Contents

President's Column ................................................................. 2
Executive Officer Column ....................................................... 5
Editor's Note ................................................................................ 5
American Board of Clinical Health Psychology Updates .............................. 6
American Board of Clinical Neuropsychology (ABCN) & American Academy of Clinical Neuropsychology (AACN) Updates .................................................. 10
American Board of Clinical Psychology Specialty: Recognition of Our Examiners .......... 12
The Business of Practice: How to Become Forensic Board Certified ............................ 14
American Board of Geropsychology Updates ........................................... 17
American Board and Academy of Psychoanalysis ........................................ 18
American Board of Rehabilitation Psychology Updates: Then and Now .................. 20
American Board of School Psychology: An Update and Request ....................... 23
What My Wiser Self Would Have Loved to Hear. Elicia Nademini ............................... 25
Path to and Benefits of Board Certification in Forensic Psychology. Danielle Rynczak .... 27
Scholarships Supporting Psychologists Seeking Board Certification. Vladimir Nacev ........ 29
In the Eye of the Beholder: The Experience of Being Mentored During the Isolation of the Pandemic. Kat L. Wright, Alexandra DW Sullivan, & Rex Forehand ....................................... 31
Loneliness and Suicide. Samuel Knapp ................................................. 35
Loneliness and Cognitive Impairment in Cancer Survivors: The Role of Assessment and Intervention for Enhancing Quality of Life. Robin Newman, Kathleen Van Dyk, Christina Weyer Jamora, Jennifer Strang, Sherry Hite, Natalie Kelly, and Arash Asher ................................................. 46
Addressing social disconnection in the context of treating later-life depression. Ann M. Steffen ................................................................................. 53
Group Telehealth for Older Adults: Learning from the COVID-19 Pandemic .................. 60
A Bridge for Others. Tim Daugherty, Blanca Martinez, and Juan Meraz .......................... 62
Gender-Based Discrimination: A “forgone conclusion” that we should stop researching? Danielle Terry .................................................................................. 65
Prisons, Psychology, and the Isolated Mentally Ill. Stephen A. Ragusea ......................... 67
The Impossibility (Difficulty) of Persuasion. David B. Tarr ........................................ 69
Loneliness as a Reflector of Psychological Problems at Later Life. Brad Lian, Ian Yeager, & Lee Hyer ............................................................................ 72
Psychologists in Public Service. Samuel James .................................................. 76
First Annual Conference of the American Academy of Forensic Psychology .................. 78
New Board-Certified Specialists/Subspecialists .................................................. 79
In Memoriam - Thomas John Vaughn, Jr., PhD, ABPP ........................................... 81

the Specialist Editor: Kristine T. Kingsley, PsyD, ABPP
I returned from my first in-person conference a few days ago and was struck by how happy my colleagues and I were to see each other in the flesh. I will admit that it took some getting used to, but quickly it began to seem almost normal. I bring this up, because one of my friends/colleagues was given a Distinguished Career Award in this organization (not ABPP, although the person does have an ABPP). In his short acceptance speech, he mentioned that he gives the following advice to each student who joins his lab: “Work hard and be nice to each other”. Those words struck a chord in me, and I wanted to share it with you as I start my two-year term as your President. The work is hard and plentiful, but it needs to be fun, and we need to be nice to each other!!! It is my new motto!

I stepped into the ABPP President’s role in January 2022, as the first Canadian (well actually dual citizen) President, and there is much to report! I am truly enjoying working with our dedicated Executive Officer, Central Office staff, and Executive Committee. We all have been hard at work in the first ½ of 2022, with some excellent outcomes! In this space, I will bring you up to date on both challenges and opportunities. Of course, as always, our ultimate goal is to further nudge the culture of professional psychology in the US and Canada toward one of board certification as a professional expectation. All our projects and initiatives are aimed at helping us achieve this goal.

First some introductions…

Our Executive Committee (EC) is comprised of the President, Past President, President Elect, Treasurer and Secretary. The Executive Officer (EO), Dr. Cox, and Associate Executive Officer, Ms. McDonald, are ex-officio members. Dr. Christina Pietz, Board Certified in Forensic Psychology, has moved into the Past President position. I have and will continue to turn to her for input based on her accumulated wisdom and experience as a Trustee and our most recent President. Dr. Rick Day joins the EC as President-elect. Board Certified in both Clinical Psychology and Organizational and Business Consulting Psychology, Dr. Day brings wisdom and pertinent experience to our leadership team. Dr. David Corey, our new Treasurer, is board certified in both Forensic Psychology and Police and Public Safety Psychology. He has already made some excellent modifications to how we think about, monitor, and plan our income/expenditures. Dr. Joel Frost remains our secretary for one more year and continues to document our meetings faithfully, while at the same time contributing his insight and creative ideas to our discussions. I am happy to say that our meetings are collegial and productive. It’s a great group and I am enjoying working with them.

Mid-Year Meeting

We are ramping up for our mid-year meeting to be held in San Diego the second week in June. This meeting is being planned as an in-person meeting and we are looking forward to having our trustees meet in San Diego. It will be a busy meeting, but it will be SO nice to see each other in person. Half of us met in person in Chapel Hill in December with the other half on Zoom, but this meeting is planned for 100% in person attendance. Can’t wait! We will work hard and be nice to each other!

Technology

We have made great progress addressing our ongoing Information Technology (IT) challenge and this continues to be at the top of my priority list for 2022. In December, the BOT approved a motion to move forward with a platform build-out for all the ABPP specialty boards. Cerebral Consulting has worked long and hard in the intervening months, and I am happy to report that all Specialty Boards now have full functionality for handling applications, generic and specialty credential review, written exam registration, practice sample registration/submission/review,
oral exam registration and results entry, and MOC. This process has been extremely challenging, in part due to the differences in culture, criteria and processes within each specialty board that has required Dr. Davis and his team to build a somewhat different platform for each specialty board.

But we now have a system for each board that will take us from application and CR, right through all the stages up to and including MOC. Like any system, it will and should evolve over time. There may be some minor glitches that need to be adjusted, but both Dr. Davis and Ms. Butcher in our central office are available to listen, respond, and help you navigate change. This change process will require patience and a spirit of adventure from everyone involved; some learning and adaptation will be needed, which we busy people do not always enjoy; some corrections will be needed; some instructions and clarification will be needed; some things may even malfunction, but we will fix them. Please be patient, willing to learn, and appreciative of the intense work that has gone into fixing this problem.

It is my hope and expectation that the system will be running smoothly by the time you read this.

Please let us hear from you about your experience with the new platform.

**New Specialty Boards**

It has been a long time since ABPP has added new Specialty Boards (SBs) to our family. We have maintained 15 SBs, and one subspecialty since 2014. During our December 2021 meeting, the Board of Trustees approved both Serious Mental Illness (SMI) Psychology and Addiction Psychology to move into the Monitoring phase of the affiliations process. Assuming they are successful during this period, they will soon become fully affiliated SBs within ABPP. This is truly an exciting time for ABPP as we welcome two new SBs.

**SB Presidents’ calls**

It has long been a tradition at ABPP for the President to hold quarterly calls with the Specialty Board Presidents. In the past, these calls were generally used to inform the SB Presidents about what was going on at the ABPP level. Dr. Pietz, my predecessor, changed the format to a more engaging and inclusive- one wherein participants contribute items to the agenda and share their experiences, ideas, and board processes with each other. There is so much to learn from one another. I have continued this practice and find it extremely stimulating and encouraging. The degree of collaboration, interaction and connection is inspiring. Great ideas are generated and shared. This is a wonderful example of what ABPP is meant to be and I look forward to each call. Work hard and be nice to each other.

**Engagement and Marketing**

The mission of ABPP is to serve “the public by promoting the provision of quality psychological services through the examination and certification of professional psychologist engaged in specialty practice.” This is achieved by certifying psychologists engaged in specialty practice and encouraging the culture of specialty practice in the US and Canada; we should expect our specialists to be board certified, as is the case in medicine. The percentage of board-certified psychologists in the US and Canada is in the range of 4-5%; we have a lot of work ahead of us.

Toward that end, our BOT is involved in several engagement and marketing enterprises that I will briefly describe here:

**The TRUST**

At our December 2021 BOT meeting, the trustees endorsed a motion to enter into a partnership agreement with the Trust, which is the largest insurer of psychologists in the US. Among other benefits, the Trust will host at least two webinars annually provided by ABPP specialists. This agreement will provide us with access to many non-board-certified psychologists.
CONCEPT

Our partnership with CONCEPT is alive and well. By the time you read this, we will have provided the first four in a series of ABPP Webinars presented by board certified psychologists.

- February 2022: Effective Documentation and Record Keeping for Psychologists
- April 2022: Ethics and Psychopharmacology for Psychologists
- May 2022: Using Motivational Interviewing to Help Patients Explore and Resolve Ambivalence to Change
- June 2022: Disability as Diversity

Several more webinars are planned throughout the year, many of which will also be available on-demand. Please visit the CONCEPT website at https://concept.paloaltou.edu/abpp/ for further information.

Logos

All board-certified psychologists may download and use the ABPP logos in your professional communications and signage (with the stipulation that the logos cannot be altered in any manner). A link is provided upon successful payment of your attestation fees that allows specialists to download the logos and add them to their signature lines, etc. Alternatively, you may visit the ABPP website (abpp.org), sign in, and go to the Specialists tab where you can find the logos for download. Help us spread the word by using an ABPP logo wherever appropriate.

Psychologists in Public Service

The Psychologists in Public Service Initiative has been extremely busy in its efforts to reach out to Psychologists who practice in the VA, Bureau of Prisons (BoP) and Department of Defense (DoD) to inform them of the benefits of ABPP board certification. We took part in the VA Psychologists Recognition week in April and are working with Dr. Kingsley, our Chair of Communications and Editor of the Specialist, to produce a special issue in the fall to highlight and profile the good work being done by board certified psychologists in these agencies.

ABPP Foundation (ABPPF) Scholarships and Grants

A variety of scholarships and grants are available through our SBs and our Foundation to help defray the costs of board certification. These are now searchable in one easy place. Please see: https://abpp.org/temp/Awards,-Grants-Scholarships.aspx for a list of opportunities and their criteria. If you would like to add a specialty-specific scholarship or award to this list, please contact Dr. Joel Frost or Ms. Lanette Melville in the Central Office.

In closing

ABPP is busy with many new and ongoing initiatives. As your President, I am grateful for the time and dedication each of our trustees and employees gives to the organization and want to ensure that our efforts are most productive. We are truly a working board, so please take a moment to thank your trustees. I look forward to our ongoing collaboration for the benefit of our specialists, the ABPP organization and our mission. Please feel free to contact me at bspiegler9@gmail.com with your feedback and suggestions.

And at the risk of being repetitive, work hard and be nice to each other!

Brenda Spiegler, PhD, ABPP
President, American Board of Professional Psychology
Board Certified in Clinical Neuropsychology
Board Certified Subspecialist in Pediatric Neuropsychology
Please be sure to read Dr. Spiegler’s column. I had the chance to read it prior to putting together this column and commented to her that I now have nothing to write about since she did such a great job! She did cover much of what I would have been writing, yet there are a few items that I will bring to your attention that are not in her column— and keep it brief.

First, I will reiterate what a nice job is being done with the new technology system that is being built for us by Cerebral Consulting and Dr. Rob Davis, with fantastic assistance from Diane Butcher in the ABPP Central Office. The CO staff have pitched in, and we are very optimistic about the future of this!

We are excited to have the two new specialty boards, Serious Mental Illness Psychology, and Addiction Psychology, starting the process of implementing exams of their founding members. Congratulations to each!

We will be meeting in-person for our Board of Trustees meeting this June. It will be very nice to see everyone at the meeting! We will also be present at the APA Convention in August in Minneapolis. ABPP will hold our convocation on Saturday, as we have historically. If you can join us, please do so.

In July, the International Project on Competence in Psychology (IPCP) was scheduled to meet. I had been asked to participate in that working meeting, as ABPP has been a party to this project since about 2013. Unfortunately, as I write this, the organizers of the IPCP sent me an email indicating that the meeting is being cancelled (as it was in 2020) due to concerns about covid and the war in Ukraine and what impact they may have on the meeting, which was scheduled for July in Slovenia. Hopefully, we can find a time to reschedule this working group.

The profession is busy these days talking about competencies at the doctoral level as well as master’s level. As APA moves toward accrediting master’s degree programs, this has created quite a stir, with a variety of opinions about the matter. Accreditation of master’s degree programs will no doubt lead to needing to deal with licensing, scope of practice, and other matters. This has been a significant discussion within APA, and I have been serving as a liaison to a working group with the APA Board of Professional Affairs (BPA). The matter has also been raised recently at the Association of State and Provincial Psychology Boards (ASPPB) meeting, which I recently attended. There are strong, and disparate, feelings about what the future holds and how to proceed. At the ASPPB meeting, some discussion was held about licensing, competency and the differences which might exist between those trained at the master’s level versus doctoral level. I took the opportunity to remind the audience that the EPPP and other credentials reviewed for licensing do not really evaluate competence and though since 1947, ABPP has done that through our specialty examinations. Granted this is an evaluation at the specialty level, yet it does provide a model for evaluation of competence which could be used in other ways.

I want ABPP to be proactive in thinking about if and how this movement may affect us. Therefore, have asked our executive committee to start thinking and discussing how that area may or may not affect ABPP. As those discussions proceed, we will bring you more information.

Enjoy the warm season and stay healthy!

David Cox, PhD, ABPP
Executive Officer
What are the causes of mass loneliness, and what consequences might it have, not only for individuals, but also for cultural and political life?

In 2017, a government commission in the U.K. issued the findings of a twelve-month investigation on the prevalence of loneliness. More than nine million Britons—14 percent of the country’s population—were reportedly suffering from loneliness. Among the most vulnerable cohorts—individuals with disabilities and the elderly. The committee made recommendations which allowed for practices and programs cultivating conversation, friendship, and empathy. The Prime Minister was committed to address the rising rates of social isolation and hence the appointment of a Minister of Loneliness in 2018.

