psychological assessment and interviews. It is our hope that this paper provides some practical suggestions on how to best offer these remote services.

References:


Authors Note:

Cerise M. Vablais received her PhD in Clinical psychology from Fielding Graduate University. She is the managing member of LEPS-PSS, PLLC, (DBA, “Public Safety Psychological Services”) a psychological services firm solely dedicated to offering assessment services to public safety agency clients throughout the Pacific Northwest. She is board certified in Police and Public safety psychology by the American Board of Professional Psychology. She is also a member of the North Sound Metro SWAT Crisis Negotiation Team.

Ryan Roberts and Michael Roberts are members of Public Safety Psychological Services. They provide psychological assessment services to numerous public safety agencies throughout the U.S. and they also author specialized test reports for public safety selection. They are also co-owners of Johnson, Roberts, & Associates, Inc. (JRA), a publisher of specialized selection reports, and receive royalties on sales of the California Psychological Inventory Police and Public Safety Report and Personality Assessment Inventory Police and Public Safety Report, respectively. Michael Roberts is board certified in Police and Public Safety Psychology, by the American Board of Professional Psychology.

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Supplementary Table 1

*Descriptive Statistics of CPI-260-PPSR Scales and Risk Statements in the Locally Proctored and Remotely Proctored Conditions*

<table>
<thead>
<tr>
<th>Scale/Risk Statement</th>
<th>Locally Proctored (n=689)</th>
<th>Remotely Proctored (n=689)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk Statements</strong></td>
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<td></td>
</tr>
<tr>
<td>Involuntary Departure</td>
<td>10.0 (4.0)</td>
<td>10.2 (4.1)</td>
</tr>
<tr>
<td>Poorly Suited</td>
<td>21.8 (12.1)</td>
<td>21.9 (12.3)</td>
</tr>
<tr>
<td>Drug Abuse</td>
<td>26.8 (9.2)</td>
<td>27.0 (9.3)</td>
</tr>
<tr>
<td>Drug Problems</td>
<td>9.9 (4.9)</td>
<td>10.2 (5.0)</td>
</tr>
<tr>
<td>Alcohol Problems</td>
<td>11.8 (5.5)</td>
<td>11.8 (5.4)</td>
</tr>
<tr>
<td>Anger Problems</td>
<td>32.9 (10.7)</td>
<td>33.2 (10.9)</td>
</tr>
<tr>
<td>Job Problems</td>
<td>34.6 (10.1)</td>
<td>35.2 (10.1)</td>
</tr>
<tr>
<td><strong>Folk Scales</strong></td>
<td></td>
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</tr>
<tr>
<td>Dominance</td>
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<td>60.4 (6.2)</td>
</tr>
<tr>
<td>Capacity for Status</td>
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<td>57.5 (6.7)</td>
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<td>Sociability</td>
<td>56.2 (6.1)</td>
<td>56.7 (6.1)</td>
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<tr>
<td>Social Presence</td>
<td>49.4 (5.6)</td>
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<td>Self-Acceptance</td>
<td>57.1 (6.4)</td>
<td>65.4 (5.5)</td>
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<td>Socialization</td>
<td>58.9 (4.9)</td>
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<td>Self-Control</td>
<td>67.4 (6.4)</td>
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<td>Scale</td>
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<td>v2</td>
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<tr>
<td>--------------------------------------------------</td>
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<td>Good Impression</td>
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<td>70.4 (6.3)</td>
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<td>Communality</td>
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<td>Well-Being</td>
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<td>Law Enforcement Orientation</td>
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<td>Hostility</td>
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*Note.* Values displayed for the risk statements, v1, v2, and v3 are raw values.
Supplementary Table 2

**Descriptive Statistics of PAI-PPSR Scales and Risk Statements in the Locally Proctored and Remotely Proctored Conditions**

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<tr>
<th>Scale/Risk Statement</th>
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<th>Remotely Proctored M (SD)</th>
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<td>34.7 (15.8)</td>
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<td>19.4 (13.2)</td>
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<td>33.5 (13.7)</td>
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<td>35.9 (19.8)</td>
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**Subscales**

<table>
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<th>Mean (SD) 1</th>
<th>Mean (SD) 2</th>
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<td>Som-Conversion (Som_C)</td>
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<td>Som-Health Concerns (Som_H)</td>
<td>45.8 (4.3)</td>
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<tr>
<td>Anx-Cognitive (Anx_C)</td>
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<td>43.3 (5.8)</td>
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<td>Anx-Affective (Anx_A)</td>
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<tr>
<td>Anx-Physiological (Anx_P)</td>
<td>42.3 (4.4)</td>
<td>42.1 (4.4)</td>
</tr>
<tr>
<td>Ard-Obsessive-Compulsive (Ard_O)</td>
<td>51.5 (8.7)</td>
<td>51.6 (8.7)</td>
</tr>
<tr>
<td>Ard-Phobia (Ard_P)</td>
<td>39 (6.2)</td>
<td>39.8 (6.7)</td>
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<tr>
<td>Ard-Traumatic Stress (Ard_T)</td>
<td>42.5 (3.1)</td>
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<td>Dep-Cognitive (Dep_C)</td>
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<td>Dep-Affective (Dep_A)</td>
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<tr>
<td>Dep-Physiological (Dep_P)</td>
<td>41.1 (5.5)</td>
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<td>Mean 2</td>
</tr>
<tr>
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<tr>
<td><strong>Man-Activity Level (Man_A)</strong></td>
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<td>42.2 (8.6)</td>
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<tr>
<td><strong>Man-Grandiosity (Man_G)</strong></td>
<td>55 (10)</td>
<td>54.9 (9.6)</td>
</tr>
<tr>
<td><strong>Man-Irritability (Man_I)</strong></td>
<td>39.8 (7.3)</td>
<td>39.5 (7.1)</td>
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<tr>
<td><strong>Par-Hypervigilance (Par_H)</strong></td>
<td>45.2 (8.9)</td>
<td>44.4 (8.7)</td>
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<tr>
<td><strong>Par-Persecution (Par_P)</strong></td>
<td>44.9 (5.4)</td>
<td>45 (5.8)</td>
</tr>
<tr>
<td><strong>Par-Resentment (Par_R)</strong></td>
<td>40.8 (7.6)</td>
<td>40.9 (8.4)</td>
</tr>
<tr>
<td><strong>Scz-Psychotic Experience (Scz_P)</strong></td>
<td>40.9 (6)</td>
<td>41.5 (6.5)</td>
</tr>
<tr>
<td><strong>Scz-Social Detachment (Scz_S)</strong></td>
<td>42.5 (6.2)</td>
<td>41.9 (5.8)</td>
</tr>
<tr>
<td><strong>Scz-Thought Disorder (Scz_T)</strong></td>
<td>40.3 (4.5)</td>
<td>40.3 (4.6)</td>
</tr>
<tr>
<td><strong>Bor-Affective Instability (Bor_A)</strong></td>
<td>39.1 (4.2)</td>
<td>39.1 (4.1)</td>
</tr>
<tr>
<td><strong>Bor-Identity Problem (Bor_I)</strong></td>
<td>40.9 (4.5)</td>
<td>41.2 (5)</td>
</tr>
<tr>
<td><strong>Bor-Negative Relations (Bor_N)</strong></td>
<td>42.2 (6.7)</td>
<td>42.5 (7.4)</td>
</tr>
<tr>
<td><strong>Bor-Self-Harm (Bor_S)</strong></td>
<td>40.5 (4.6)</td>
<td>40.5 (4.6)</td>
</tr>
<tr>
<td><strong>Ant-Antisocial Behavior (Ant_A)</strong></td>
<td>47 (7.4)</td>
<td>47.4 (7.8)</td>
</tr>
<tr>
<td><strong>Ant-Egocentricity (Ant_E)</strong></td>
<td>44.6 (5.5)</td>
<td>44.1 (5.1)</td>
</tr>
<tr>
<td><strong>Ant-Stimulus-Seeking (Ant_S)</strong></td>
<td>45.4 (6.2)</td>
<td>45.4 (5.8)</td>
</tr>
<tr>
<td><strong>Agg-Aggressive Attitude (Agg_A)</strong></td>
<td>36.8 (4.3)</td>
<td>36.7 (4.4)</td>
</tr>
<tr>
<td><strong>Agg-Verbal Aggression (Agg_V)</strong></td>
<td>43.1 (7.4)</td>
<td>42.3 (7.5)</td>
</tr>
<tr>
<td><strong>Agg-Physical Aggression (Agg_P)</strong></td>
<td>43.1 (3)</td>
<td>43.2 (3.2)</td>
</tr>
</tbody>
</table>