Then came a global pandemic. Now, it appears that we are facing a mass epidemic of loneliness—one likely exacerbated by the fear of illness and ensuring quarantine. Approximately 20-43 percent of American adults over the age of 60 experience “frequent or intense loneliness.” It is clear from medical research that loneliness has significant health impacts: lonely people are more likely to develop chronic health conditions and die younger. The rate of social isolation was rated worse than smoking 15 cigarettes per day (Mark Robinson, chief officer of the UK). Loneliness and social isolation are growing public concerns in our society regardless of individual characteristics. With that concept in mind, we asked our ABPP membership last March comment on the topic. More specifically, we announced that we were interested in receiving featured stories—covering assessment, intervention, education, and advocacy to reduce loneliness and promote connection between those we serve, as well as amongst ourselves as professionals. We added that we want to showcase the work of specialists done to restore and maintain the social ties that foster wellness and growth in individuals and groups across the lifespan. I am excited to say that quite a few of you responded to the call; I am deeply grateful. We received a number of excellent articles written about interventions regarding loneliness and suicidality, loneliness and cancer, mentorship, and training during the era of a pandemic, loneliness and the incarcerated seriously mentally ill, social isolation and later life depression.

In addition to our featured articles, this issue is filled with updates, opportunities for training as well as stories shedding light to the future orientation of our organization.

We, members of the Communications Committee, are always eager to receive great submissions. Please take a moment to provide to the Editor and/or the Committee at thespecialist@abpp.org your thoughts on how we can improve our publication and media presence.

Alas, volume 50, would not be possible without the support and guidance provided by the members of the Communications Committee—Drs. Catherine (Kitty) Deering, Laura Anne Flashman, Jay Earles, Shane Owens, Susan Whitbourne, & John Watkins. I must also not neglect to mention the valued mentorship offered by Dr. David Cox (Executive Officer) and the hands-on guidance and reality check I receive from Ms. Nancy McDonald (ABPP Associate Executive Officer) and Ms. Lanette Melville (ABPP Information Systems & Marketing).

For Submission Guidelines, please click https://abpp.org/News-Events/Newsletter-Online-CE-Exam/SubmissionGuidelines-the-Specialist.aspx. Lastly, follow us on via our ABPP Facebook page or on twitter @getabpp.

Respectfully,

Kristine T. Kingsley, PsyD, ABPP-Rp
Editor, the Specialist
ABPP Communications Committee Chair
Edward Hopper, Automat, 1927.

Despite the challenges of what feels like an unending pandemic, the American Board of Clinical Health Psychology (ABCHP) continues to experience high levels of interest in board certification in Clinical Health Psychology and concurrent increases in the numbers of applicants for board certification. While waning in intensity, COVID continues to pose challenges to the boarding process in terms of applicants’ altered work schedule and personal lives, limited access to patients, transition to virtual care, and disruption in travel for oral exams. ABCHP, with the assistance of ABPP Central Office, worked tirelessly to assist applicants facing unusual challenges and to revise the exam process to accommodate these challenges.

As is the case with other ABPP boards, ABCHP shifted to enable virtual examinations, and this model remains necessary, yet presents some challenges. For instance, during a recent exam, examiners and examinees navigated unexpected disruptions in connectivity due to power outages in Texas during a historic ice storm. Molly Clark, PhD, our phenomenal exam coordinator devised a contingency plan for virtual exams that helped tremendously in circumventing the technological issues that arose during that virtual exam. Due to ongoing issues with facility travel restrictions due to COVID, we continue to offer virtual exams, but are also resuming some in-person exams. February 2022 was our first in-person exam since COVID.

We acknowledge that oral exams are stressful for many and that opportunities to improve the process arise. To continuously improve the exam process, we closely monitor and discuss examinee feedback after each exam. With more recent exams, most examinees reported a preference for in-person examinations, yet most also reported high satisfaction with the virtual exam process and were particularly grateful for an opportunity to practice with Zoom prior to the actual exam. As we continue to process more and more applicants, we are fortunate that so many of our newly minted specialist are eager to become involved with ABCHP activities, which is evidenced by the number of new specialists who trained as oral examiners or practice sample reviewers. Additionally, new specialists, as fellows of the American Academy of Clinical Health Psychology (ACHP), are increasingly joining the ranks within our mentorship program for board certification candidates.

Dr. Rena Nicolas serves as the ABCHP credentials reviewer and Dr. Kathleen Darchuk is our practice sample coordinator. Over the past six months or so, both dealt with significant technical issues related to the ABPP server transition. Unfortunately, due to technical issues beyond our control, several applicants experienced a longer than expected wait time for credential and practice sample reviews. Naturally, some candidates experienced frustration with this process. The ABCHP board would like to extend our sincerest apologies to all affected by this transition. While still in process, the migration to a new IT platform will greatly improve the accessibility of documents and make the review process more timely and hopefully seamless.

The voice of early career psychologists (ECP) on our board and in the ACHP is important for development of the next generation of specialists. In recent months, our early career member-at-large on the board, Dr. Stacy Ogbeide, conducted an ECP survey to assess ways in which the ABCHP could better serve the needs of ECP members. The most popular activity of interest to ECPs was availability of webinars addressing ECP issues unique to clinical health psychology. ECPs also voiced interest in regional networking events and a mentoring program. The board looks forward to implementing many of the suggestions offered in the survey and working closely with Dr. Ogbeide on issues of importance to ECPs.

ABCHP works hand and glove with the American Academy of Clinical Health Psychology (ACHP). Dr. Christina B. Shook, the Academy President, continues to spearhead several important activities for recruitment and education. Educational sessions and webinars via YouTube and other electronic means of communication are utilized to reach an increasing number of potential candidates. The busy mentoring program for new candidates for board certification is currently in full swing.
certification continues to thrive and mentor the future of clinical health psychology. The significant efforts of the Academy are instrumental in driving the remarkable increase in interest in board certification in CHP.

Both the ABCHP and the ACHP value diversity and inclusion and engage in ongoing efforts to promote and embrace diversity in terms of gender, ethnicity, cultural background, ability status, sexual orientation, and professional background of the two boards and in Academy membership. Recent efforts by ACHP include working to increase representation of individuals of color in educational content, particularly webinar presentations and educational videos aimed at marketing and mentoring candidates seeking board certification in CHP.

Other diversity activities deserve recognition. Dr. Marquisha Lee, an ABCHP board member, is collaborating with Dr. Tanecia Blue, Diversity, and Inclusion officer for Society for Health Psychology (SfHP), and Dr. Christina B. Shook, President of the Academy aimed at promoting the benefits of board certification and SfHP membership to a broader and more diverse audience. Drs. Marie Weil and Chaska Gomez, members of the Academy Board, are also involved in more purposeful efforts to promote diversity among the membership. The Academy BOD and its Board will be meeting to discuss opportunities to purposefully connect with people of diverse backgrounds to educate and create opportunities to learn more about board certification in CHP.

The last few years threw us a few curve balls for sure. No doubt COVID has changed us all in incalculable ways and tested our ability to adapt to a new way of living and doing business; however, given the recent trends in COVID data, it is our hope that our world, as we know it, is lurking right around the corner. The directors and board members of ABCHP and ACHP wish you all the best going forward and look forward to better days ahead.
American Board of Clinical Neuropsychology (ABCN) and American Academy of Clinical Neuropsychology (AACN) Updates and Announcements

Kathleen Fuchs, PhD, ABPP, President ABCN
Dean Beebe, PhD, ABPP, President AACN

ABCN and AACN are very proud to support the Minnesota 2022 Conference to Update Education and Training Guidelines in Clinical Neuropsychology which will be held September 12-16, 2022. This is a multi-organizational initiative to update the Houston Conference Guidelines which were developed in 1997 to define and promote a competency-based model of education and training in the specialty of neuropsychology. Much has changed in our society and in the practice of neuropsychology since 1997 including how technology impacts our assessment methods as well as increased sensitivity to the needs of a diverse workforce and patient population. This conference aims to develop an updated policy statement that details a well-articulated competency-based approach to training, integrates diversity and cultural issues within every training experience and competency, and incorporates of new technologies and advances in neuroscience, data analytics, and computer technology.

This is a significant undertaking for our field. A planning commission of more than 35 representatives from the major education, training, and practice organizations in neuropsychology has been meeting for the past year to work out the logistics, financing, delegate selection, and conference program and process.

The commission selected Minneapolis, MN as the site of the conference for several reasons. That area has a significant neuropsychology presence, is relatively easy for delegates to travel to, and has relatively low on-the-ground costs. The Funding and Logistic Committee is in the process of securing donations and sponsorships from several practice organizations, and to date AACN has been the largest financial sponsor. Many individuals have also made donations in honor of their mentors or colleagues. An important feature is that donations can be made specifically to support the equity and inclusion goals of the conference by removing financial barriers to participation faced by some delegates.

The Delegate Selection Committee was tasked with obtaining and reviewing nominations from the training, practice, and identity organizations within neuropsychology as well as self-nominated “at large” candidates. A key goal is to include voices that have not always been heard or had a seat at the table. Accordingly, care was taken to ensure that there would be representation from individuals at all stages of training and practice, geography, and identity. Of the 55 delegates and alternates selected, 40% identify as BIPOC.
The planning commission is currently working on setting the agenda and incorporating content experts to guide discussion and crafting of guidelines in practice and professional competencies; diversity, equity, and inclusion; and technology. Specific aspects of the previous guidelines will be reviewed and worked upon each day by breakout groups with a synthesis of work, plan for implementation, and goals for the “next steps” to be set by the end of the week.

It is an ambitious undertaking and we at ABCN and AACN thank the delegates in advance for their commitment to this work. For more information and updates, please visit: https://minnesotaconference.org

Outreach to Trainees

With the Minnesota Conference Update on the horizon, this is an appropriate time to highlight the activities of AACN’s Student Affairs Committee. This highly group supports our emerging scientists and practitioners in several ways. It offers travel scholarships to the AACN annual conference, free student and trainee-specific content at the conference, and awards for outstanding student-led papers and posters. The student mentorship program is especially popular and to date has paired 310 mentors and mentees. The Student Affairs Committee also recognizes particularly outstanding mentors for their dedication to the next generation of leaders in neuropsychology. It has also worked with other committees to present webinars that demystify the field and the board certification process for trainees. Finally, members of this committee have spearheaded three empirical papers in recent years to identify the needs of students, both before and during the pandemic.

Additional Initiatives

The emphasis on equity and inclusion in the Minnesota Conference Update also echoes an emphasis within the specialty. The AACN has earmarked at least 10% of its gross annual revenue to its Relevance 2050 initiative, which is dedicated to promoting diversity, equity, and inclusion within the profession and in the clinical care we provide. The name of the initiative is based on the projection that the United States will have a “minority-majority” populace by 2050; the goal is to make the specialty even more relevant then as it is now. Recent activities have included an official position paper on the use of race in demographic test norms, as well as the development of an “Author Accelerator Program.” That program is a partnership with three major publications of neuropsychology textbooks, in which authors from underrepresented populations are provided with mentorship to develop book proposals. Relevance 2050 has also agreed to co-fund with the APA a series of books and presentations on neuropsychology as a career, targeting students at academic institutions serving BIPOC communities. Soon, the committee plans a pre-conference networking event for undergraduates and high school students each year in the host city for the annual AACN conference, as well as a webinar series to showcase pathways to careers in neuropsychology.

Finally, the Public and Professional Information Committee of the AACN has around 10000 Facebook followers and >3100 twitter followers. It posts timely, lay-friendly infographics, expert summaries of relevant topics, and professional announcements. The goal is to leverage contemporary ways to inform our colleagues and the public and engage the next generation of specialists.
American Board of Clinical Psychology Specialty: Recognition of our Examiners

Lindsay A. Phillips, PsyD, ABPP
President, American Board of Clinical Psychology

The American Board of Clinical Psychology has been active in the last several months - conducting practice sample reviews, oral examinations, and making improvements regarding both technology and process. Our board’s work and the growth of the clinical specialty would not be possible without the dedication of our specialists who serve as examiners.

Our board hosted examinations and comprehensive examiner training in Charlotte, North Carolina on April 22nd followed by our board meeting on April 23rd. Our examinations held the day prior to our board meetings have always served the function of training new examiners and chairs, as well as conducting examinations together as board members to ensure that all regions conduct examinations that follow the procedures of our examination manual and provide a collegial experience for candidates. In this most recent meeting, we devoted additional time to process our procedures after our Friday examinations and spent more time with new examiners – aimed at improving examiner training and hopefully retaining examiners by devoting more time to answering their questions and getting to know them. Our board was in unanimous agreement that spending more time with examiners and more time processing after the examination experience will likely improve training of new examiners – and it also proved to be a rewarding and enjoyable experience. More time in training and processing of the examination experience will also better serve our board members’ ability to recalibrate, learn from other experienced examiners, and ensure that we are following procedures.

In addition to improving training during our recent examinations in Charlotte, we have developed new resources for training examiners, including handouts that summarize relevant procedures for examiners in our examination manual and provide suggestions. We have also developed videos on the benefits of being an examiner and tips for oral examinations. These resources are available to all examiners. We also hope to increase our benefits of service for examiners, as well as recognition of the vital service they provide to the Clinical Psychology specialty. We are appreciative of ABPP for pursuing and obtaining the ability to earn CE for serving in oral examinations. The education facet of our academy has also developed two CE based on our examination manual, which could be an attractive benefit for recently board-certified specialists as well as our examiners, as they regularly utilize our manual.

We are also excited to increase our recognition of specialists who devote their time to serving as examiners. Leo Caraballo, current Vice President, and Membership Director developed a Senior Examiner designation which was approved by our board in our fall 2021 meeting. Senior Examiners are those specialists who are board certified in Clinical Psychology and have demonstrated dedicated service to the American Board of Clinical Psychology as examiners. Examiners will be recognized when they have had exemplary service - having served on at least 10 board examination committees and as an examination chair on no fewer than 3 committees. We look forward to announcing our first group of recognized Senior Examiners in an upcoming edition of The Specialist.
In addition to improving training and recognition of examiners, we continue to aspire to increase our number of examiners and actively recruit and welcome examiners of diverse backgrounds, varied practice settings, and with a range of years in practice. The predominant location for oral examinations is now virtual, which eliminates travel costs for candidates and allows for examiners from diverse locations to gather. For our specialists reading this update, if you do not currently serve as an examiner and want to be more involved, this is a great time! The now-common occurrence of virtual examinations allows all specialists to be involved regardless of location. Your willingness to serve as an examiner in your region is one way to continue your commitment to the organization. You can contact me or any of our Regional Directors if you wish to learn more about being involved and serving as an examiner. We are committed to being an inclusive board, welcoming specialists of all backgrounds and experiences to work together to conduct examinations and grow our specialty. Our recent training and examinations in Charlotte were both productive and enjoyable – our board looks forward to getting to know more of our specialists through engaging in examinations and training together.

Lindsay A. Phillips, PsyD, ABPP
Board Certified in Clinical Psychology
President, American Board of Clinical Psychology
lphillips@marywood.edu
The Business of Practice: How to Become Forensic Board Certified

Board certification provides clinical psychologists the opportunity to advance in their career academically, access positions with higher pay, and fit specialized professional roles. This article covers the steps necessary to become a board-certified forensic psychologist through the American Board of Professional Psychology.

Forensic board certification is one of only two specialty board certifications recognized by the American Psychological Association Directory meaning the certificate holds a longstanding significance in the psychological community.

Dr. Richart L. DeMier is a board-certified forensic and clinical psychologist who offers a program, in partnership with the American Academy of Forensic Psychology and CONCEPT, on preparing for board certification in forensic psychology. Dr. DeMier covers:

- The fundamentals of forensic psychology
- Why earning board certification is valuable
- How to navigate available resources in preparation

To see how board certification is achievable with CONCEPT, read Dr. Kyle Clayton’s case study. Dr. Clayton, Ph.D., ABPP, is now a Board-Certified Forensic Psychologist.

Forensic Organizations to Know Familiarize yourself with the following psychology organizations to avoid confusion throughout the application process:

The American Board of Professional Psychology (ABPP) is the major organization to offer specialty board certification for various specialties like forensic psychology. ABPP is where the application process resides.

The American Board of Forensic Psychology (ABFP) is responsible for the certifying process. ABFP-certified professionals work with the ABPP to conduct various parts of the certification process, such as the oral exam.

The American Academy of Forensic Psychology (AAFP) is a nonprofit organization composed of board-certified forensic psychologists. AAFP offers continuing education, promotes scientific discourse, and presents professional awards.

AAFP, AAFP, and ABFP are independent yet affiliated organizations. They consist of similar organizational goals to maintain high standards of specialization within the forensic psychology field.

Step 1: Apply for ABPP Board Certification

A licensed psychologist needs to complete the application with the American Board of Professional Psychology to begin the forensic board certification process. Here’s a link to register for the application process.

Step 2: Meet General Requirements

- Accredited Doctoral Degree Program or Equivalent
- Licensure
- Accredited Internship or Supervision
To earn a specialty certification in forensic psychology, an applicant must meet both the specialty and general requirements indicated by the American Board of Professional Psychology. An applicant needs a doctoral degree from an accredited program to meet the general requirement.

Acceptable degrees include American Psychological Association accreditation, Canadian Psychological Association accreditation, or a Certificate of Professional Qualification (CPQ) by the Association of State and Provincial Psychology Boards (ASPPB). After 2018, health service psychology programs are eligible with the proper accreditation.

Also, the candidate must be a doctoral, licensed psychologist who is able to practice independently. This ASPPB resource details location-specific licensure requirements. The applicant must also complete their accredited internship or supervised experience to fulfill the general requirement.

If your psychology program does not have the necessary accreditation, there are supplemental forms to upload with your application for the ABPP committee's consideration. This option applies to degrees earned in the United States and Canada.

At this point in the process, the application undergoes a review to certify their credentials. If accepted, the candidate is eligible to continue with the rest of the application process.

### Step 3: Meet Specialty Requirements

**Accredited Doctoral Degree Program or Equivalent in Professional Psychology**

100 Hours of Postdoctoral, Specialty Training

**Continuing Education**

1:1 Supervision with Qualified Professional

**Graduate Level Course**

**Postdoctoral Specialty Experience**

1,000 hours of direct experience in forensic psychology over a minimum of 5 years

OR

2,000 hours formal postdoctoral training program in forensic psychology

Your professional psychology degree needs to hold APA or CPA accreditation to meet the specialty-specific requirements. Certification requires at least 100 hours of qualifying, specialized training after completing a doctoral program.

One-to-one supervision with a qualified professional, certified continuing education programs from an organization like CONCEPT, and didactic graduate-level courses satisfy the 100-hour requirement.

Specific programs qualify for a waiver toward the postdoctoral specialty experience, so browse the ABFP Experience Waiver Postdoc Training Guidelines from the forensic specialty document library.

### Step 4: Complete Written Exam & Submit Practice Samples

Certification in forensic psychology requires a written exam. The exam includes 208 questions covering seven subjects in forensic psychology. The written score is valid for five years. Candidates who pass the written exam are able to submit practice samples.

Practice samples are necessary to demonstrate specialty skills. ABFP requires two distinct samples, usually forensic reports written during their time as a practicing professional. The accepted samples decide the topics evaluated during the oral examination.
The written examination includes a $300 fee, and the practice samples require a $250 payment. Certain discounts apply to members like those who hold a Certificate of Professional Qualification (CPQ).

**Step 5: Complete Oral Exam**

The oral examination consists of three ABFP certified psychologists who assess a candidate's breadth of knowledge in the provided samples, forensic ethics, and core competencies. The time during the exam is split between discussing the two distinct cases in the forensic report provided as a sample. The oral examination rubric lists ethical standards, quality of practice, and knowledge of forensic areas as measurable components. There is a $550 fee to take the oral examination, which lasts approximately 3 hours.

Candidates who pass become specialists with ABFP, ABPP, and AAFP. Those who do not pass the oral examination either must submit two new samples in the following examination, and candidates who do not pass twice must wait one year before their next attempt. There is also a process to appeal a decision in the oral examination guidelines.

**Step 6: Receive Certification**

After succeeding through the previous steps, the final one is celebrating board certification. ABPP provides a list of twelve certification benefits. Most certification benefits involve pay benefits, professional career advancement, and privileges in hospitals or medical centers.

**Application Checklist**

- Doctoral Program Information
- Internship Program Information
- State Licensure Details
- Specialty Experience Documentation & Details
- Membership Affiliation Details
- Ethical Violations History
- Endorsement Forms or Letters of Recommendation
- Current CV
- Application Fees

This official overview and introduction to ABFP includes a guideline to the board certification process, the importance, and the rationale behind the examination procedure.

**About the Author**

**Jasmine Monfared | Written for CONCEPT Continuing & Professional Studies, Palo Alto University**

Jasmine Monfared holds a post-bacc certificate in Counseling and Psychology professions from UC Berkeley Extension. She volunteers as a crisis counselor on a local hotline that serves 15+ counties in Northern California. Jasmine graduated from UC Berkeley with a sociology major and a minor in journalism. As an undergraduate, she implemented mental health curriculum in a faculty-sponsored sociology course with an emphasis on accessibility and diversity.
Updates from the American Board of Geropsychology (ABGERO)

The American Board of Geropsychology (ABGERO) continues to add new specialists to its membership at a healthy pace, with 9 candidates successfully passing the oral examinations since January alone! We have set a goal of having a total of 100 ABGERO specialists by the end of this year, and we appear on pace to exceed that goal. We are also introducing a new scholarship program aimed at defraying examination costs for members of underrepresented groups and/or early career professionals. Details will be announced soon. We also continue to interface heavily with the VA system in terms of recruitment and providing educational offerings in tandem with other Geropsychology organizations.

Andrew L. Heck, PsyD, ABPP
Licensed Clinical Psychologist
Board Certified in Geropsychology and Clinical Psychology
President, American Board of Geropsychology (ABGERO)
Before I review the activities of our Board and Academy—enumerate the many exciting developments that have taken place in the last year and the changes yet to come, I would like to take a moment to acknowledge that everything that has transpired in the last two plus years for all of us, has been in the context of a pandemic that has cost millions of lives and has directly or indirectly affected the lives of everyone. I extend my heartfelt wishes for good health to all, and my sincere appreciation to my fellow professionals who give their time and energy for the betterment of the profession, while insuring through board certification, excellence in the delivery of psychological services to the public.

While the pandemic has required modifications in the way we practice and teach, such as our needing to suspend in-person contacts with our clients, students, supervisees, and colleagues, it has also afforded us new, and sometimes unanticipated opportunities. While we at ABAPsa sorely missed our yearly in-person board meetings during the annual spring meeting of Division 39 these past three years, the Zoom format offered us, and other Boards, the ability to conduct oral exams via videoconferencing for the first time. The result is that we were able to better accommodate applicants, eliminate travel expenses for applicants and examiners, lower the overall carbon footprint associated with exams, and board certify more applicants during this period than in comparable periods in previous years.

In addition to board function of conducting exams, we are combined with a very active Academy. Our Academy is offering our eighth annual book award which honors outstanding scholarship, raises awareness and visibility of the field, and educates the public on the value of psychoanalytic thought. Book Prizes are offered in four categories: theoretical, clinical, historical, and applied psychoanalysis. We also have an online journal Metalepsis, which is in its third year of publication, and is accessible through our completely redesigned website, https://www.abapsa.org.

Also accessible on our website is our annual FreeBook which is provided in collaboration with Routledge Press. The book presents clinical work from the practices of Board-Certified Psychoanalytic Psychologists working from a wide array of theoretical orientations with patients whose problems in living are equally diverse. The Academy has an active Mentorship Program and is working to establish ongoing mentoring liaisons with training sites.

We are also proud to announce that 2022 marks the second year of our Diversity Application Scholarship Program. Each year ABAPsa offers two specialist applicants a Diversity Scholarship covering all fees and expenses related to application and examination processes. As part of our mission to address Equity, Diversity, and Inclusion, we have added a Diversity, Anti-Racism and Racial Equality, and Social Justice Statement to our website. ABAPsa is dedicated to the development and growth of an increasingly open and diverse organization by supporting and including the engagement of members from varying backgrounds based on race, culture, ethnicity, sexual orientation, socioeconomic status, disability, and sexual and gender expression. ABAPsa works to promote an understanding of how psychoanalytic theories influence clinical practice with people from oppressed and disenfranchised racial and ethnic identifications, sexual orientations, and gender variances. To this end we have grown our board by adding two standing liaison positions: Early Career Psychologist, and Graduate Student. The first appointees are of diverse heritage and identification.

To continue to address EDI, to better reflect how psychoanalysts and psychodynamic psychologists practice, and to represent the vast majority of doctoral psychology members of the Society for Psychoanalysis and Psychoanalytic Psychology (SPPP, Division 39) more accurately, ABAPsa began an initiative in 2019 to grow and restructure our board. In coordination with the Psychoanalysis Specialty Council of CoS, we developed CRSSPP petitions for a new Specialty in Psychoanalytic and Psychodynamic Psychology and Subspecialty in Psychoanalysis. We are pleased to
announce that CRSSPP has recommended both the Specialty and Subspecialty to APA Council of Representatives for full approval. In support of this initiative, Division 39, Psychoanalytic Specialty Council (PSC), and ABAPsa jointly conducted a survey of Division 39 and local chapters, with N = 1,350 respondents completing this survey. This survey was the first of its kind representing both psychodynamic psychologists and psychoanalysts. The survey included a Specialty and Subspecialty change needs assessment; diversity, equity, inclusion data; taxonomic levels of opportunity for all stages of training; patient populations, clinical settings, practice patterns; student loan and income ratios; integration with other theories and techniques; regional population density differences; and continuing education and post-licensure education and training.

Our research and investigative efforts led us to develop a Comprehensive Interactive Research Database in Psychoanalytic and Psychodynamic Psychology: Containing over 1,200 articles organized into a searchable, interactive database, including abstracts and citations coded on 15 dimensions for over 50 variables. The database includes over 300 randomized control trials as well as psychoanalytic and psychodynamic psychology dissertations. We have also developed a Multicultural, Diversity, and Social Justice Database in Psychodynamic Psychology and Psychoanalysis, the Discipline-Specific Knowledge Foundations of Psychodynamic Psychology Database, and the Education and Training Database.

Based upon our survey, we found that 81% of psychologists in the SPPP (Division 39) identify as Psychoanalytic and Psychodynamic Psychologists (PA/PD psychologists), and that 70% do not meet the criterion for the current specialty in Psychoanalysis. A great majority of these members have education and training in psychoanalytic and psychodynamic psychology equivalent to other specialists recognized by CRSSPP and ABPP, and are more representative of cultural, economic, racial, gender, sexual, disability, geographic, and immigrant diversity.

Results of our survey indicate widespread interest and commitment to the field, and significant interest in applying for specialty certification in Psychodynamic Psychology. Survey respondents had substantial Psychoanalytic and Psychodynamic Psychology experiences at all levels of training and thus represent a sample of the psychologists most likely to apply for Psychodynamic Psychology Specialty Board Certification. When asked, “How likely is it that you would apply for an ABPP Specialty Board Certification?”, 63% said they were likely to apply for the Psychoanalytic and Psychodynamic ABPP within 5 years. Over a third of the respondents expressed an intention to pursue subspecialty training in Psychoanalysis.

With the recommendation to the APA Council from CRSSPP, and the support of the Accreditation Council for Psychoanalytic Education (ACPEinc), SPPP (Division 39), and the Psychoanalytic Specialty Council (PSC), ABAPsa is currently in the process of submitting applications to the ABPP Affiliations Committee for the reorganization of the current specialty board in Psychoanalysis into a Specialty Board in Psychodynamic Psychology, with a Subspecialty in Psychoanalysis.
American Board of Rehabilitation Psychology Updates: Then and Now

Serina Hoover, PsyD, ABPP-RP, QME
ABPPRP/CN, President of the ABRP

Kathleen Bechtold, PhD,
Board of Trustees
Representative of ABRP

The American Board of Rehabilitation Psychology (ABRP), which was established in 1995, is a specialty area of psychology practice that serves people across the lifespan who have been affected by an injury or chronic condition that leads to disability. The goal for rehabilitation psychologists is to help patients maximize health, emotional well-being, independence, and functional outcomes who have a congenital or acquired disability. Rehabilitation psychologists can serve in a variety of settings, including acute care hospitals, rehabilitation centers, outpatient facilities, nursing homes, specialty clinics, private practice offices, academic institutions, research settings, forensic settings and/or at community agencies that advocate for individuals with disabilities. To date, there are 208 Board Certified Rehabilitation Psychologists in the US and Canada with active certifications and another 57 candidates who are currently in the candidacy process.