*Note.* Values displayed for the risk statements are raw values.
Improving Your Therapy Practice

By Jan Alan Eglen, PhD, HSPP, ABPP

My oldest brother has seemingly always been a very good amateur golfer. Not just very good, he goes into the column of exceptional individuals who have played in major tournaments like the British Open, the Irish Open, and the like, and I would add multiple times. Those are "by invitation only". You get the idea. Most of the time when he is playing, he "Tees the ball up". There may be times on shorter holes where he would hit off the ground, but not often. Why? Teeing the ball up usually means more consistent, often longer, repeatable, more accurate drives. A therapy session is like that. You should "Tee up your therapy" by having a good model that allows you to be more consistent, on target, repeatable, and directly addressing the issues for which the client came to see you. This article is about helping you to do that or at least helping you to think about your current model regarding the mechanics of your therapy sessions and psychology practice in a general sense.

Before you launch into your session, you might be considering what that session is telling you. Perhaps you have heard that a physician can tell many things about a patient just by shaking their hand and looking at their presentation. You can do something similar if you are just observant and thoughtful. The best therapists are constantly assessing, comparing congruency of what is being said with the behaviors, understanding how this all fits together rationally (at least for the patient) and relating it to the database in your head of theory you have learned, experiences you have gained, and the meaning or interpretation of all this, what they now call Big Data. This is the best of the best mental status examinations – not a Folstein or Mini-Mental, more global, but nonetheless highly revealing. This is a comprehensive process of consolidating therapy with evaluation. In my model you cannot become so consumed with therapy (treating), that you fail to constantly be aware of symptoms. You must be able to organize all incoming information and synthesize it into a structure that becomes your plan of therapy recognizing that change in the individual should be occurring if the therapy is effective necessitating a need for treatment to keep up with the individual's status.

The ideas expressed in this chart are not all mine. Several years ago (1990), I believe, I attended a two-day workshop at Georgetown University on how to become an ABPP. The procedure I went through was a bit different than what we use today, but both were / are challenging. During the workshop the participants created a chart like the one that follows though I have added, subtracted, clarified the points to be assessed over the last three decades. I thought the idea was good and adapted it to my model and style of therapy.

So, let's look at what you might be thinking as you conduct the session.

Organizational Structuring of the Relational Model:

<table>
<thead>
<tr>
<th>ASSESSMENT</th>
<th>THERAPY PLAN</th>
<th>THEORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>vegetative states</td>
<td>medical evaluation</td>
<td>cause &amp; effect (linkage)</td>
</tr>
<tr>
<td>history of illness</td>
<td>psychiatric evaluation</td>
<td>associations</td>
</tr>
<tr>
<td>mental status</td>
<td>Neuropsych need</td>
<td>what's going on here (process)</td>
</tr>
<tr>
<td>energy</td>
<td>assets/support groups</td>
<td>what is problem to be solved</td>
</tr>
<tr>
<td>affect</td>
<td>individual</td>
<td>how can problem be broken down</td>
</tr>
</tbody>
</table>
interrelationship skills    bibliotherapy    environmental factors
speech pattern            handouts        history (including family)
physical illness          behavioral recommendations biological factors
concrete vs abstract     agreement on goals           how does patient view me
                                                                          Personal reaction

Now what?

Even though you may think this is a great deal to consider during your session you probably think about many of these things as you conduct the interview. This is just a more formal way to be sure you aren't leaving out important data when you write your session note. You might even want to make a checklist that you can take into each session until this becomes a memorized procedure that you can reference after the session. When you have your data base collected and can view in light of the entire session you can then begin to think in terms of:

1) These are my impressions (overview and then be more specific) – “Here is what I think is wrong.”

2) This is the data that supports my underlying hypothesis. – “Here is the basis for the problem”

3) Here is the treatment approach that the hypothesis supports. – “This is what I think should be done.”

So, in summary, you have a bit of a written plan for how you conduct each session with important data points to be noted which should make for a richer, objective (and subjective) fund of knowledge from the immediate session. Did I do this for every session? Absolutely! You become very adept over time and it can become second nature to you.

I like to review each session with the client before they leave so they know, perhaps, what we both learned from the session and what the takeaways might be. The manner in which you report your findings to the patient might include:

Conceptualization – In the context of the immediate session, have you changed your overview (the way you are thinking about) of the clinical question (the reason they came to see you) at hand for this client. Will this overview substantially change your therapy plan?

Hypotheses - Are you still able to use your same theoretical explanation for treating the presenting issue or have confounding variables shown up causing a change in your map?

Methods - Will a different methodological approach work better for this client now that you are a little more familiar with their presentation and follow-up, be more applicable or should it be tried, e.g., behavioral instead of cognitive?

Concerns - Does any change at this point introduce any new potential risks which require mitigation or discussion with the client?

Prognosis – Is the client making progress toward a stated/written goal? If not, why not?

Go To Ideas (Lamination of Good Thoughts)

There is the possibility that a rare bump in the road will arise in therapy that temporarily is problematic for even an experienced therapist. What to do? Most of my practice years I have kept several Moleskine notebooks where I
write thoughts, ideas, suggestions, which I think will be helpful for review and consideration at some point. They cover a wide range of subject matter and indeed have proven to be helpful when there came a situation that I didn’t know exactly what to do and a colleague may not have been available for a discussion. The best of these ideas I usually take to my local office supply store and have laminated with 10 mil clear plastic. Then the card (which it is now) becomes part of my master file of psychological critical responses.

Said another way……..) “Always have some core beliefs and/or a Plan B on which you can fall back which are consistent with your theory of clinical practice.” If you get stuck it is not a bad idea to initiate having the patient maintain a daily mood/thoughts/behavior diary. The diary may suggest a pattern you previously might have missed.

Let me give you an example of a card I have had for years. It is based upon Paul Hauck’s Theory of Assertion.¹

Problems with people are usually the result of three behaviors:

(1) We get the behavior we tolerate,

(2) Others will not change unless we change first

(3) What must be changed is our excessive toleration.

In my world this is an elegant theoretical perspective accompanied by excellent corrective direction.

And finally……………..

Be able to obtain measurable results if you are going to do anything where success is involved. In other words, be able to define what success means to you and to the person you are trying to help. If you feel you can help the individual reach their expectations then you may have a client.

Jan Alan Eglen, PhD, HSPP, ABPP
National Board of Examiners
Academy of Counseling Psychology
Private Practice Telehealth Psychologist
During January of 2021, I participated in three 90-minute focus group sessions developed by the American Group Psychotherapy Association (AGPA) Diversity, Equity and Inclusion Task Force entitled, “Promoting Anti-racism Practices for White Members”. The group was co-led by 2 white women with approximately 12 mixed gender regularly attending members. This is one facet of AGPA’s attempts, like those of other professional organizations dealing with a racial reckoning, to grapple with our history and current structure as an organization trying to embrace social justice concerns. Since many other AGPA members will be participating in similar antiracist focus groups over the next several months, I thought it might be useful to share some initial impressions. Including in the title “A View from the Bridge” (Miller, 1957) is intended to underscore that, in my opinion, this focus group program represents an effort to construct a transitional bridge to an organization that is more consciously antiracist. Simultaneously, it encourages bridging (Ormont, 1990) to occur between group members as an antidote to isolation and exclusion. Our focus groups was charged with collecting, examining, and understanding our feelings, thoughts, attitudes, experiences and biases, on the basis of which we can convey recommendations for change to be reviewed and integrated---a particularly loaded word in this context---by AGPA leadership. This is an important first step in this process.