As a member board of the American Board of Professional Psychology (ABPP), the ABRP increases consumer protection through the examination and certification of psychologists who can demonstrate specialty knowledge and application of that knowledge in the practice of rehabilitation psychology. Consistent with the broad competency areas delineated by the ABPP, the ABRP Board has created specific behavioral anchors that define the specific empirically validated practices in the field of rehabilitation psychology. The process for examining candidates for board certification in RP is a living entity that evolves over time to ensure the approach is accessible, approachable, transparent, and fair. In the past two years, the ABPP Specialty Boards were faced with several unique challenges given the travel restrictions and social distancing aimed at controlling the pandemic. Although challenged, the ABRP Board discovered several opportunities to re-evaluate the Board certification process and approach. As a result, there have been some key changes that have improved the process.

Welcome to the virtual world...

To continue the examination process unhindered by the imposition of travel restrictions and social distancing due to the COVID-19 pandemic, a virtual examination process was developed and implemented. Through this process, it became clear that the virtual examination reduced or removed barriers to the oral examination process, allowing individuals to access and engage in the process more readily. Consequently, the ABRP Board has decided to continue hosting virtual examinations once a year. For those who prefer to be examined in person, there will also be an annual in-person examination option immediately preceding the Mid-Winter Rehabilitation Psychology Annual Conference.
Evolution of the process…

With an eye to keeping the process fair and transparent, the ABRP Board re-examined the process by which supplemental competencies are assessed. Newly applying candidates will now be asked to identify within their credentialing application if they engage in any of the four supplemental activities (Research, Management/Administration, Supervision, and/or Teaching). If they have engaged in these activities within the prior two years, they will be required to demonstrate their specialty knowledge of that supplemental competency area(s) during the examination process. This approach allows the Board to identify at the beginning of the process which candidates engage in these supplementary areas of practice thus allowing for a more streamlined approach to the examination of those areas of competency.

The ABRP Board has traditionally provided mentorship for candidates in the process. However, this practice has stretched resources given that Board member who are serving as a mentor cannot also serve on the examination team for that particular candidate. To evolve the process but ensure that candidates still received mentorship, the Board is collaborating with the Academy of Rehabilitation Psychology, which an association of individuals board-certified in rehabilitation psychology who promote the science, education, and practice of rehabilitation psychology through continuing education. There are plans afoot for the Academy to take over the mentorship process with candidates by January of 2023. This will remain a collaborative effort in that the ABRP Board and Academy will work closely to create the mentorship program and to provide training to mentors over time to ensure that the process continues to be accessible, approachable, fair, and transparent.

Inclusion for all…

As a Specialty Board that values diversity, the ABRP Board strives to certify quality psychologists of diverse backgrounds and abilities, including race, ethnicity, gender identity, age, sexual orientation, and disability status. The ABRP Board is committed to provide equal access so that more people with disabilities and other marginalized groups can participate in this professional growth process. The ABRP Board has a Diversity Chair and Task Force that is actively working to explore ways to recruit psychologists with disability or varied backgrounds into the process. Furthermore, the ABRP Board has created ways to ensure that our examination process does not have physical or attitudinal barriers to people with disabilities and to those from other underrepresented groups. For example, a policy has been created in implemented that will ensure that any candidate can be provided with reasonable accommodations to minimize barriers so that they may comfortably engage in the examination process. We also ensure that our Board members are provided with any necessary accommodations so that each member of the Board can participate in all Board meetings and activities without restrictions. We strive to be proactive in exploring unique opportunities to ensure that the specialization process is not only accessible but approachable to all individuals so that all who want to engage in this process have equal opportunity.

Come join us…

The ABRP continues to encourage specialty certification in Rehabilitation Psychology and has been actively working with different organizations to educate them about the benefits of Board Certification in Rehabilitation Psychology. To this aim, the ABRP President will be conducting a webinar about Board Certification in Rehabilitation Psychology to the Veteran’s Affairs, Bureau of Prisons, and the Department of Defense in June in 2022 to encourage awareness about the personal and professional benefits of specialty certification. The goal is also recruit psychologists who may be unaware that their professional training would qualify them for rehabilitation psychology specialty certification.

The ABRP Board understands that there needs to be more visibility and distinction of the field of rehabilitation psychology starting at the early phases of training. Therefore, the ABRP has joined the APA Division 22 Rehabilitation Psychology’s Membership Committee and Education and Training Committee to create a literacy campaign for graduate students about the field of rehabilitation psychology. Rehabilitation psychologists across the country will present to various graduate program about the history of the field, our foundational principles, the various professional roles of a rehabilitation psychologist, and how to get involved within the field. The hope is that earlier exposure in graduate training will reveal the benefits of the field of practice resulting in a growth of our professional community.
American Board of Rehabilitation Psychology

Then to Now
We are pleased to announce that ABSP has a new representative to the ABPP Board of Trustees. Dr. Israel Sarasti has been elected and began his term in January 2022. He is a licensed psychologist working for the Miami-Dade County Public Schools (MDCPS). He has been practicing for over ten years as a bilingual school psychologist. His experience has spanned various settings that includes urban public school and non-public archdiocesan schools. For the past four years, he has been the Doctoral Internship Training Coordinator supervising pre-doctoral interns and post-doctoral residents for the Division of Psychological Services of the MDCPS. Dr. Sarasti has served on the Executive Boards for the American Academy of School Psychology (AASP) and the American Board of School Psychology (ABSP) and is currently the Director of Examinations for the ABSP. He is a member of the American Psychological Association’s Committee on Professional Practice and Standards (COPPS) and co-chairs the Record Keeping Guidelines revisions work group. We are fortunate to have Dr. Sarasti as our Board of Trustees representative for school psychology. He is replacing Dr. Shelley Pelletier. She had served on both the AASP and ABSP boards since 2005 including president of both boards and had been our school psychology representative on the ABPP Board of Trustees since 2014. Her term on the BOT ended in December 2021. Her dedication, service, wisdom, and guidance have been invaluable to our Board. We offer her our sincere gratitude for all she has done for us.

As an organization, like most professional groups, we are always in need of additional help carrying out our duties and responsibilities as a board. I would like you all to consider serving as mentors for those applying for specialty board certification, as oral examiners for candidates, and as prospective board members. We also hope that you will encourage other colleagues to consider board certification.

Becoming a mentor is a great way to connect with others and provide support for applicants as they prepare their professional statements and practice samples for submission. It’s an opportunity to give back for the support that you received from your mentor while going through the certification process. We provide training for that role. We are looking for mentors who work in a variety of settings since we try to match applicants with mentors who have similar professional experience and who practice in similar settings. It can be a very rewarding experience for the mentor. Those interested can contact Dr. Emma Cole, our Director of Mentoring (coleem@kennedykrieger.org).

We think that it is a natural progression to move from mentor to oral examination committee member since you become very familiar with the process and the expectations for board certification as a mentor. You would be one member of a three-person team that would conduct the oral exam. As an examination committee member, you would review professional statements and practice samples prior to the examination and determine if a candidate is ready to sit for the exam. We may have exams before or after professional meetings (APA, NASP, CDSPP, etc.) or at other independent times and locations. We also have been conducting exams virtually as needed. All typical travel expenses are covered when exams are scheduled. We provide training prior to becoming an examiner which includes observing oral exams and practice in using the rubrics designed to rate the candidate’s performance. For those of you interested in being an examiner, contact Dr. Israel Sarasti (israel.sarasti@gmail.com).
Two of our board members, Dr. Mark Swerdlik and Dr. Syretta James, will be completing their second and final terms in December and are not eligible for another term. We will be looking for potential board members and will send out an email later in the year requesting nominations or self-nominations. This a great opportunity to participate in board activities and hope several of our board-certified specialists will consider it.

The ABSP has engaged in numerous activities to help raise the board’s visibility within the school psychology specialty. For several years, ABSP has been a member of the School Psychology Leadership Roundtable (SPLR). Other members include APA Division 16 (School Psychology), Trainers of School Psychologists, Council of Directors of School Psychology Programs, Society for the Study of School Psychology, and the National Association of School Psychologists. We meet periodically to discuss issues and concerns related to our specialty and ways to address them. We are currently serving on the steering committee for the Futures Conference with other members of the SPLR. This conference is held every ten years to project a comprehensive plan for the future of school psychology. This year’s conference will focus on social justice as it impacts training, practice, advocacy, recruitment, and leadership. Unlike other conferences, this will be a yearlong event with a variety of engaging activities. There will be more information forthcoming.

In addition, ABSP has provided financial support for this and other conferences which has provided ABSP more exposure to the professional school psychology community. We are supporting APA Division 16’s initiative “Grant Program in School Psychology Internship” to help develop more APA accredited internship sites within individual school systems, within a consortium of school systems, and other agencies and/or universities that work closely with schools. Grants are provided to support and supplement funds to develop internships through several phases of initial development, APPIC member status, APA self-study submission, and APA-accreditation. To assist others in promoting board certification, we are developing PowerPoint presentations on the importance and significance of board certification in school psychology that can be used at professional conferences by our board members and board-certified specialists. We hope that specialists would volunteer to present at their state psychological association meetings and other venues to provide information and create interest in board certification. Those of you who are trainers or directors of training in school psychology programs and internships should encourage other staff to pursue board certification as well as early entry for interns. There are available stipends to help defray the application costs upon successful completion of certification through the ABPP Foundation.

We hope that you will thoughtfully consider volunteering and provide your time and talent in supporting your board as a potential mentor, examiner, board member, and recruiter. Continued board certification demonstrates your commitment to the specialty of school psychology and your professional expertise to the communities that you serve.
What my Wiser Self would have Loved to Hear

Elicia Nademin, PhD, ABPP

Knowing what I know now, there are so many things I would have done differently as I prepared for board certification. Firstly, I wouldn't have taken myself so seriously. I made it so much more stressful than it needed to be. I put a great deal of pressure on myself to be perfect, to be polished, to know every answer, to know every theory, and every famous theorist… I told myself that if I failed, I would make a fool of not only myself but every institution, faculty, and staff who contributed to my training and career. Surely, I'd be a laughingstock of my community. Well, I'm here to tell you none of that is true.

What I know now that I wish I would have known then is that I already knew so much more than I gave myself credit for. The average person who pursues board certification is mostly likely already someone with high standards for excellence and a commitment to high quality care and practice. The person who pursues board certification is very likely already an overachiever (who often knows imposter syndrome QUITE well!). And worst-case scenario, if I were to fail, perhaps it would be a sign that I did not communicate what I know effectively and would have more work to do – that would be ok. I could try again. I'm not a failure, and neither are you.

Looking back, I would have allowed myself to enjoy the process more. Preparing my materials for the ABPP was actually fascinating. I impressed myself with what a student I'd been to my discipline of choice. I thought many times, “Well look at that…I want to be considered an expert in behavioral and cognitive psychology and come to find out…I actually am quite good. I actually do integrate a lot of CBT in my work already. I'm pretty good at what I do. Why don't I give myself more credit?”

I pursued my application process very differently than the average applicant. I set a plan to overcome my weakness and susceptibility to distraction by flying Las Vegas with my laptop and application. I spent a weekend with headphones on in bustling coffee shops where I prepared my written samples then enjoyed breaks for dinner and Vegas shows! I returned home with all of my examination documents ready for editing. Unique? Yes. Effective? Yes! Then, I simply waited. I sent in each prepared item when the board asked for it. For the clinical sample, I showed up to a patient session and got consent to record an example of our success in treatment. Voila!

The real fear set in when I scheduled my oral exam and was assigned my panel of examiners. I familiarized myself with their backgrounds and works. I obsessed about any articles they'd published. I asked colleagues for copies of Psychology journals and information they had on any up-and-coming research in the Behavioral & Cognitive Psychology arena. I robbed myself of an opportunity to enjoy the process by focusing too heavily on cramming in as much research as I possibly could for fear, they'd ask a question I didn't know. Well, they did…and I didn't know it…and I simply said, “I don't know…” (albeit with an increase in heart rate, but that's neither here nor there. I left that exam and emailed 2 colleagues who encouraged me toward ABPP. I apologize pre-emptively for having embarrassed them and thanked them for their supports but was sure I had failed. Truth is, I did great. I not only passed, but I was so moved by feedback from my examiners weeks later that I proceeded to volunteer as a mentor and Ambassador to the Board encouraging future examinees to undertake board certification. I carry so much pride in my credential and the process that helped me establish confidence in my skill.
I invite you, my friends, to see the exam as a collegial exchange and chat among peers who admire and respect one another’s contributions. You are already good enough. I just recommend you prepare to speak intelligently about what you do well, arrive on time, communicate what you know to be effective, and be prepared to be challenged if others think differently. It’s natural to feel nerves. It’s natural to feel pressure. Focus on your passion and communicate in a way that others feel it. Be prepared to support your position on practices and theories. Welcome discourse of different perspectives, show enthusiasm for discussion of how you might approach scenarios differently with ethical considerations in mind, and show compassion and sensitivity for diverse perspectives. Enjoy the process as though engaging in an enriching and intellectual exchange among friends. This is the advice my wiser self would have loved to hear then. Today, I’m grateful to still be here to speak about it. Good luck, and don’t hesitate to reach out if I can help!

Elicia Nademin, PhD, ABPP
Board Certified in Behavioral & Cognitive Psychology
Author, Don’t Be a Stranger
elician@gmail.com
www.4ANewYou2.com
Path to and Benefits of Board Certification in Forensic Psychology

Danielle Rynczak, JD, PsyD, ABPP

In 2016, four years after graduating with my doctorate in clinical psychology, I obtained my board certification in forensic psychology. To be honest, the path was cobblestoned with sacrifice; it was long, challenging, and arduous. While colleagues were enjoying their first taste of freedom from being a student and trainee, I took part in yet another round of interviews and participated in yet another match process to secure a postdoctoral fellowship. I sacrificed a higher paying job, when I moved to the fifth state in my educational career to participate in a year-long postdoctoral residency in forensic psychology. And then during my first formal job outside of training, I spent the first two years interlibrary loan requesting articles and books the forensic board recommends in preparation for the written examination because, as an early career psychologist, I could not justify spending so much money on supplies. I did not have a mentor who was boarded so there were no wise words to guide me, and when I turned down social activities to focus on outlining readings and studying, there was no boarded mentor to encourage me. Yet, with hard work, I passed through the stages; first, I passed the written examination. Soon after I submitted writing samples which were approved. Due to a long line of applicants, I was initially going to have to wait almost a year to take my oral exam, only to be surprised with an invitation to take it earlier when someone withdrew. And I passed! Despite the sacrifices made and time spent, the benefits far outweigh the now seemingly insignificant missed social opportunities. Board certification was likely the best career decision I made and the biggest steppingstone in my career as a forensic psychologist.

First, as a board certified forensic psychologist you are awarded with membership to an exclusive listserv where you can learn from, share ideas with, and pose questions to, what we boarded forensic psychologists affectionally call the “brain trust,” or the most brilliant members of our field - with the likes of Dave Matteo, Randy Otto, Barry Rosenfield, and Joel Dvoskin, to name a few, - welcoming you as a colleague, and willing to provide consultation, guidance, mentorship, words of wisdom, and practical resources. The comradery, the respect, and the knowledge shared is invaluable, and truly one of the best environments for an early career psychologist.

Second, jobs and opportunities abound. Board certified colleagues are often willing to refer clients/cases to other boarded forensic psychologists because the certification speaks to one’s credibility, substantive and procedural knowledge, expertise, professionalism, and hardworking nature. Despite being new to the field, I was referred cases that allowed me to maintain a small private practice in addition to my full-time job. Within years, Ira Packer, a giant in our field, offered me a position at the University of Massachusetts Chan Medical School. Staff trusted that with my board certification I would easily be able to transition from juvenile to adult evaluations and have valuable expertise to serve as faculty in one of the longest continuous APA accredited internship programs. I have also had an opportunity to teach residents, forensic psychiatry fellows, and forensic postdoctoral fellows. Being boarded translated to a very easy inter-state professional license transition and allowed me to forego some aspects of the Massachusetts state specific certification process to become a forensic examiner. Other doors that I thought would be closed to an early career psychologist were opened to me, including committee work, invitations to provide local and national trainings, and offers to collaborate on projects and scholarly work.
Finally, my board certification has given me confidence. As an early career psychologist, one can be burdened by a sense of overwhelm, and the nagging imposter syndrome, especially in forensic psychology where your work is submitted as evidence and scrutinized by opponents in an adversarial system. My confidence grew exponentially as the opportunities I was granted led to my earning a professional early career achievement award, serving as an early career ambassador in forensic psychology for the American Board of Professional Psychology, and volunteering as a mentor for the American Board of Forensic Psychology. If one is even considering this process, take a chance. There are now scholarships that reimburse costs for early career psychologists, as well as diversity scholarships, and many mentors, including myself, who can serve to guide and encourage you on your journey. You will have no regrets.
Scholarships Supporting Psychologists Seeking Board Certification

Vladimir Nacev, PhD, ABPP

The ABPP Foundation Is formally recognized by the IRS as a 501 (c) (3) charitable organization whose purpose is to receive, administer, and expend funds for board certified specialty practice in psychology and other activities. Its major purpose is to promote 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 board certification to the public and related professions. To achieve this goal, the mission of the Foundation includes raising funds.

The work of the Foundation is very much financially dependent on donations from our ABPP specialists and their families, friends, and colleagues, and we hope that you will show your support for the ABPP Foundation.

For almost a decade, the ABPP Foundation has steadfastly supported psychologists’ efforts to earn board certification through scholarship programs that reimburse 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.

Since its inception, the Foundation has awarded 152 scholarships. In 2021 alone, the Foundation awarded thirty-seven (37) scholarships for a total of $40,075 while in 2020 the Foundation awarded thirty-four (34) scholarships for a total of $34,250. This accomplishment was all due to your donations and support by organizations like ABPP, APPIC, and the National Register.

The Scholarships that the Foundation sponsors are:

Training Directors’ Scholarship (annually funded by APPIC, ABPP, and the ABPP Foundation). This scholarship 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 clinical, counseling, or school psychology.

• The Early Career Psychologists Scholarship is supported by a gift from the Council of Presidents of Psychology Specialty Academies (CPPSA).

• The Kaslow Family Fund Scholarship is for individuals seeking board certification in couples and family psychology.

• The Walter Katkovsky Scholarship was established through a generous donation to the ABPPF by Dr. Walter Katkovsky.

• The Eileen Gupton Memorial Scholarship is for psychologists pursuing board specialization in Police and Public Safety Psychology.

The Foundation generally receives periodic donations that are made when specialists renew their status with ABPP, but our major fundraising event is held during an APA convention. Due to the COVID-19 public health pandemic, APA pivoted from an in-person venue to virtual meetings. With no conventions for the past two years, the Foundation is working diligently to increase both individual and corporate donations.
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In the Eye of the Beholder: The Experience of Being Mentored During the Isolation of the Pandemic

Kat L. Wright1, Alexandra D. W. Sullivan2, & Rex Forehand2, Phd, ABPP

Background

This article reports the perspective of an undergraduate student Kat L. Wright, who developed a long-distance mentoring relationship with a graduate student- Alexandra D. W. Sullivan, during the isolation imposed by the pandemic. In the original article (Sullivan, Wright, & Forehand, 2021), the authors describe the advanced level graduate student's perspective on mentorship- as both an opportunity to promote learning and support the undergraduate student in overcoming isolation and loneliness. It is important to note that the third author, Rex Forehand on both this article and the article detailing the perspective of the graduate student, supervised the mentored relationship between the first and second authors. Together, these three authors, situated at three markedly different points on their developmental progression of psychological research and two geographic locations 900 miles apart, collaborated to support Kat's growth in the field of psychological research and Allie's growth as a mentor. He is certified by ABPP and is a faculty member. Together, these three authors, situated at three markedly different points on their developmental progression of psychological research and two geographic locations 900 miles apart, collaborated to support Kat's growth in the field of psychological research and Allie's growth as a mentor. Kat will tell her own story of the mentoring relationship below and how it contributed to her ability to address her isolation and grow as a student of psychology. Allie on the other hand, did not only provide professional skills to Kat, but served as a role model for how to continue to grow as a student of psychology during the isolation of the pandemic.

Overcoming Isolation as a Mentee During COVID: The Kat Wright Account

In the summer of 2020, following my first year in college as a Psychology major at the University of Kentucky, I contacted Dr. Rex Forehand, an established clinical psychology faculty member who studies families and how parents influence children. I asked if he, or someone with whom he worked, could provide me with some experience in psychology. At this point in my college career, I had mainly only taken courses, with a few of them being in psychology. Additionally, the pandemic had hit several months earlier and imposed an extreme degree of isolation (e.g., classes were held on Zoom). Therefore, both learning new skills and overcoming isolation in my major were my goals. Dr. Forehand agreed and paired me with an advanced level graduate student in Clinical Psychology: Alexandra (Allie) Sullivan. During frequent Zoom meetings with Allie and Dr. Forehand, we discussed a wide range of psychological topics and eventually settled on analyzing data from an existing dataset examining parental stress. Allie analyzed the data and patiently explained the meaning of the results of the data analysis. Furthermore, she had me conduct literature reviews, read extensively, and do some (not a lot!) of the writing of an article resulting from the literature review and data analyses. Not only did Allie patiently guide me through the steps of analyzing and writing an article but involved me in the submission and revision process. I am proud to say that the article has now been published in a reputable journal (Sullivan, Wright, Jones, Breslend, Highlander, & Forehand, 2021). In addition, with Allie's guidance, I have presented a poster virtually based on the findings (Wright, Sullivan, Breslend, Highlander, Forehand, & Jones, 2021).

During a time when my college career was upended by the pandemic and the isolation it imposed, I found human contact (albeit through Zoom), a learning experience well beyond the classroom, and, through various phone calls with professionals in the field set up by Dr. Forehand, a beginning knowledge of the careers that one can consider as a clinical psychologist (e.g., faculty member at either a university or teaching college, work in a medical school or center, private practice). Furthermore, I learned from Allie that graduate students in Clinical Psychology can be kind, funny, have a personal life, and simultaneously grow in their knowledge of psychology. These experiences helped me through a difficult period of isolation when I was trying to decide on a career path.
My story does not end here. As a result of my mentored experience with Allie, I applied for an advertised research lab experience with Dr. Shannon Sauer-Zavala at the University of Kentucky. I was successful, no doubt due in part to the mentoring (and success with publications and posters) I received at the University of Vermont. While working in Dr. Sauer-Zavala’s lab, I have had the wonderful experience of being mentored by Dr. Matt Southward, who works with Dr. Sauer-Zavala. This experience has led me not only to do “everyday lab work” but to conduct research under a Summer Undergraduate Research Fellowship (SURF) Award. I am currently responsible for the data collection in a study in the lab and have submitted my SURF research for a poster presentation at a national (as well as a state) convention. As with my initial experience with Allie remotely at the University of Vermont, my experience in Dr. Sauer-Zavala’s lab has helped me overcome the isolation imposed by the pandemic.

Finally, based on my research experience in Drs. Forehand’s and Sauer-Zavala’s labs, I reached out to Dr. Justin Parent at Brown University, hoping to establish a remote mentoring relationship to continue my development in psychological research. Dr. Parent’s research extends Dr. Forehand’s, investigating epigenetic mechanisms through which behavioral parent training can support child and family well-being. I envisioned that working with him remotely as the pandemic (hopefully) winds down would be a way to continue to develop my skills and knowledge. Further, of importance, although I now no longer feel isolated due to the pandemic, it is a way to establish contacts in the field that will help guide me in my profession.

Particularly during my early college years, the COVID pandemic was, and continues to be, isolating and leads to loneliness in my Psychology major. However, there was also a silver lining: It facilitated my reaching out and making contacts both within and beyond my university. Would my college experience as a psychology major been better without the isolation imposed by the pandemic? Who knows, but I suspect it would be very different! In any case, I believe I have made the best of a difficult situation.

The Future of Remote Mentoring

Life in the academy has changed radically over the past two years with the onset of the pandemic: Aspects of teaching, research, and service have become virtual rather than in-person. While there is certainly a loss from lack of in-person contact, one potential positive avenue that working remotely opens up is the opportunity for students to be mentored by faculty and advanced level graduate students from almost any university or college regardless of location. This is beneficial in at least three ways. First, as there is no one right way to mentor (Forehand, 2008; Reuman, 2022), the opportunity for “fit” between mentee and mentor, which is critical, is enhanced. That is, the larger pool of participants (in terms of both students and faculty) from across universities and colleges increases the likelihood of finding a fit. This point is particularly important for students who are historically underrepresented in research and healthcare and/or who may be coming from environments with limited resources and research opportunities. Such students may be able to connect with qualified and willing mentors at outside institutions. In turn, these relationships can support career advancement (refer to Mahayosnand et al., 2021 & Stephonson-Hunter et al., 2021 for examples of virtual mentorship for underrepresented students). Second, the opportunity for exposure to multiple remote mentors can offer more varied experiences/role models to the student (Reuman, 2022). Third, both of the preceding opportunities decreases the chances of isolation. The catch to this model is that faculty members need to be available and willing to mentor, and undergraduate, as well as graduate, students need to reach out across universities. As evident by the efforts of our first author, until one reaches out, it is not possible to know what is available.

Life as it has been known in academics for many, many years may never be the same. Although some aspects will be missed and may lead to fewer learning opportunities, the “reach” of students to faculty will no longer be limited to a single university. And an important side effect of this approach is that the isolation felt by students can be overcome.
**Kat Wright** is currently a junior at the University of Kentucky. She is an outstanding student (e.g., 4.0 GPA, a Psychology Scholar in the Psychology Department, completing a double major). Kat’s desire for an in-depth experience in psychological research was the impetus for the development of this mentoring relationship. During her first year in college, the pandemic had shut down face-to-face contact with faculty. Consequently, she reached out to overcome the isolation and enrich her educational experience. She contacted the third author (a University of Vermont faculty member), whom she knew and whose research with families interested her. He paired her with an advanced level graduate student interested in mentoring. This mentoring relationship spanned 900 miles, from Burlington, VT, to Lexington, KY. Kat will tell her own story of the mentoring relationship below and how it contributed to her ability to address her isolation and grow as a student of psychology.

**Alexandra (Allie) Sullivan** is an advanced level graduate student in an APA-approved Clinical Psychology Program at the University of Vermont. At the time of initial contact with Kat, she was entering her fifth year at the University of Vermont. She is currently completing her pre-doctoral internship at the Medical University of South Carolina and will begin a post-doctoral fellowship at the University of California, San Francisco in September. Allie is committed to mentoring and has the skills (both personal and professional) and experience to do so. In addition, she is an accomplished researcher as a graduate student (e.g., 20 publications, an NRSA award, APA Division 53 Student Achievement Award in Research), a skilled clinician, and is meeting the requirements for two PhD degrees – one in clinical and one in developmental psychology. Importantly for this article, Allie provided not only professional skills to Kat but served as a role model for how to continue to grow as a student of psychology during the isolation of the pandemic.
Rex Forehand has been a clinical psychology faculty member for over 50 years – first at the University of Georgia and subsequently at the University of Vermont. He has been certified by ABPP since the early 1980s. One of his primary goals as an academic psychologist is mentoring students and junior faculty. He has done this by trying to model skills that promote growth. In addition, he has published over 450 peer-reviewed publications, chapters, and books, all with current and former graduate students. His work has focused on families, the stressors they experience (e.g., HIV/AIDS, divorce, parental depression), and the positive results that these families can achieve with authoritative parenting. He has been the PI on three major NIH/CDC grants to develop prevention/intervention programs for families. He has served on many editorial boards, has received APA’s Award for Distinguished Career Contributions to Education and Training in Psychology, and has received APA’s Division 53 Distinguished Career Award.

References


Suicide is a national health problem and the tenth leading cause of death in the United States (Ehlman et al., 2022). Research on loneliness has helped psychologists to better understand and intervene with their suicidal patients.

Lonely people feel a discrepancy between their desired and actual social network. Loneliness and isolation are not identical. Isolation can be quantified; loneliness is subjective. One can be isolated – have a small social network--but not feel lonely, or one may have a large social network and many contacts and still feel lonely. Loneliness is associated with an increased risk of suicide, although depression may be a mediating variable (McClelland et al., 2020). The quality of the individual’s relationships is also important. Among suicidal persons the lack of closeness with others is linked to suicidal thoughts and attempts more than the frequency of their contacts (Mueller et al., 2022).