Impressions

Just to be clear, what follows are my own thoughts and impressions gathered during the course of group discussions and stimulated by written communications among group members between sessions. A separate composite report of our group’s deliberations and experiences, along with a comprehensive set of recommendations, already has been provided to AGPA.

1. Commitment and Energy. Group members brought energy, passion, thoughtfulness and honesty to our sessions. The focus group experience proved to be stimulating, challenging, disturbing, and useful in clarifying some of our own individual attitudes and biases, as well as those of AGPA as an organization. This was an effective use of a group modality.

2. Differentiating Focus from Process Groups. An early obstacle to be overcome during our discussions was
confusion about what constituted a “focus group”. Several participants seemed to equate a “focus group” with a “process group”. Each emanates from different sources, pursues different tasks and utilizes different methods.

The process group, widely used in AGPA institutes, comes from educational, social psychology and psychotherapeutic traditions (e.g., National Training Laboratory founded in 1947; Yalom & Leszcz, 2005). The focus group, in contrast, became widely used within the area of market research. The process group is not constructed to pursue a personal change task for its members, which is the province of the psychotherapy group. As such, no systematic attempts are made by its leaders to work through personal problems that might emerge during process group sessions. The process group is intended to address a learning task. More specifically, it is to learn about group dynamics and levels of group process (intrapersonal, interpersonal and group-as-a-whole). The process group relies upon leaders inviting members to examine their experiences in the here-and-now to enable them to get in touch with their own reactions and to explore evolving relationships within the group.

The focus group has a different purpose. It does not rely solely upon expressing and examining members’ here-and-now experiences, but invites them to share their thoughts, feelings, perceptions, attitudes, experiences, as well as their histories with regard to a particular product, idea or political campaign. Its purpose is to address a predetermined, more narrowly defined topic by using the here-and-now, as well as current life experiences outside of the group and historical experiences. A brief explanation/orientation at the outset of the focus group would be useful since group therapists are often inclined to transform such events into process groups!

3. Are we Racist? We agreed that we are all racist to one degree or another. This is difficult for many of us to own. But, if you were raised in the US or lived here for any significant period of time, it is virtually impossible not to be racist; racism is in our bones and in the air we breathe. It is the prevailing system of racial caste that has been in existence for more than 400 years (Wilkerson, 2020). We are trained from birth to accept and to maintain this system. It is reinforced in a thousand different ways on a daily basis.

Given this reality, we agreed that we must be especially careful about judging, blaming or excluding others; our reliance upon denial, avoidance, splitting and projection when dealing with emotionally loaded, radioactive issues deserves scrutiny.

4. Is AGPA Racist? AGPA, as an organization reflects the larger culture of which it is a part. It, too, is racist and elitist. Bias also has existed within our organization since its inception with regard to professional degree, who is able to become a member or to hold an office, gender, ageism and classism/affordability (Klein & Buchele, 2019). There is nothing in the mission statements of AGPA, The Foundation or the Registry which addresses racism. Nor is such a concern included in our Strategic Plan. Our efforts to recruit and retain BIPOC members and to expand our membership base largely have been unsuccessful and require reexamination. We are primarily an organization of aging white upper middle class private practice clinical professionals who can afford to remain members, and who can afford to attend our week-long annual meetings held in big-city expensive locations.

5. The Unseen and Not Included in AGPA. In contrast, thousands of groups are led each day in this country by people with limited training or supervision in agencies, schools, institutions, counseling centers, hospitals, day programs, religious organizations, addiction programs, etc. Many of these folks, however, have never even heard of AGPA, much less become members. We are not including most of the people across the country who are currently leading groups.

Furthermore, AGPA leadership positions have been occupied primarily by white people. We have never had a non-white President. Our Nominating Committee that presents a slate of candidates for elected leadership positions has, for the most part, been lacking in diversity.

We need to address a fundamental question regarding organizational racism: Who among BIPOC wants to join an
organization like ours that bears so little resemblance to them, is too expensive and doesn’t seem to embrace their concerns; more importantly, what can we do to change that?

6. Social Justice and Group Psychotherapy. AGPA identifies itself as a group psychotherapy association, not a social justice organization. Our primary mission for the past nearly 80 years has been to provide education, training, research that will improve the practice, quality and efficacy of group psychotherapy. Social justice and racial equity has not been identified historically as a primary task of the organization. However, many focus group members believe that it is time to amend or broaden our mission statements and Strategic Plan to make them more relevant and responsive to current antiracist concerns. Not doing so may render us obsolete, or worse, racist, in the eyes of younger activists and potential new members.

But, shifting the focus to embrace social justice and racial equity as a primary goal of AGPA might risk overlooking or minimizing other essential aspects of group therapy. Doing so may make AGPA a fundamentally different organization, even unrecognizable, to some longer-term members who have been steadfast supporters and contributors to the organization as they have known it. On the one hand, the tail should not wag the dog. Promoting racial justice and equity in our groups and in our organization is one important aspect of group psychotherapy. It is not the only aspect, nor necessarily the most important aspect. On the other hand, to selectively ignore or overlook instances of structural, cultural or individual racial injustice and inequality, and to not require a clear organizational and individual member commitment to promote racial justice, we may risk maintaining an organization that has fundamental flaws in its very foundation that now require repair.

7. The Need for Cultural and Structural Change. It became increasingly clear during our discussions that significant cultural and structural change is needed within AGPA to deal with racism, “white supremacism”, and caste. We need new organizational norms, vigorously presented and endorsed by our leaders, to begin to reshape both the culture and the structure that preserves its existence. Leaders who “fess up” when they “mess up” can serve as effective models.

8. The Change Process. Significant differences in our group primarily emerged around what we thought the pace of change in AGPA should be, how radical vs. gradual it should be, and the most effective means to be used to promote change.

These differences are likely to remain the focal points of tension as we move forward.

Not unexpectedly, some younger more passionate and impatient group members were calling for “revolution” now, while others urged less drastic, gentler approaches. Some older participants, themselves long-term members of AGPA, advocated for a less radical, more gradual transition in culture and organizational structure. How much skin you have in the game is a powerful motivating factor.

9. The AGPA Listserv. A variety of impassioned concerns about the listserv kept resurfacing throughout our group discussions. My experience here is limited. I have looked at the listserv only a few times and have not been an active participant. But my impression was, prior to the imposition by leadership of rules of engagement, that this was becoming a culture that authorized the use of violence, in the form of repeated cycles of accusing, attacking, shaming, scapegoating, projective targeting, and threatening individuals with ostracism and/or expulsion for their behavior. Apologies from offenders seemed to be greeted with skepticism followed by yet another volley of shaming, blaming, and rejection. These methods, when carried to extremes, are a form of emotional harming/bullying.

That is not the path I think AGPA should follow. Such ways of relating to others, are fundamentally emotionally driven calls to action. Reform your ways! Do it now, if not sooner! They are not necessarily linked with careful thinking and deliberation about complicated issues. Nor are they linked with compassion and empathy. Those
qualities are often linked by those advocating revolution and radical change with weakness and a reluctance to take necessary immediate action in the heat of battle

10. Rules of Engagement. The articulation of rules of engagement on the listserv by AGPA leadership was constructive. I did not want to participate in what I was seeing on the listserv. I thought it was brutal. This way of treating others, which seemed at the time to be widely sanctioned by listserv participants, felt very different from that endorsed by the organization I have loved for years. I found the use of these tactics under the banner of antiracism disturbing. The ends do not justify the means. Whatever the avowed reason for resorting to such tactics, I was struck by the irony of combating racism by using tactics that were equally brutal and devaluing as those employed by racists. Those adopting such tactics were in the very act of becoming indistinguishable from the people they were ostensibly fighting against, the racists amongst us.