This loneliness/suicide link is consistent with predictions from recognized theories of suicide. For example, evidence has supported the claim of the interpersonal theory of suicide that perceived burdensomeness (a belief that one is a burden to others) and thwarted belongingness (a belief that one is not accepted by a valued social group) are correlated with suicidal thoughts (Chu et al., 2017), although the research into thwarted interpersonal needs and suicide is ongoing (e.g., Brown et al., 2021). Similarly, in the integrated volitional-motivational model of suicide, O’Connor (2021) considers perceived burdensomeness as a motivational moderator that increases the likelihood of having suicidal thoughts.

An analysis of the immediate precipitants of suicides also demonstrates a link between social relationships and suicide. Relationship problems were identified as precipitants in 42% of all suicide attempts, followed by physical health problems (22%), job/financial problems (16%), and legal problems (13%; Stone et al., 2018). These relationship problems could lead to the loss of a relationship (such as the death of a loved one), the threatened loss of a relationship, or a noticeable decline in the quality of the relationship (such as arguments with loved ones).

Conversely, strong social networks and support systems reduce the likelihood that an individual will have suicidal thoughts. For example, US Army soldiers who perceived more social cohesion and unit cohesion had a lower risk of suicide (Dempsey et al., 2020). Married persons and parents also have lower risks of suicide (Øien-Ødegaard et al., 2021). When identifying protective factors (i.e., reasons for not making an attempt), suicidal patients often identify their obligations to others, their responsibility to their children, or even their concern for their pets (Bryan, 2021).

The link between psychological wellbeing and loneliness appears to be partly bidirectional. Chronic loneliness can precipitate a decline in one’s wellbeing. On the other hand, chronic loneliness may sometimes reflect or reduce a person’s lack of skills when dealing with others or impair their ability to process social information accurately. Nonetheless, “the causal arrow flows more strongly from relationships to mental health than vice versa” (Braithwaite & Holt-Lunstad, 2017, p. 120).

The reasons that social relationships protect people from suicide are not fully understood. It is possible that quality social relationships reduce the body’s overall stress level. Stress increases the likelihood of non-productive responses such as smoking, drinking alcohol, or misusing drugs. It can also activate physiological responses through the sympathetic nervous system and the hypothalamic-pituitary-adrenal cortical axis. However, social supports can mitigate the impact of stress by increasing resources and helping persons to reappraise their situation. Social support can be instrumental, informational, or emotional. Instrumental support refers to “the provision of material aid,” informational support refers to “the provision of relevant information,” and emotional support refers
to “the expression of empathy, caring, reasoning and trust, and provide opportunity for emotional expression and venting” (Cohen, 2004; p. 676-77).

Psychologists should consider the role of loneliness even in the lives of patients who do not have suicidal thoughts because loneliness is linked to other emotional problems, such as depression or social anxiety, and to physical health risks. Social disconnections are associated with an increased risk of Type 2 diabetes, upper respiratory illnesses, heart disease, and an increased risk of death. Social disconnections present a health risk comparable to obesity or physical inactivity (Holt-Lunstad, 2021).

**Addressing Loneliness Among Suicidal Patients**

Psychologists can take the following steps to help patients to establish or re-establish strong social networks:

Focus on the treatment relationship. At the end of the first session, patients should have an opportunity to tell their story and believe that their psychotherapists cared about them. The quality of the psychotherapist-patient relationship is associated with a lower risk of a suicide attempt (Dunster-Page et al., 2017). When asked why they did not kill themselves, the most common response given by one sample of patients was that their psychotherapists cared about them (Montross Thomas et al., 2014).

Include increasingly, the number and quality of social contacts as an option in the patient's safety plan. Effective treatments for suicidal patients involve safety or crisis response plans for patients to follow when their suicidal thoughts become strong. These safety plans typically include self-management steps so that patients can learn to manage their emotions before they enter in a suicidal crisis. The effective self-management steps identified by patients often involve social activities with friends such as going to a movie, going out to dinner, attending other social events, or just talking.

Involving family members or close friends in treatment, if clinically indicated to do so. Psychologists should usually refer to patients on whether or how to involve family members in treatment because some families do a lot of psychological harm and involving them would be clinically contraindicated. Nonetheless, often family members and close friends can provide important resources and supports for the patient's recovery.

Address loneliness in psychotherapy. Because loneliness does not have a single cause, psychologists should tailor their interventions based on their patient's needs. Sometimes the interventions can be basic, such as encouraging patients to involve themselves with a social group or making social connections more routine. At other times, psychologists may need to address maladaptive beliefs that keep patients from interacting easily with others or teach patients social skills to improve their interactions with others. Finally, sometimes family or couples counseling may help patients to preserve or enrich their existing relationships.

**References**


Short Bio:

Samuel Knapp, EdD, ABPP (Counseling Psychology) is a retired psychologist who was the Director of Professional Affairs for the Pennsylvania Psychological Association from 1987 to 2021. He has written and presented frequently on ethical issues and on suicide prevention. In 2020 his book, Suicide Prevention: An ethically and scientifically informed approach, was published by the American Psychological Association.
Suicide Prevention Core Competencies: COVID-19 Era Considerations for Loneliness and Social Isolation

Gloria M. Workman¹, Michelle M. Lee², and Christina K. Wilson³

Gloria M. Workman, PhD, ABPP is a clinical psychologist, board certified in clinical psychology and a supervisory psychologist with the Department of Homeland Security, U.S. Immigration and Customs Enforcement. Her research and professional interests include suicide prevention, resilience promotion, trauma, training, quality improvement and program evaluation. She completed her doctoral training in Clinical Psychology at DePaul University in Chicago, Illinois and her pre-doctoral internship at Illinois Masonic Medical Center in Chicago, Illinois. She has served in several leadership roles within the Department of Defense, Department of Veterans Affairs and Homeland Security, including outpatient, and administrative health settings, and operational law enforcement, and has held academic appointments at both Midwestern University and the University of Washington Tacoma.

Michelle M. Lee, PhD, ABPP is a Professor and Associate Program Director in the Department of Behavioral Sciences at Midwestern University. She is a clinical psychologist and is Board Certified in Clinical Psychology. Her clinical, academic, and research interests include psychological issues in later life, dementia, educational/training effectiveness for students in various healthcare disciplines, and interprofessional education. She earned her PhD in Clinical Psychology from Case Western Reserve University. She completed her internship at the Minneapolis VA and her post-doctoral fellowship at the VA Pittsburgh Healthcare System. She currently teaches clinical psychology to PsyD students, advises student doctoral research, and collaborates with interdisciplinary colleagues on research and teaching.

Christina K. Wilson, PhD, is a clinical psychologist and program manager with the U.S. Department of Veterans Affairs VISN 20 Clinical Resource Hub. Her research and professional interests include trauma, suicide prevention, telepsychology, interprofessional education, and quality improvement. She completed her doctoral training in Clinical Psychology at the California School of Professional Psychology at Alliant International University in San Francisco, CA and her post-doctoral fellowship at Emory University School of Medicine in Atlanta, GA. She has served in several leadership roles within the Department of Veterans Affairs, including inpatient, outpatient, and tele-mental health settings, and has held academic appointments at both Emory and Morehouse Schools of Medicine.
Introduction

The impact of the coronavirus disease 2019 (COVID-19) pandemic on mental health has been stark (Luo et al., 2020). In 2020, Americans reported elevated psychological distress, including anxiety and depression related to the COVID-19 pandemic (Park et al., 2021). Scientific advisors warn that the emotional impact of the COVID-19 pandemic, heightened by its sequelae (e.g., social isolation, loneliness, physical distancing, loss, grief, etc.), may increase suicide risk for many individuals during and post-pandemic (Sher, 2020; Wasserman et al., 2020). Further, the Centers for Disease Control warns of a possible increase in suicide deaths in the post-pandemic era (Stone, 2021). As such, there is concern regarding the long-term impact of COVID-19 on mental health, including suicidal behaviors (Sher, 2020).

Social Isolation, Loneliness, and Suicide Risk

Social isolation and the subjective feeling of loneliness contribute to suicidal outcomes and should be included in assessment of suicide risk (Calati et al., 2019). Individuals who engaged in stricter social practices due to staying at home during COVID-19 reported more loneliness, greater psychological distress, and elevated suicidal ideation compared to individuals with less social restrictions (Gelezelyte et al., 2021; de Mendonça et al., 2021). The social restrictions during the pandemic have further resulted in increased perceived social isolation and negative changes in the quality and quantity of interpersonal relationships (Buecker & Horstmann, 2021). As such, considering social isolation and loneliness, within the context of the long-term impact of the pandemic, becomes an essential aspect of competent suicide assessment and management in the post-COVID-19 era.

Cramer’s Competency-based Framework

A predominant competency framework for suicidality was developed by Cramer and colleagues (2013). This set of 10 core competencies (see Table 1) has been used successfully as the foundation for suicide prevention training curricula and the effective assessment and management of suicidal clients (Cramer et al., 2013; Cramer et al., 2019). Acquiring core competencies in suicide prevention can increase psychologists’ effectiveness via mastering suicide prevention skills and understanding the rationale for counseling decisions (Knapp, 2020). We highlight several core competencies in suicide prevention believed to be particularly relevant to social isolation and loneliness (2, 3, and 6; Cramer et al., 2013) and considerations to provide effective care for clients with suicidal risk in the COVID-19 aftermath.

Competency 2: Establishing and Sustaining a Client-Centered Collaborative Relationship

Cramer and colleagues’ (2013) second competency depicts the interpersonal connection between the therapist and the suicidal client as vital. They note it is crucial to establish a sustainable, empathic, collaborative relationship with suicidal clients.
Competency 2 Considerations

Given the increased social isolation and ongoing distress of the COVID-19 pandemic, it is important to ensure continuity of care and foster supportive connections as part of suicide prevention efforts (Gunnell et al., 2020; Levi-Belz & Aisenberg, 2020). Within psychotherapy, a caring, therapeutic relationship provides consistent, authentic, and meaningful connection for suicidal clients, which can reduce loneliness and risk of suicide behaviors (Knapp, 2020). In the COVID-19 era with its heightened stressors and disrupted social connections, the therapeutic relationship may take on even greater significance for suicidal patients, especially for those most isolated and lonely. Individuals with existing mental health conditions, the bereaved, the marginalized, people living alone, older adults and those in rural communities may be at greater risk for pandemic-related loneliness and isolation (see Gunnell et al., 2020; Monteith et al., 2020; Moutier, 2020; Pruitt et al., 2020; Wasserman et al., 2020).

Given ongoing COVID-19 case surges and declines, psychologists should discuss any client concerns about therapeutic continuity, review contingency plans for illness-related therapeutic disruption, and collaboratively plan for care transitions.

Competency 3: Awareness of Evidence-Based Risk and Protective Factors

Awareness of evidence-based suicide risk and protective factors is a core competency (Cramer et al., 2013). Extensive research exists investigating factors that contribute to or buffer against suicide risk (Franklin et al., 2017; Cassidy et al., 2018). Psychologists may find it helpful to utilize theoretical frameworks, such as the socio-ecological model, the interpersonal theory of suicide, or the three-step theory, to guide conceptualization of suicide risk and protective factors (Joiner, 2005; Klonsky & May, 2015; Wasserman et al., 2020).

Competency 3 Considerations

Psychologists should attempt to bolster client protective factors and overcome barriers presented by COVID-19, including those related to loneliness and social experiences. The socio-ecological model, which emphasizes the interaction of individual, interpersonal, community, and social influences, can help psychologists comprehensively consider factors that may inform a client's psychological well-being (World Health Organization, 2014). Table 2 outlines suicide risk and protective factors across multiple levels of the socio-ecological system and identifies the type of impact resulting from COVID-19. On the individual level, COVID-19 has contributed to increased depression, substance use, and suicidal ideation (Park et al., 2021). Of note, at the relationship level, social distancing has decreased availability of social support (Marroquin et al., 2020), which is a protective factor against suicide, while COVID-19 exacerbated suicide risk factors of loneliness and trauma/abuse. On the community level, COVID-19 has made it more difficult to maintain community cohesion, which can serve as a vital buffer against suicide (Wasserman et al., 2020). The unique and overlapping influence of these factors is important for psychologists to consider in evaluating suicide risk within the COVID-19 era, particularly when working with clients prone to experiencing loneliness and limited social support.

Psychologists can collaboratively work with clients to jointly address sources of pain, including perceived burdensomeness, failed belongingness, limited connectedness, and acquired capability (Joiner, 2005; Klonsky & May, 2015), and manage suicide risk over time in the pandemic aftermath. Psychologists should also assess frequency/quality of social interactions to detect any declines over time, as well as subsequent increases in perceived burdensomeness, thwarted belongingness, and loneliness (e.g., “Do you feel disconnected from other people?”) as part of suicide risk assessment (Levi-Belz & Aisenberg, 2020, p. S124). It is important to further highlight that connectedness plays an important protective role in countering isolation and reducing suicidal ideation (Klonsky & May, 2015).

It is vital for psychologists to stay abreast of emerging suicide prevention research, particularly because COVID-19 may have changed the landscape of suicide risk and protective factors (Sher, 2020).

Competency 6: Mutually Create and Implement an Evidence-Based Treatment Plan

A key component of Competency 6 is to collaboratively establish an evidence-based treatment plan for safety that targets current suicidal thoughts/actions, reduces distress, and monitors vacillating suicidal risk over time (Cramer...
et al., 2013). This includes jointly developing coping techniques, delineating safe people/places, identifying reasons to live, and assembling emergency contacts (Cramer et al., 2013). Other sources (e.g., family/friends, other professionals) also may help inform treatment planning and monitor change (Knapp, 2020).

**Competency 6 Considerations**

Psychologists should critically analyze how to adapt suicide safety planning since COVID-19 (Pruitt et al., 2020) and continue to do so in the post-COVID era. This entails psychologists addressing the following:

Identify specific triggers that elicit suicidality and utilize coping strategies accommodating of social distancing (see Pruitt et al., 2020, Table 1, pp.744-745).

Plan which supportive individuals and professional resources should be contacted and how to contact them if emergent, while ensuring these remain accessible and responsive throughout the COVID-19 era (Pruitt et al., 2020).

Ensure clients’ environments remain safe over time, especially given potential increased access to lethal means (e.g., firearms, stockpiled medication, etc.) since the COVID-19 pandemic (Gunnell et al., 2020; Moutier, 2020; Pruitt et al., 2020).

Given negative changes in the quality and quantity of interpersonal relationships with the pandemic (Buecker & Horstmann, 2021), family/friends’ informing of treatment planning and monitoring change could be limited, as could the clients’ ability to appreciate the negative impact of their suicide on others.

Increasing social connection is an important mitigating strategy to combat suicide risk factors of social isolation and loneliness during the pandemic (see Moutier, 2020). Psychologists may work with the client and/or the client’s social support system/health care providers/community resources to encourage and facilitate safe, regular social connection, caring contacts, and check ins (see Moutier, 2020). Psychologists may encourage client exploration of community resources (e.g., religious, cultural, volunteer/fundraising organizations, etc.) offering meaningful, value-based activity and safe social engagement to help decrease thwarted belongness, isolation, loneliness, and perceived burdensomeness (Monteith et al., 2020).

**Conclusion and Implications**

The effects of the COVID-19 pandemic, a natural disaster, are pervasive and will endure for many clients, including those at risk for suicidality. Social isolation and loneliness, previously identified contributors to suicidal outcomes (Calati et al., 2019), were further exacerbated by the COVID-19 pandemic (Buecker & Horstmann, 2021). To promote competency development in suicide assessment and management in the COVID-19 era and beyond, three of Cramer and colleagues’ (2013) 10 competencies relevant to social isolation and loneliness were reexamined considering the pandemic’s long-term impact.

As part of competent suicide risk assessment and management, psychologists can play a key role in combatting suicide risk factors related to social isolation and loneliness, while facilitating suicide protective factors related to social connection, that have been exacerbated or limited, respectfully, in the COVID-19 era. This requires psychologists to be keenly aware of the potential increased value of their unique, empathic, collaborative relationship in the COVID-19 era to clients at risk for suicide, and make extra efforts to demonstrate care, compassion, and consistent connection during and between sessions. It is also important to openly explore any client concerns related to potential care disruptions/transitions and eventual termination (e.g., potential feelings of abandonment or burdensomeness). Psychologists should systematically incorporate direct evaluation of clients’ social relationship changes, connectedness, thwarted belongness, and perceived burdensomeness into suicide risk procedures in the COVID-era (Joiner, 2005; Klonsky & May, 2015; Levi-Belz & Aisenberg, 2020), which can then be incorporated into theoretical frameworks (e.g., interpersonal theory of suicide, the three-step-theory, the socio-ecological model), to guide conceptualization of the client’s suicide risk and protective factors related to social isolation and loneliness within the COVID-era.

Connectedness plays an important protective role in countering isolation and loneliness and reducing suicidal ideation (Klonsky & May, 2015). Facilitating social connectedness to combat isolation and loneliness to reduce suicide risk in the COVID-19 era will require psychologists (and their clients) to use innovative approaches involving technology and creative exploration of community resources and outreach possibilities.
As the long-term impact of the COVID-19 era continues to manifest, psychologists need to persist in adapting accordingly to provide competent suicide risk management. They need to determine if and how current suicide risk and protective factors (both pre-existing, and pandemic-specific) change in different phases of the COVID-19 era and how to subsequently update suicide risk assessment and management strategies. Further, COVID-19 may be considered a natural disaster. Hence, psychologists can benefit from training in disaster preparedness to understand the distinct phases of a natural disaster, the accompanying emotional and behavioral reactions, strategies for coping with the psychological sequelae of a disaster or pandemic, and knowledge of existing community resources (Yun et al., 2010). Finally, it is important for psychologists to consider definitive mechanisms for how they will obtain training and evaluate themselves on Cramer and colleagues’ (2013) core competencies for suicide risk assessment and management, as the COVID-19 era progresses.

Future research is necessary to examine the long-term trajectories of suicide risk, social relationships, isolation, and loneliness over the extended course of the COVID-19 pandemic (Buecker & Horstmann; 2021). This may include identifying groups of individuals at risk for suicidality due to loneliness or social isolation, the factors underlying loneliness/social isolation, and the motivations for suicidality post-COVID to enable tailored risk management strategies and treatment intervention for specific at-risk groups.

In closing, at the onset of the COVID-19 pandemic, psychologists were called to rapidly alter health care delivery, including suicide risk assessment and management. Given the expected rise in suicidal behaviors in the post pandemic era, psychologists working with clients at increased risk for suicide are called to identify and implement protective strategies to address enhanced connectedness, loneliness, and social isolation and to intervene with competence. This call will continue in the COVID-19 era and will serve to help guide preparation for clinical care in the wake of other disasters.

References


Table 1

*10 Core Competencies of Suicide Risk Assessment and Management*

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<tbody>
<tr>
<td>1. Self-awareness and Managing Attitudes Regarding Suicide</td>
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<td>2. Establishing and Sustaining a Client-Centered Collaborative Relationship*</td>
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<td>3. Awareness of Evidence-Based Risk and Protective Factors*</td>
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<td>4. Address Suicidal Plan and Intent</td>
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<td>5. Identifying Level of Suicide Risk</td>
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<td>6. Mutually Create and Implement an Evidence-Based Treatment Plan*</td>
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<td>7. Notify Other Professionals and Engage Trusted Persons</td>
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<td>8. Detailed Documentation of Risk, Plan and Rationale for Clinical Care</td>
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<td>9. Knowledge of Laws Regarding Suicide</td>
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<td>10. Self-Care Imperative and Debriefing Process</td>
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*Core competency especially involves connectedness, social isolation, and loneliness*  

Adapted from Cramer et al., 2013
Table 2

*Risk and Protective Factors for Suicide*

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<thead>
<tr>
<th>Individual Level</th>
<th>Protective Factors</th>
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<td><strong>Risk Factors</strong></td>
<td><strong>Protective Factors</strong></td>
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<td>Mental Health Diagnosis*</td>
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<td>Limited Access to Health Care*</td>
<td>Economic Supports**</td>
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<td>Trauma and Abuse*</td>
<td>Health Care Access**</td>
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*Factor exacerbated by COVID-19  **Factor limited due to COVID-19

Adapted from Wasserman et al., 2020
Loneliness and Cognitive Impairment in Cancer Survivors: The Role of Assessment and Intervention for Enhancing Quality of Life.

Robin Newman, Kathleen Van Dyk, Christina Weyer Jamora, Jennifer Strang, Sherry Hite, Natalie Kelly, and Arash Asher

With approximately 17 million cancer survivors today in the United States alone, cancer-related cognitive impairment (CRCI) represents a major cancer survivorship concern [20, 29, 35]. Even after active treatment, lingering cognitive symptoms can continue to significantly impact the quality of life even for those with non-central nervous system cancers. Moreover, issues related to loneliness, particularly in cancer populations, have been highlighted as possibly contributing to and perpetuating both CRCI and poor quality of life. The goal of this article is to provide an overview of loneliness and CRCI, as well as guidance for assessment and intervention.

CRCI is common among cancer survivors. Authors note that prior to treatment, up to 30% of these individuals demonstrate cognitive impairments; during treatment, more than 75% show impairments; and after treatment, 35% demonstrate persistent cognitive changes [20]. Commonly, CRCI includes functionally impairing problems with memory, executive functioning, attention, and concentration [19, 39]. Of note, executive function impairments have been linked to diminished quality of life related to return to work, social relationships, and general community reintegration [32].

CRCI-related mechanisms remain poorly understood, however primary factors such as demographics [36], alterations in brain and immune function [10, 23] genetics, and related medical [2] and psychosocial issues have been implicated [15]. From a biologic perspective, authors note potential mechanisms such as oxidative damage, the production of inflammatory cytokines, and accelerated aging from cancer treatment or the cancer itself, as contributors to CRCI [7, 12]. Research has also associated a range of modifiable factors, including psychological (anxiety, depression), physical (fatigue), and lifestyle (sleep, diet, exercise) [15, 20] components, with CRCI. More recently, the psychosocial aspects of chronic loneliness have emerged as a potential contributing factor to CRCI, particularly as it relates to quality of life [21].

Chronic loneliness can be defined as an unfulfilled need for belonging and connection with others, which has strong implications for health and cognitive processes [3]. Chronic loneliness differs from social isolation, which is related to lack of social contacts [3]. This distinction is clinically important for assessing a patient’s lived experience, in addition to social ties, although the two can be correlated [14, 40].

Chronic loneliness has significant health implications. For the cancer population specifically, loneliness among cancer survivors is relatively common, with one recent study finding that approximately 40% of survivors experience loneliness one year after their diagnosis [9]. In the general population, chronic loneliness is known to contribute to poorer overall cognitive performance and is associated with a 26% risk of premature death, as well as increased risk of infections, heart disease, and depression, among other health problems [5, 16]. In the breast cancer population, chronic loneliness has been associated with a higher rate of cancer mortality, including a hazard ratio of 1.7 for breast cancer-related mortality [17, 27].

Cognitively, loneliness is associated with faster cognitive decline and poorer executive functioning, which has similar overlap with CRCI [4] and implications for diminished quality of life. More specifically, in a study of three samples of breast cancer survivors, loneliness was linked to concentration and memory complaints, as well as the experience of objective concentration problems [21]. Importantly, these relationships were independent of any treatment-related effects and found across treatment types. Thus, given recent literature supporting the intersectionality of loneliness and CRCI, researchers have begun to investigate associated factors and mechanistic models to inform assessment and treatment models.

Significantly more research is needed to expose and understand how loneliness can affect cognition in cancer survivorship, including candidate pathways that need to be further explored. Many conditions associated with cancer survivorship, which are also considered risks to cognitive health, are linked to loneliness [15]; these include psychological stress (current and pre-existing), anxiety, fatigue, hypervigilance, depression, sleep disturbance, lifestyle factors, demographics, and social constraints [11, 25, 33]. These biopsychosocial factors can impact multiple biological systems, including some hypothesized drivers of CRCI, such as elevated inflammation and increases in stress-related hormones. Elevated inflammation in the context of cancer treatment is a suspected
mechanism for CRCI. Data suggest that lonelier individuals are more stress reactive, as evidenced by “exaggerated proinflammatory cytokine production following an acute stressor” [22, p. 1096]. Loneliness is also associated with increases in stress hormones. Data suggest that chronically elevated stress hormones negatively influence the medial prefrontal cortex, which is crucial for regulating higher order attentional processes and may be particularly sensitive to the effects of chronic stress [26]. Other brain regions that may be impacted include the orbitofrontal cortex and hippocampus, areas essential for social appraisal, and learning and memory [37, 38]. Loneliness can exacerbate an already elevated stress response in cancer survivors, which can contribute to increased cognitive impairment [22]. Loneliness could therefore directly affect risk for poorer cognitive outcomes and/or indirectly affect risk by interacting with other biopsychosocial risk factors for CRCI.

Current literature supports the intersectionality of loneliness and CRCI, arguing for increased assessment and intervention of these factors to support improved quality of life in cancer populations. While neuropsychological assessment is commonly considered the gold standard for cognitive assessment [24, 39], assessment of loneliness is far less established. In an effort to highlight assessment and screening of loneliness in cancer populations, the authors present a brief overview of literature for assessing loneliness in cancer populations.

Assessing Loneliness

Routine clinical evaluation of loneliness is critical for optimal, comprehensive biopsychosocial care. Recognizing the importance of loneliness assessment, the National Academy of Sciences has recently begun supporting national screening for social isolation and/or loneliness [30]. Similarly, the United States Centers for Medicare requires reporting measures of social isolation, including questions such as, “How often do you feel lonely or isolated from those around you?” with five possible answers ranging from “never” to “always.”

One formal tool that is commonly utilized is the Revised UCLA (R-UCLA) Loneliness Scale. Developed with healthcare worker populations, R-UCLA is a 20-item, self-administered questionnaire that measures subjective loneliness [34]. R-UCLA was noted to have adequate internal consistency (alpha ranged from 0.89 to 0.94) and test re-test reliability (r = 0.73), with evidence to support good construct validity. Item response is based on a four-point scale, with greater scores indicating higher levels of loneliness (no recommended cutoff). Other authors have adapted the R-UCLA into a shorter, three-item UCLA Loneliness Scale, which was developed for use in telephone surveys [18]. The three-item UCLA scale was noted to have adequate reliability with an alpha coefficient of 0.72, as well as adequate intercorrelations between the longer and shorter UCLA Loneliness scales at 0.82.

Another more recently developed scale is the Cancer Loneliness Scale (CLS) [1]. The CLS is a 7-item, self-administered questionnaire developed with cancer populations to measure cancer-related loneliness. CLS was noted to have adequate internal consistency (alpha coefficient = 0.94) and evidence to support good construct validity. Item response is based on a five-point scale, with greater scores indicating higher levels of cancer-related loneliness (no recommended cutoff).

Other measures include the De Jong Gierveld 6-item short scale for emotional and social loneliness [8] and The Campaign to End Loneliness Measurement Tool which is a three-item tool that measures loneliness with the purpose of measuring potential change in loneliness as a result of interventions [13]. The De Jong Gierveld scale was noted to have adequate reliability (alpha coefficient of 0.81 to 0.85) and validity. Psychometric data was not available for the Campaign to End Loneliness Measurement Tool, therefore additional research is needed regarding its use.

A key limiting factor in more formal assessment of loneliness has been the lack of time and knowledge regarding appropriate objective measures to assess loneliness. Many tools exist to measure social isolation and loneliness, however most are used for research purposes and not routinely used in the clinical setting. Research with these tools generally focuses on identifying the prevalence of and risk factors for loneliness rather than clinical endpoints.

Complicating loneliness assessment are issues related to self-report bias, scarcity of time, and varying ability to distinguish orthogonal aspects of loneliness and social isolation constructs, which is particularly crucial for clinical purposes. Additionally, one limitation of loneliness screening and assessment is that none of these measures contain subscales related to cognitive symptoms; therefore, symptom intersectionality remains at risk for under-detection. Further, factors such as resources, time, patient quality of life preferences, provider scope, and facility needs must be considered for implementation. Beyond assessment, interventional approaches designed to improve the quality
of life for individuals struggling with loneliness in the context of cancer survivorship remain of critical importance and are reviewed below.