11. Damage Control. I suspect that significant damage was done to individuals during these encounters on the listserv. I think AGPA would be well advised to acknowledge this, to devote some time and effort to explore what happened, and to make amends and repairs for those who felt injured, as well as for those who simply witnessed these developments.

12. Identifying Racism, Getting Rid of Racists and “Calling People Out”. The group discussed the idea of getting rid of those AGPA members who some think are reluctant or unwilling to examine their own racism. I was troubled by this discussion, and also found it difficult to identify the so-called “repeat offenders”, those individuals who have joined AGPA because of a shared interest in group therapy but appear to remain unable or unwilling to examine instances of racism in their own behavior. Who are “those people”? And, is there a more effective, more humanitarian and compassionate way to help them learn?

The importance of “calling those people out” was also emphasized. I agreed that if you see something, you should say something. You can't try to fix the problem if you can't see it. But for me “calling people out” was too steeped in potential violence, too punitive, projectively shaming, and perhaps might disguise underlying sadistic impulses. The challenge for us, I believe, is to find a way of identifying something as racist when we see it without causing folks to feel heightened anxiety, to feel so caught in the intense line of projective fire that they shut down and have to withdraw or flee. I do not want to be part of an antiracist police force in AGPA that demands compliance or else you will be shamed, punished or banished.

We must be able to see racism in ourselves and in our organization, but without feeling overwhelmed by a fear of retribution. The aim in my mind is not simply to “call people out”. It's more complicated than that.

“Calling people out” needs to be accompanied by efforts to “call people in”. That's more consistent with the idea of inclusion: call people in to sharing and examining what is happening; in to thinking and introspection; in to caring, empathy and compassion. There was widespread agreement in our group that we need to create an atmosphere in which people feel safe enough so that we are able to work together to recognize and to acknowledge instances of racism, own them, apologize to those we are hurting, try to understand what is happening, and learn through working collaboratively from our own mistakes---not flee in shame and under threat of attack or ostracism. The absence of dialogue prevents, rather than promotes, learning. When that happens, racism is more likely to go underground. That would not constitute progress.

13. The Attraction and Danger of Becoming a Fight/Flight (F/F) Group. On a broader level, I also do not think it is healthy for us to slip into becoming a fight/flight group (Bion, 1951) to “battle” racism, a group which, when carried to extremes, promulgates the use of avoidance and denial, splitting, projection and scapegoating, a group which resorts to coercion: “You are either with us or against us”. These are core aspects of racism itself. We have all lived through “the war on drugs”, “the war against illegal immigrants”. The very idea of “combating” or “battling” racism makes me concerned. It shapes and corrupts our thinking. It focuses on action and aggression, and invites
us to form and enter into the fight/flight mode, away from rationality. It can empower those who believe in the stated cause and rally those who have not felt heard. It can also easily lead to rationalizing and justifying the use of tactics that are fundamentally antithetical to the very cause at issue and to conveniently suspending or disregarding ethical considerations.

Participating in a F/F group primarily gets the juices flowing and arouses us emotionally to take immediate action against a perceived threat or enemy, not to engage in any careful thinking. As in our country, the emotional temperature needs to be lowered before rationality and sustained access to neural pathways connected with the cortex can be restored (Perry, 2021). The F/F group mentality is anti-intellectual, anti-science, anti-introspection, and anti-rationality: it is a call for uncritically examined action based on the stimulation our most primitive emotions. Also, aggressively rooting out racism in other individual members allows the rest of us, and perhaps the organization, to remain morally outraged, righteously indignant and to avoid exposure.

14. **Paths to Prominence, Visibility and Power in AGPA and the Role of the AGPA Listserv.** We live in the age of social media. Not surprisingly, many people recently have achieved rapid recognition and notoriety in AGPA through their presence on our listserv. In the past that medium was not available. People rose to prominence in the organization through serving for years in multiple responsible roles, distinguishing themselves through their service and contributions, whether those involved serving on the BOD, holding office, chairing a committee or Task Force, publishing or presenting frequently, etc.

Development of the listserv, in my opinion, has provided a convenient short-cut to all that. It has become significantly easier to make a name for yourself in the organization if you are fast on your feet, verbally agile, type quickly and can respond rapidly to emerging threads on the listserv, it is likely that you can quickly gain name recognition and instant celebrity status, someone whose presence cannot be overlooked.

Some of our older members, like me, who have not yet evolved beyond the single-finger-hunt-and-peck approach to the internet, may have felt shoved aside, pushed to the periphery. Perhaps anxious about risking exposure and the potentially humiliating prospect of being attacked and shamed for being labeled racist, many of us may have allowed ourselves to be relegated to the unseen margins, unable to contribute or to compete for attention and air-time. Not surprisingly, heightened anxiety, unhappiness and concerns about being displaced may have been aroused among us. My own fear, expressed during the initial focus group session, was that as a member of a different generation and being unfamiliar with the new language and concepts, I would be viewed as a relic from the distant past, an anachronism, and, importantly, as someone who had failed to help create and sustain a more equitable organization.

As we seek to engage new younger and BIPOC potential members, it is also important for AGPA to try to re-engage those who feel this way; we cannot afford to lose this older sub-group of long-term AGPA members and supporters who, despite their failings, have remained a valuable resource, a repository of organizational culture, history, experience and knowledge, and a reliable source of financial support.

15. **The Registry.** A number of questions were raised during the group discussion about the Registry. Is it outmoded? Is it racist/elitist? Does the CGP impose unfair burdens on BIPOC? Should it be disbanded or scrapped entirely? It was clear to me that most group members did not understand the historical context and purpose of the Registry. Nor did I think they appreciated the value of the CGP designation as a measure of baseline experience and competence, a means of recognition within the organization and a protection for the public. I was, at various moments, the lone voice advocating that we may want/need to modify or expand the CGP by adding an additional measure of social justice competence, rather than throwing the baby out with the bathwater. Past delectable edibles that are now growing green in the back of the refrigerator may need to be removed, discarded and replaced. That does not mean everything must go.
16. Financial Structure of AGPA & the Role of the Foundation. The question of how we maintain financial viability and sustainability continues to remain something of a mystery for most of our members. During the group discussions, for example, there were vague rumblings about financial elitism and allusions to the Foundation, but no overt or clear discussions of the role of the Foundation in supporting AGPA. Members appear to lack a firm grasp of our essential financial underpinnings, with a clear picture of our basic sources of income and expense. If one were to ask, "How much does AGPA rely upon financial support from the Foundation", most members would be hard pressed to answer knowledgeably. Even a question of "What and who is the Foundation, and what is its mission?" might be tough for most to answer. Many harbor the unspoken belief that the Foundation is composed of older white rich folks who control and potentially corrupt the organization through their financial contributions. While I agree that presenting financial information in any detail, even to Boards of Directors, results in members' eyes crossing and glazing over, increased confusion and tuning out, some form of a clearer explanation of this complex set of issues needs to be provided for all AGPA members as we move forward.

17. How Will AGPA Change? It was recognized that the process of change is likely to be quite difficult. Several related concerns were expressed: AGPA may well look very different. How will we successfully recruit and retain BIPOC members and younger professionals? The way the organization functions may be very different. Can we remain a membership organization? If so, how will membership need to change? How might our dues structure need to be modified? Will we need to become an online specialty store that sells group psychotherapy training? Do we need to become more closely connected to our communities? How should we alter our leadership structure? Might we have to sell our home office? How do we balance our commitment to group psychotherapy with our commitment to social justice? Do we need to change the nature, structure, length, and cost of our annual meetings? How do we avoid losing our long-term members who have provided financial support for the organization and have maintained a deep emotional commitment to AGPA?

18. A View from the Bridge. These and many other questions remain for us to tackle. But, by the conclusion of our focus group, we were able to effectively work together to create a comprehensive list of specific recommendations for AGPA to implement to move us toward becoming a more antiracist organization. Our recommendations included: forming a White Accountability SIG; the need for structural changes in AGPA; carefully reviewing our policies, codified norms and mission statements; changing the nature of our annual meeting; reexamining competency training and evaluation for faculty; a method for addressing racist incidents within the organization; the importance of leadership in shaping the culture; prioritizing BIPOC amongst leadership; the importance of diversifying our membership; requiring an anti-racist and full inclusiveness commitment from new members, plus a requirement to participate in antiracist training.

All this and more flowed from our one small focus group, demonstrating once again the power of groups. I for one emerged from our focus group optimistic that, together, we can rise to the challenge.

References


Readers of the Specialist are aware that certification credentials offered by the American Board of Professional Psychology (ABPP) are respected within health service psychology (e.g., Bent et al., 1999; Hill & Packard, 2013). Perhaps less appreciated is that decades ago several observers questioned if any credential was a useful indicator of a therapist’s competence. Koocher (1979) thought it unlikely that credentials actually provided highly valid measures of a psychologist’s abilities, and others agreed (e.g. Dawes, 1994; Gross, 1978). Woody (1997) extended a discussion of these issues to dubious, if not outright bogus certification credentials that “have less concern about quality assurance than concern about bringing income to the source and providing promotional benefits to the purchaser” (p. 341).

**Dubious mental health specialty certifications.**

Rosen, Washburn and Lilienfeld (2020) provided a cautionary case study that illustrated how timely remained
Woody’s comments. The case study was based on Rosen attending a two-day workshop on “The 10 Core Competencies of Trauma, PTSD, Grief and Loss,” a workshop that met educational requirements for obtaining certification status as a trauma professional. At the end of the workshop, which had been sponsored by PESI, Inc., participants were reminded of the credentialing opportunity and told about the remaining steps to obtain their certification: (1) register as a member of a national trauma organization (International Association of Trauma Professionals, IATP); (2) log on to the website for Evergreen Certifications and score 80% or higher on a 50-item multiple choice test; and (3) pay the required fees. The workshop's presenter also informed participants that they could access an on-line study guide that would provide specific statements related to each specific question. Rosen followed these steps and became a Clinical Certified Trauma Professional (CCTP).

The prospect that an on-line study guide might provide answers to a qualifying exam raised troubling questions about the validity of that test to determine certification status. It occurred to Rosen that virtually anyone with computer skills, absent knowledge of trauma-related disorders, might be able to pass the on-line exam. To test this possibility, permission was obtained from the publisher to use the test materials, after which an 8th grader was provided with test items and access to the study guide. After confirming an understanding of the task at hand, this 8th grader worked independently and correctly answered all 50 questions. Rosen et al. (2020) considered the implications of their finding and recalled the famous house cat, Dr. Zoe D. Katz who obtained certification status from the now defunct American College of Forensic Examiners International (Bartos, 2012).

Certification as a Telehealth Professional

The first cases of COVID-19 in the United States were reported in January 2020. Less than three months later, in March 2020 Evergreen Certifications began to offer a new certification credential in the area of telehealth services, once again paired with course offerings by PESI, Inc. A visit to PESI’s website, informs how this new credential has been promoted (PESI, 2021):

"Become a Certified Clinical Telemental Health Provider (CTMH) faster and easier than you ever thought possible! Providing telehealth services is a must for today’s clinician, allowing you to effectively expand your practice and reach clients... Purchase today, enhance your clinical practice, and fundamentally improve the lives of your clients as a Certified Telemental Health Provider (CTMH)... Become Certified!"

It also is instructive to visit Evergreen Certifications’ (2021) website where professionals are told:

"Telemental Health is the fastest growing Clinical Mental Health service in the United States. Don’t be left behind- get trained and certified in Telemental Health and begin providing distance therapy today!"

Rosen signed up for PESI’s on-line courses when he received a flyer announcing the new "Telemental Health" program. He reviewed the instructional materials; took the required on-line tests; found that these tests allowed for unlimited changes to incorrect multiple-choice responses until such time as 80% were passed; and on May 6, 2020 became a Certified Professional in Clinical Telemental Health. In this instance an 8th grader was not recruited to demonstrate the lack of criterion validity for establishing specialty skills in telehealth. However, it seems more than reasonable to assume that any computer competent individual could respond to multiple-choice questions and repeatedly change answers to flagged items until such time as the tests were passed. Once again, there does not appear to be a valid basis upon which to bestow certification status to a mental health professional.

Look Mom, I’m an Expert

Technically, Rosen now can advertise on the internet and sign his reports as “Gerald M. Rosen, PhD, CCTP, CTMH.” While he may feel it improper to do so, it is surprising how many mental health professionals bolster their credentials with a long list of clustered letters. One just needs to do a quick Google search along the lines of “therapist” followed by one or more acronyms to see what is being presented to members of the public who seek professional help. The current situation brings to the forefront past concerns expressed by Koocher, Dawes, Woody and others.
A comprehensive analysis of issues surrounding specialty mental health certifications requires consideration of the business models and marketing efforts employed by relevant companies. In the present case a sponsor of continuing education (PESI, Inc.), a national professional organization (IATP), and a credentialing company (Evergreen Certifications) joined together to offer courses tied to certifications. Perhaps unbeknownst to a typical professional who signs up for the workshops and pays various fees is that PESI, Inc. actually owns the other entities. In other words, the same company that markets continuing education workshops also profits from professional membership fees and the very certification credentials made possible by attending the original workshop. Some might think that this business structure and the launching of a telehealth certification credential so soon after a pandemic crisis would raise eyebrows. Certainly, the American Psychological Association (APA), in concert with other professional groups, needs to look at what has been happening in the world of specialty mental health credentials. The APA and associated groups also might do well to develop supportive guidelines that assist practitioners who must decide how to ethically present their expertise in a highly competitive marketplace.

References:


Provider Reluctance to Seek Emotional Support: Failure of an Early COVID-19 Wellness/Resilience Program

The University of Kansas Medical Center
The University of Kansas Health System
Kansas City, Kansas

Submitted by:
Elizabeth C. Penick, PhD, ABPP*, Monica F. Kurylo, PhD, ABPP*, Danielle M. Johnson, PhD*, Jessica L. Hamilton, PhD*, Gregory Nawalanic, PsyD,* Kathleen Riegelman, MDiv, BCC**, & Rebecca J. Johnson, MDiv, BCC**

Introduction: The United States Department of Health and Human Services (HHS) declared a public health emergency for COVID-19 beginning January 27, 2020. The University of Kansas Health System responded quickly to the HHS declaration by mobilizing resources, systems and personnel to manage the anticipated changes to the growing pandemic (KUMC Executive Vice Chancellor, March 5, 2020). The Division of Psychology, under the leadership of Dr. Monica Kurylo, initiated several efforts to reach out to medical providers who would be most impacted by the institutional response to the coronavirus.

Method: In March 2020, the Department of Psychiatry and Behavioral Sciences formed the COVID-19 Wellness/Resilience Consultation Program. The goal was to reach out to medical providers who were likely to experience the greatest amount of stress from the growing demands imposed by COVID-19. The program was intended to offer medical staff a simple way to ventilate and talk confidentially to a licensed counselor about any concerns or issues that may have arisen because of the coronavirus pandemic. A cost-free, confidential, call-in telephone service was established that allowed medical providers to choose an hour in their day when they might wish to talk anonymously to someone about the impact the virus had on them personally, on their families, or on the hospital service they represented. We anticipated that each hourly opportunity to speak to a Psychologist or Chaplain would attract multiple participants. A total of 24 Psychologists and Chaplains volunteered to take responsibility for the scheduled, hourly, telephone appointments. Most of the counselor facilitators signed up for multiple sessions. A great deal of enthusiasm existed among the voluntary staff. Call-in sessions were scheduled throughout the day and evening, five days a week for an hour. Notification of this opportunity was sent via email, on three occasions. After each session, the counselor facilitator completed a short form which captured elements of the counseling experience, even when the scheduled hour was not filled.

Results: This Report covers the first four weeks of the program (March 20 through April 15, 2020). The program ended after that time because of the very low response rate. As noted in the table below, 116 one-hour, talk-session slots were created. Of these, only 11 talk-session slots were actually utilized (7.7%). Nine of the 11 sessions consisted of a single caller. Two of the 11 sessions had two people call in at the same time. No group calls emerged.

Activity Summary of the KUMC COVID-19 Wellness/Resilience Program

<table>
<thead>
<tr>
<th>Description</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Participating Psychology and Chaplain Telephone Facilitators</td>
<td>24</td>
</tr>
<tr>
<td>Number of Hourly Call-In Sessions Created</td>
<td>116</td>
</tr>
<tr>
<td>Number of Medical Staff Who Called In</td>
<td>11</td>
</tr>
<tr>
<td>Number of Sessions with at least 1 Participant</td>
<td>9</td>
</tr>
<tr>
<td>Number of Sessions with 2 Participants</td>
<td>2</td>
</tr>
<tr>
<td>Percent of Scheduled Sessions Utilized</td>
<td>7.7%</td>
</tr>
<tr>
<td>Time Volunteered by Psychology/Chaplain Facilitator</td>
<td>68.3 hours</td>
</tr>
<tr>
<td>Average Time Spent by Psychology/Chaplain Facilitators when a Participant was Present</td>
<td>40.8 minutes</td>
</tr>
</tbody>
</table>
The 24 telephone counselor facilitators spent a total of 68.3 hours covering the 116 scheduled call-in sessions. The average call that included a healthcare participant lasted a little over 40 minutes. Sign-in sessions were available about 3 ½ hours a day, excluding weekends, starting at 7 am and ending at 9 pm. The AM and PM calls were roughly equal.

Although a small sample, the content of the sessions was very similar. Concern about job security and worries about meeting financial responsibilities were often mentioned. Frustration with and uncertainty about job demands, including needed equipment, seemed next on the minds of this small group. Emotional reactions, including anger, fear, anxiety, and emotional exhaustion was another source of concern. Participants worried about giving the virus to a family member. Several emphasized positive coping skills such as reaching out to others for support, finding ways of remaining hopeful and giving thanks for their family and health. After the session, 7 of the 9 participants thanked the facilitator for making time available to talk to them about their reactions to the COVID-19; all of them suggested it was a helpful conversation.

Comment: Because of the disappointing response, the Wellness/Resilience Program was ended after one month. What happened? The service was free, confidential, offered at very convenient times and was easy to access. We frankly expected to be overwhelmed and had backup plans ready in case that happened. When that did not happen, we wondered if the “marketing” of the service was insufficient. We also wondered if the group format was not attractive; the response may have been stronger if one-on-one telephone conversations were offered instead. After speaking to people who thought about, but chose not, to take advantage of the program, we think that the first two explanations are not likely to account for the failure to attract more healthcare providers to the program. We believe that a third explanation is more likely. The late Robert Strauss spoke about “derived stigma” occurring when treatment providers and their interventions that are associated with stigmatized conditions, such as alcoholism, themselves become stigmatized and targets of avoidance. Most of us in the mental health field have spoken to people who clearly wanted and needed psychotherapy but were too “afraid” of what their family, friends, colleagues, or superiors would think about them if they did. Numerous studies have shown that the pandemic has caused marked increases in stress-related symptoms associated with anxiety, depression and disturbed sleep (APA 2020). When speaking to several medical staff providers who had “thought about” contacting the Resilience/Wellness Program, a common reason given for not doing so was “I didn’t think my concerns were bad enough!” and “I thought other people needed it more than I did.” The simple act of embracing a program of resilience and wellness seemed to require recognition of psychological vulnerability that was not acceptable under a situation where the stress is “external”, widely shared, and “silent” suffering is the expected norm. Although we made an effort to dissociate the COVID-19 Resilience/Wellness Program from “mental health” and “psychological” issues, we do not believe we were successful in doing this. The importance of stigma in preventing individuals from seeking help for a variety of well-established mental health disorders has become increasingly recognized (Corrigan, 2004; Corrigan, Roe and Tsang, 2011, Earnshaw, 2020). We suspect that the role of stigma is even greater for those suffering from less severe, subsyndromal conditions, which are sometimes referred to as “problems of living.” It is as though “counseling” or “therapy” for any kind of emotional or social or behavioral issue has unfortunately become associated with the more severe and severely stigmatized psychiatric disorders.

As noted by Dr. Arthur Evans, CEO of the American Psychological Association, . . .”it has become clear that the general public often does not recognize when there is applicable knowledge from our field that could be useful to them” (Evans, 2021). It would seem that more effort is needed to help the public understand that “counseling” and “psychotherapy” can greatly help with emotional and behavioral issues that are largely “silent” at the time, but are nevertheless distressing, and have the potential to cause them great harm in the future.

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**Bibliotherapy for Weight Control: Modest but Noteworthy Effects**

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**Keywords:** Bibliotherapy, weight control, weight loss, adolescents

**Abstract**

The National Library of Medicine defined bibliotherapy as a form of psychotherapy in which the patient is given carefully selected material to read.1 This paper examined the existing literature related to the impact of bibliotherapy on the treatment of adolescent obesity. Despite the extensive use of bibliotherapy by virtually every professional program, no prior review determined if research supports the perceived vital role of bibliotherapy. To place this review in empirical context, we first considered the overall impact of bibliotherapy on medical conditions and psychological distress. The evidence does suggest some benefits of bibliotherapy on moods and weight management, but primarily noteworthy only when included in professional programs. The mechanisms of these benefits (e.g., improving understanding of the science of weight management; increasing commitment; modifying cognitive biases) remains unknown. We recommended three evidenced based books and several lines of research that could help maximize benefits from such books when used in bibliotherapy.

The medical and psychological literature uses a wide variety of definitions to define bibliotherapy. The National Library of Medicine defined bibliotherapy in a way that captures the essence of it: “Bibliotherapy is a form of psychotherapy in which the patient is given carefully selected material to read”1. As defined this way, let us examine the impact of bibliotherapy on the treatment of adolescent obesity. That seems warranted due to the extensive use of bibliotherapy by virtually every professional program presumably based on the vital role of such an intervention.
Yet, no prior review determined if research supports that perception of bibliotherapy's importance. To place this review in empirical context, we will first consider the overall impact of bibliotherapy on medical conditions and psychological distress.

**Bibliotherapy Focused on Medical Conditions**

**Adults**

Only one study specifically examined the impact of bibliotherapy on a medical condition other than obesity, even though this study included treatment for excess weight. This study compared a bibliotherapy only intervention to a bibliotherapy plus minimal contact with a professional via a weekly telephone call for twelve weeks for cardiac patients. This investigation sought to help cardiac patients lose weight to reduce cardiovascular disorders. They found that both the bibliotherapy only and the bibliotherapy plus telephone contact groups lost weight; however, the bibliotherapy plus contact group lost significantly more weight and probably improved cardiac health more than the bibliotherapy only group.

**Adolescents**

We found one study that investigated the effect of bibliotherapy on medical conditions among children or adolescents. The study examined the use of bibliotherapy in an effort to help two different groups of children, one with a genetic disorder and the other with diabetes, to discuss their feelings with treatment professionals. The results indicated that using bibliotherapy, compared to no intervention at all, helped both groups of children discuss their experience more freely, identify coping skills, and discuss management of their disease with treatment professionals.

**Bibliotherapy and Behavioral Health**

**Adults**

A 1995 meta-analysis found that bibliotherapy seemed more effective with anxiety, sexual dysfunction, and assertion and less effective with studying problems, weight control, and impulse issues. Marrs indicated that for problems like weight control, bibliotherapy with professional contact produced better results. For example, bibliotherapy was more effective when there was at least eight minutes or more of professional contact per week.

More recent meta-analyses examined the effectiveness of bibliotherapy in adults suffering from depression and anxiety. Evidence suggests that over the long-term bibliotherapy improved depressive affect significantly more than waiting list or non-treated controls. The positive results were similar in size of effects to those obtained via short-term (average of 7 weeks) of individual Cognitive Behavioral Therapy (CBT). For example, the depression meta-analysis found bibliotherapy had an effect size of 0.77 for studies with traditional designs of treatment group compared to a wait list control group. With anxiety disorders, two small studies by the same researchers indicated that bibliotherapy decreased anxiety significantly pre- to post-bibliotherapy. These studies did not include control groups but comparisons were made with standards of improvement from individual counseling of various types. The bibliotherapy improved moods to a clinically meaningful degree based on those standards.

**Adolescents**

Meta-analyses illustrated that bibliotherapy decreased depression symptoms and anxiety symptoms in adolescents relative to no treatment and wait list controls. Bibliotherapy may also help prevent depressive affect in teenagers, although notably less effective than CBT in this regard. Yuan et al. also indicated that bibliotherapy may not decrease anxiety as well as it reduces depression.

**Bibliotherapy and Obesity**

**Adults**

For obese adults, bibliotherapy helped participants lose weight as a part of a stepped-care approach where the individuals started with bibliotherapy and then stepped up to more comprehensive interventions when weight...
loss plateaued. Bibliotherapy also helped make an intervention with minimal professional interaction generate increased weight loss compared to participants who stayed in the bibliotherapy phase. For example, in Black and Threlfall’s 15 15 month study, participants who complied with the bibliotherapy intervention increased the effectiveness of their weight loss by nine pounds compared to those who did not comply with the intervention.

Adolescents

Only one study specifically explored the impact of bibliotherapy on childhood obesity. For obese children and teenagers, health-oriented fiction helped lower BMI more effectively (0.71% decrease) than a non-health-oriented fiction intervention and control groups (0.33% decrease) over a two-month period.16

Key Elements of Change in Weight Management

The research on bibliotherapy reviewed in this paper suggests similar conclusions to research on educational interventions for weight management. In both cases, educationally oriented approaches can do some good some of the time, but generally such interventions on their own produce modest effects, with little evidence showing long-term independent benefits without additional therapeutic contact. For example, Saelens et al. 17 randomly assigned overweight and obese adolescents to either an intervention group or a comparison group. The comparison group received one educational session; they became significantly more overweight four months later. The intervention group completed an elaborate computerized assessment; received: an educational session to review an explicit plan for change; a detailed treatment manual; a family consultation; and, eleven telephone counseling sessions. The intervention group did not lose weight initially or at a three-month follow-up. If this elaborate educational intervention proved so ineffective with overweight teens, could we really expect preventive oriented education presented in classroom settings to work? The results of Stice, Shaw & Marti’s 18 comprehensive meta-analysis suggests not. They found that the average effect size (r=.04) of primarily classroom based educational programs was so small that it “would be considered trivial by most researchers and clinicians.” Only 3 programs out of 64 (<5%) produced significant weight reductions that persisted over time.

The same conclusion emerges from educational interventions and bibliotherapy for weight control: information per se (i.e., as an independent intervention) does not lead to the type of major changes in lifestyle necessary to help obese young people permanently lose weight. This identical conclusion applies to young athletes as well. Young athletes attempting to maximize success in their sports almost never do it simply by reading books or just learning about their sports by listening to expert coaches. To transform their bodies and minds they maximize training and focus through extensive in-person work with highly skilled coaches. 19

Athletes rely extensively on coaching, but weight controllers currently do not. When studying successful weight controllers over the past 25 years, Rena Wing, James Hill and their colleagues 20 documented that relatively few notably successful adult weight controllers used professional counseling of any type. Also, even when participating in the most widely recommended and tested approach, intensive outpatient CBT (e.g., weekly X six months in outpatient programs), about 50% of families with young weight controllers drop out prematurely—virtually guaranteeing failure.21-22 Kirschenbaum and Krawczyk identified a variety of cognitive biases that seem to create excuses that promote attrition (paper under review, 2020). Some powerful CBT techniques (e.g., Rational Emotive Therapy, Therapeutic Understanding of Science) may well help reverse such tendencies, thereby enhancing commitment. 23 Fifty years of research on motivational interviewing (formerly called decisional counseling) makes it very clear that maximizing commitment greatly improves success at making challenging changes in lifestyle.24-25

For weight controllers, the present authors advocate for several vital elements based on, collectively, more than 50 years of studying and contributing to research on weight management, as well as working with more than 12,000 young weight controllers and their families. All of those elements have substantial bases in empirical evidence.26-33 They also go well beyond what bibliotherapy or education can convey effectively. Working intensively with experts in CBT can help young weight controllers and their families permanently adopt these changes in lifestyle over time.
by maximizing sustained commitment and refining methods of solving frequent problems, especially in a culture that promotes sedentary lifestyles and consumption of high fat and excessive foods:

Education/bibliotherapy + Intensive CBT
Overall Mission: Healthy Obsession – sustained preoccupation with the planning and execution of target behaviors to reach a healthy goal
Four clear goals (i.e., objective, readily assessed, but not easy):
100% self-monitoring of food and movement
Very low-fat eating (0 fat grams as an aspirational but not achievable goal)
Low calorie consumption (1000-1500 as difficult but achievable goals for most)
12,000 steps per day

Bibliotherapy’s Role in Intensive CBT
Virtually every CBT intervention for decades has included bibliotherapy. The present review does indicate that bibliotherapy can assist the process through decreasing emotional distress and also via assisting with weight management to some degree. No studies, however, focused on the mechanisms by which bibliotherapy actually promoted positive changes in weight management. For example, does it work via increasing positive moods? Does it work by improving focus on specific goals like calorie consumption or use of low-fat foods and recipes? Perhaps it helps by enhancing overall commitment and engagement on a daily basis that facilitates the development of healthy obsessions? We believe many such possibilities exist. Compelling books in combination with CBT might even assist in reducing the power of excuses for abandoning efforts to lose weight (i.e., attrition or failure to seek professional assistance) based on the power of cognitive biases. The latter might happen due to Therapeutic Understanding of Science (TUS).

Recommendations

Three Books
In view of the benefits of bibliotherapy, we believe evidenced based books can maximize its value for obese adolescents and others. Hundreds of books focused on losing weight emerge every year, including the currently most popular diet books: keto diet books. We recently did a search on Amazon for best-selling diet books and found a separate search available for “best sellers in ketogenic diets.” That search identified the current best-selling keto diet book and forty-nine other books focused on Keto diets on that list. That revelation contrasts dramatically with the 2019 US News and World Report ranking of diets (their ninth year of such rankings) by a group of 25 experts in nutrition, weight loss and related medical conditions. US News and World Report summarized the expert opinions about keto diets: “The Keto diet was among the lowest-ranked diets overall [of 41 ranked]. Many of our experts expressed concerns about the diet’s emphasis on fat-rich foods. ‘This diet is fundamentally at odds with everything we know about long-term health,’ one expert said.”

The three evidenced-based books we recommend include two best sellers, updated from prior best sellers by the same authors, focused on very low fat diets (written by a physician famous for remarkably important research on cardiology) and a key dietary element for weight controllers – low caloric density (i.e., relatively few calories per gram of weight or ounce of volume; authored by the nutritionist who conducted pioneering studies documenting the impressive benefits for weight controllers [improved satiation, decreased fat intake] of eating foods low in caloric density). The author of the third book designed and clinically supervised what became the leading provider of treatment services for overweight young people in the USA for many years – Wellspring (as many as twelve intensive immersion CBT weight loss camps and the world’s first two boarding schools focused on weight management). That third book is a substantially updated version of several previous bibliotherapy books written by the same author that were used for ten years in Wellspring.
UnDo It! How Simple Lifestyle Changes Can Reverse Most Chronic Diseases by Dean Ornish, MD, and Anne Ornish.35

**Primary Focus**: Very low-fat whole foods diet

**Four Major Components:**

A Whole-foods Plant-based Diet – described as “naturally low in fat and sugar and high in flavor”

Moderate Exercise – such as walking

Stress Management – including meditation and gentle yoga practices

Love, Social Support, and Intimacy- “transform loneliness into healing”

The Ultimate Volumetrics Diet: Smart, Simple, Science-Based Strategies for Losing Weight and Keeping it Off by Barbara Rolls, Ph.D., with Mindy Hermann, R.D.36

**Primary Focus**: “Choosing foods that pack fewer calories into each bite – that is, they are lower in calorie density.” That means focusing on eating foods low in fat and high in liquid like low fat broth-based soups, fruits and vegetables. Such foods can “fill your day with plenty of enjoyable, healthful foods and leave you feeling full and satisfied.”

**Key Components**: The book provides dozens of recipes (lots of soups and salads) in addition to a twelve week plan to create a commitment to this approach: starts with “Week 0: Getting Started, Week 1: More on Calorie Density, Week 3: Portion Size: When Bigger is Better” and ends with “Week 10: Eating Away from Home, Week 11: Your Personal Environment, and Week 12: Maintaining Your Volumetrics Lifestyle.”

Taming the 7 Most Fattening Excuses in the World: Re-thinking Your Healthy Obsession Pathway to Lifelong Weight Loss by Daniel S. Kirschenbaum, Ph.D., ABPP23

**Primary Focus**: Based on Nobel Prize winning research on cognitive barriers that impact decision making, this book helps weight controllers understand and overcome their cognitive barriers to weight control. These problematic decisions amount to seven common and understandable excuses to avoid using scientifically based CBT – 7 Stymie Beasts (Can’t, Won’t, Addict, Hate, Lazy, Waiting, and How). The book also presents the essence of effective CBT: developing a healthy obsession (sustained preoccupation with planning and executing target behaviors to reach a healthy goal).

**Key Components:**

- Two Ways to Tame Your Stymie Beasts: Therapeutic Understand of Science and Rational Emotive Therapy

- Developing a Healthy Obsession

- Eating and Moving to Lose Weight (3 key goals: 100% self-monitoring, 0 fat grams, 12,000 steps per day; plus: calorie control (1200-1500 calories per day), eating foods low in caloric density, and finding foods that you like that like you back.

- Creating a Supportive World around You.
Future Research

The existing body of research inadequately understands and explains the role of bibliotherapy in current interventions. Therefore, we suggest several avenues for future study. More research could help answer the question, “Is bibliotherapy a crucial part of existing interventions?” Clinical trials could compare intensive CBT (outpatient or immersion treatment) with and without bibliotherapy supplementation. Some research could focus on such interventions for teenagers alone or with a parent or perhaps with a best friend. Prior studies show that parents and best friends can really make a difference in long-term outcomes. Bibliotherapy may produce greater impact with strong social support than solo interventions due to enhanced understanding of the process and goals by supportive teammates. Those comparisons seem most critical to understand the role of bibliotherapy in programs that do the most good for young weight controllers.

The interaction of the efficacy of bibliotherapy with outcomes may also vary depending on many other factors, such as: age, education level of support people or weight controllers’ own academic achievement and devotion to reading. Considering how consistently clinicians use bibliotherapy in their interventions, additional research on it would help provide better direction about how to use it, including whether to decrease reliance on it (i.e., minimize it as a key element in intensive CBT) or increase its role in some cases (e.g., for those who love reading books).

Finally, researching the mechanisms by which bibliotherapy works for weight controllers could certainly help reinforce the value of such materials and may provide direction for how to write the most useful books. Such studies could evaluate the impact of bibliotherapy for weight management in teenagers/families on moods, cognitive biases/excuses, consistency of self-monitoring, development of healthy obsessions, and other factors.

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35 Ornish D, Ornish A. *Undo it! How simple lifestyle changes can reverse most chronic diseases.* NY: Ballentine Books; 2019.


New Releases by Specialists:


*Sexual Boundary Violations in Psychotherapy: Therapy Indiscretions, Transgressions, and Misconduct.*


We are pleased to announce the publication of our edited book which can be now pre-ordered. *(Publisher: American Psychological Association; ISBN: 9781433834608. Number of pages: 436 ; Dimensions: 229 x 152 mm)*

The book is different from other published books on sexual boundary violations. We seek to reach a broad audience of mental health professionals, covering topics which previously received little or no attention. We begin with an historical overview of the topic, followed by a chapter on the APA ethics code and legal statutes and one on boundary challenges. Victim/survivor clients are given center stage in this book, with consideration of why those who report are typically treated poorly, with suspicion or outright disbelief. We recommend the need for compassionate and respectful response for them as individuals and an increased understanding of the confusion/ambivalence they often express due to the betrayal trauma they experienced. We extend the concept of betrayal trauma from the individual therapist abuser to colleagues and others as bystanders and to organizations and their attempts to cover-up such complaints. We suggest what might be done differently going forward to give victims the care and attention they deserve.

In another contemporary approach to the topic, we consider sexual boundary violations from various theoretical perspectives (e.g., cognitive behavioral, sex therapy, gestalt therapy, feminist therapy, psychoanalytically-oriented psychotherapy), and we consider boundary violations in a variety of settings (e.g., pastoral counseling, private practice, community mental health center) involving new contexts (e.g., digital and social media mechanisms) and
with various populations (e.g., racial and cultural and sexually diverse dyads). The most common dyad until recently has been the older male therapist and the younger female client; however, reports of abuse by female therapists are now on the rise. The often convoluted dynamics of such abuse, the therapist’s character, and the range of serious aftereffects to the victim, therapist, and others are considered as well. Survivor stories and a detailed interview with Andrea Celenza are included.

The book contains chapters on treating previously abused clients in subsequent therapy, supervision of therapists who have engaged in sexual conduct, and the treatment of therapists who sexually offend with an eye towards whether rehabilitation is possible. In the epilogue, major themes are identified as well as directions for prevention and intervention.

This text includes chapters by some of the major contributors to the sexual boundary violations literature (e.g., Andrea Celenza, Philip Hemphill, Mark Gold, Gary Schoener, Laura Brown, Linda Campbell, Stephen Levine, Elizabeth Goren, Sue Grand, Christine Courtois, Judith Alpert, & Arline Steinberg).

Christine A. Courtois, PhD, ABPP, a counseling psychologist, is retired from clinical practice and now serves as a consultant/trainer on trauma psychology and treatment. She is a Fellow of the American Psychological Association (APA) and the International Society for the Study of Trauma and Dissociation. Dr. Courtois is a past president of APA Division 56 (Trauma Psychology) and served as Chair of the APA’s Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder in Adults. She has received the Award for Distinguished Contributions to Independent Practice from the APA, the Sarah Haley Award for Clinical Excellence from the International Society for Traumatic Stress Studies, the Award for Distinguished Service and Contributions to the Profession of Psychology from the American Board of Professional Psychology, and the APA Division 56 Lifetime Achievement Award. She is coeditor of Treating Complex Traumatic Stress Disorders in Adults, Second Edition, and Treating Complex Traumatic Stress Disorders in Children and Adolescents, and coauthor of Treatment of Complex Trauma: A Sequenced, Relationship-Based Approach.

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