**Interventions for Loneliness**

A recent systematic review concluded that there is a dearth of evidence for interventions designed to address loneliness in cancer survivors [28]. Despite these findings, several evidence-based intervention features known to mitigate loneliness have been highlighted in the literature [6, 28, 31] including 1) increasing opportunities for social contact, 2) enhancing social support, 3) focusing on social skills, and 4) addressing maladaptive social cognition. Table 1 highlights these intervention features with practical examples that can be integrated into clinical practice. Because loneliness may be a potentially modifiable risk factor for cognitive impairment in cancer survivors [21], rehabilitation providers may have a unique opportunity to address the impact of loneliness on daily function. Table 2 highlights the contributions of rehabilitation providers to cancer survivors who experience or are at risk for chronic loneliness.

**Clinical Implications and Recommendations for Education**

*Clinical:*

- Assess for chronic loneliness in cancer patients as a standard of practice using both non-standardized (informal) and standardized (formal) methods
- Establish a network of providers that is recognized as providing value in mitigating chronic loneliness, such as rehabilitation providers
- Investigate telehealth accessibility and assess technological literacy of patients, particularly for patients who are isolated or homebound

*Education:*

- Provide counseling on the negative health implications of chronic loneliness with the goal of catalyzing social connectivity for optimization of patient health and well-being.
- Create patient education materials to support their understanding of the health implications of chronic loneliness
- Differentiate between social isolation and loneliness among and between providers and patients to facilitate referral to clinically appropriate interventions.

**Conclusion**

Loneliness is a clinical challenge that has important and emerging concerns for cancer survivorship. Loneliness could directly affect risk for poorer cognitive outcomes and/or indirectly exacerbate other biopsychosocial risk factors for CRCI. Rehabilitation providers are well-positioned to intervene to improve loneliness in cancer survivorship. While more research is needed, clinical attention to loneliness in cancer survivors could prove to be a valuable component of survivorship care, with significant impact on optimizing patients’ cognitive and functional well-being.
## Intervention Features to Address Loneliness in Cancer Survivors

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<tr>
<th>Intervention Features to Address Loneliness</th>
<th>Practical Examples</th>
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<tr>
<td><strong>Increase opportunities for social contact</strong></td>
<td>Individual (1:1) interventions</td>
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<td>Telephone- or web-based interventions</td>
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<td>Interest- or hobby-based meetups</td>
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<td>Group interventions</td>
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<td>Community-based social or leisure interventions (e.g., municipal facilities/community centers, church)</td>
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<tr>
<td><strong>Enhance social support</strong></td>
<td>Peer mentoring programs</td>
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<td>Support groups (e.g., cancer-specific support groups, caregiver support groups)</td>
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<td>Caregiver, family, and community education (e.g., check-ins, family dinners)</td>
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<td>Hospital-based support groups</td>
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<td>Group-based activity/exercise programs (e.g., yoga, Qi Gong, fitness groups).</td>
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<tr>
<td><strong>Focus on social skills</strong></td>
<td>Social skills groups</td>
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<td><strong>Address maladaptive social cognition</strong></td>
<td>Cognitive behavioral therapy (CBT)</td>
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<td>Mindfulness-based stress reduction</td>
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<td>Communication strategies</td>
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Adapted from: (McElfrish et al., 2021; Raque-Bogdan et al., 2019; Cacioppo et al., 2015)

## References


Authors

Robin Newman, OTD, OTR, CLT, FAOTA, Boston University College of Health and Rehabilitation Sciences: Sargent College, 635 Commonwealth Avenue, Boston, MA 02215

Jennifer M Strang PhD, ABPP-CN, Washington DC VA Medical Center, 50 Irving Street NW, Washington, DC 20422

Christina Weyer Jamora, PhD, University of California-San Francisco, 400 Parnassus Ave, 8th floor, San Francisco, CA 94143

Sherry Hite MOT, OTR/L, City of Hope Medical Center, 1500 E. Duarte Rd, Duarte, CA 91010

Natalie C. Kelly, PhD, ABPP-CN, City of Hope, 1500 East Duarte Rd, Duarte, CA 91010

Kathleen van Dyk, PhD, Semel Institute and Department of Psychiatry and Biobehavioral Sciences, David Geffen School of Medicine. Jonsson Comprehensive Cancer Center, UCLA, Los Angeles, USA

Arash Asher, MD, Samuel Oschin Comprehensive Cancer Institute at Cedars-Sinai Medical Center, 8700 Beverly Blvd, Los Angeles, CA 90048

Corresponding Author:

Robin Newman, OTD, OTR, FAOTA, Boston University College of Health and Rehabilitation Sciences: Sargent College, 635 Commonwealth Avenue, Boston, MA 02215. newmanro@bu.edu

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Addressing Social Disconnection in the Context of Treating Later-life Depression.

Anne M. Stefen, PhD, ABPP

Introduction

Occasionally feeling lonely is a common human experience for all of us, regardless of our age, and is unrelated to physical and mental health outcomes. Chronic loneliness, however, is problematic and shows significant heterogeneity across the globe and by age group (Surkalim et al., 2021). There is a complex relationship between loneliness severity and age, with increased loneliness in the late-20s, mid-50s, and late 80s (Lee et al., 2021a). For older adults, there is support for bi-directional relationships between chronic loneliness and depressive symptoms (Van As et al., 2021). Loneliness is a moderately strong risk factor for depression, with recent estimates that 11-18% of cases of depression in middle-aged and older adults could potentially be prevented if chronic loneliness were eliminated (Lee et al., 2021b). Chronic loneliness doubles the odds of experiencing suicidal thoughts in later life. Objective social isolation (i.e., few social relationships or infrequent contact with others) may have as much as a 3-fold greater risk of death by suicide for middle-aged and older adults; this supports the interpersonal theory of suicide (Van Orden et al., 2010).

Despite common misconceptions that aging individuals are especially likely to be alone, lonely, and depressed, most older adults are psychologically healthy and actively take part in rewarding social relationships. A cross-sectional study of 945 Americans aged 18-76 offers an example of the psychological benefits of aging, even during the global COVID-19 pandemic. While increased age was associated with more time spent listening to worrisome media coverage and higher levels of physical isolation, age was positively associated with well-being. Older participants reported more and stronger positive emotions, along with fewer and weaker negative emotions in the context of COVID-related stressors (Carstensen et al., 2020). As we age, we tend to improve interpersonal skills (e.g., use strategies to optimize positive social experiences, reduce use of strategies that promote conflict) that lead to higher levels of satisfaction with our social relationships (Luong et al., 2011). AARP conducted a nationally representative sample of 3012 adults aged 45 and older (Anderson, 2010) and found lower rates of chronic loneliness in adults aged 70 and older (25%) compared to those age 45-49 (43%).

It is also the case that specific subgroups of middle aged and older adults are socially isolated and/or chronically lonely. Within the AARP study, for example, participants who reported chronic feelings of loneliness were less likely to be involved in activities that build social networks, such as taking part in a community organization or spending time on a hobby (Anderson, 2010). Chronically alone, lonely, and depressed individuals can benefit from behavioral and cognitive treatment strategies that intentionally target social activities and appraisals of their social interactions. This article provides a brief overview of social relationships in the context of aging, followed by a description of how social disconnection is targeted within the newly released second edition of Treating Later-Life Depression: A Cognitive Behavioral Approach (Steffen et al., 2021a & b).

Conceptual Models of Supportive Relationships Across the Lifespan

As we age, we tend to improve in terms of both emotional literacy and social problem-solving skills. Socioemotional Selectivity Theory (Carstensen & Hershfield, 2021) reflects a body of research showing that, compared to younger individuals, older adults tend to prioritize positive experiences and relationships that are emotionally satisfying. Compared to earlier in life, the actual size of social networks may decrease while rewarding interactions and network density (i.e., degree of interconnections among friends and family) increase. This heightened emphasis on the emotional value of relationships and corresponding decrease in nonrewarding contacts is similar for others living with limited time horizons (e.g., college seniors, individuals close to retirement, patients diagnosed with life threatening conditions). A clinically valuable lesson from Socioemotional Selectivity Theory is the reminder to not equate network size with the experience of chronic loneliness. Some aging individuals with relatively small social networks have their needs met and are satisfied with these relationships.
The ways in which multiple dimensions of social relations combine over the lifespan to influence health and well-being are captured within another well-established theory, with implications for clinical practice. The Social Convoy model (Antonucci et al., 2014; Fuller et al., 2020) describes the pathways by which individual, situational and cultural factors influence convoy structure and composition, support provided and received, and social support satisfaction. In addition to helping us conceptualize the complex linkages between social relations and quality of life, the Social Convoy model supplies a reminder that objective measures of social support provided and received do not directly correspond to satisfaction. Individuals vary in the strategies they use to evaluate if they are satisfied with their social interactions and if existing social relationships are sufficient to meet identified needs.

Across the sizable social support research literature, perceived availability of support has repeatedly shown stronger relationships with mental health outcomes than objective indicators of received emotional or instrumental support (Cohen & McKay, 2020). Thus, clinical interventions need to directly target appraisals of support availability with more nuance than a patient's report of support received in the past. The effectiveness of social support as a stress buffer, for example, is likely dependent upon both the source and type of support. The type of emotional sustenance that can be effectively offered by close friends or siblings is different from the emotional support and role modeling provided by peers/similar others. At the same time, similar others may be more effective in supporting active coping efforts while providing opportunities for reciprocity in support provision (Thoits, 2011). Many older adults prefer to differentiate among sources for various support functions; family members (including chosen family) may be preferred sources of instrumental support so that close friendships can retain reciprocal patterns of emotional support (Heller & Rook, 2001). Clinicians should be wary of the common tendency to assume that all individuals within an aging individual's social network are interchangeable in their effectiveness in providing diverse types of instrumental and emotional support. Further, meaningful opportunities to provide support to others are as important as receiving support. Older adults have good reasons for the common wish to avoid blurring social roles. We also must be aware of mistaken expectations that geographic proximity to similar-aged others (e.g., moving to senior housing or a retirement community) is sufficient to develop new reciprocal and emotionally satisfying relationships.

**Intersectionality of Marginalized and Oppressed Identities**

As reflected by the APA Multicultural Guidelines (Clauss-Ehlers et al., 2019), we experience our lives and relationships through the combination of personal identities that are (1) held simultaneously, (2) impact exposure to discrimination and access to power/privilege and that (3) are likely to change in salience across our lifetime. Aging is experienced as an identity that intersects powerfully with other identities, such as gender, race and ethnicity, SES, immigration status and sexual orientation, among others. The implications of social isolation can vary dramatically; the heightened risk for suicide is especially alarming for older white men who live alone (Zeppegno et al., 2019). Social isolation is particularly harmful for individuals who immigrate later in life (Jang & Tang, 2021) and for lower income older adults who lack the resources to use formal paid services to replace many supports commonly provided by family. Considering the intersection of age/gender/sexual orientation, a review of the social networks of older individuals who identify as LGBT found that older female respondents reported larger and more diverse networks than older male respondents. In this study, the importance of chosen family was very salient (Breder & Bockting, 2022).

**Revising the *Treating Later-Life Depression* Workbook for Oxford’s Treatments that Work Series to support social connections**

The first edition of *Treating Late-Life Depression: A Cognitive Behavioral Approach Workbook* (and associated clinician guide) came out in 2010 following the decades-long research program by Larry Thompson (ABGERO), Dolores Gallagher-Thompson (ABGERO, ABCP) and their colleagues. Their series of randomized clinical trials began in the 1980s and focused on CBT with older adults experiencing clinical and subsyndromal depression. For the recently released second edition, we implemented a user-centered revision process (Lyon & Koerner, 2016), with beta-testing initiated in the spring of 2020 just as psychotherapy and integrated primary care appointments were transitioning to telehealth. This allowed us to identify the clinical materials most useful for telehealth appointments with aging patients. We were also able to incorporate best practices for clinical work with ethnically diverse older adults (Lau & Kinoshita, 2019). Culturally responsive resources were developed to facilitate, among other things, discussion of (1) most salient cultural identities, (2) personal strengths and values, and (3) attention
The most significant changes to the second edition of the patient workbook include single page format for all psychoeducational materials (“Learn Pages”) and worksheets (“Practice Forms”); this single-page format improves utility for behavioral health visits integrated within primary care and also for generalist psychotherapists who want the flexibility to select from among a variety of pages and forms. In addition to each page of the workbook functioning in a “stand alone” way, the workbook’s modular format for coverage of specific problem areas allows clinicians and patients to personalize treatment planning. Clinicians have the ability to photocopy workbook materials to share with patients (not all of whom may benefit from having the full workbook). Of note, any given patient is not expected to use all materials in any one module. Importantly, we included attention to building and supporting social relationships across all the workbook modules. Efforts to foster patients’ connections with their social network were spread across the newly added CBT change strategies (i.e., emotional literacy, positive psychology, habit formation and change, self-compassion) as well as within the original change strategies of behavioral activation, problem-solving skills training, cognitive reappraisal, and communication skills training.

The modules in this treatment are organized into those that we have labeled “core” and others that we refer to as “personalized” in the context of psychotherapy.

**Core Sections (for most psychotherapy patients)**

- Skills for Getting Started (Therapy Orientation and Goal Setting)
- Skills for Feeling (Emotional Literacy, Positive and specific negative emotions)
- Skills for Doing (Behavioral Activation and Problem-Solving)
- Skills for Thinking (Self-Compassion and Cognitive Reappraisal)

**Personalized Sections (for some psychotherapy patients)**

- Skills for Brain Health (Preventing and managing cognitive concerns)
- Skills for Managing Chronic Pain (Psychoeducation and pain management)
- Skills for Healthy Sleep (Psychoeducation and Sleep Hygiene)
- Skills for Caregiving (For family and informal caregivers)
- Skills for Living with Loss (Support for healthy grieving)
- Skills for Relating (Communication and interpersonal effectiveness skills)

**Core Section (for most psychotherapy patients)**

Skills for Wrapping Up (Termination processes and plans)

Psychologists working in primary care settings are especially likely to use psychoeducational and brief intervention materials related to recognizing depression (Skills for Getting Started), and then materials from the personalized sections on brain health, chronic pain and healthy sleep. In the final section of this article, I provide some examples for how various modules of the workbook provide opportunities for enhancing existing relationships and reducing chronic loneliness.

In the **Skills for Getting Started** module, materials provide psychoeducation and elicit within-session discussions of (1) depression, (2) treatment options including antidepressant medications, (3) expectations for CBT therapy, (4) most salient cultural identities, (5) personal values and personal strengths, (6) expectations for treatment length, (7) therapy goals, and (8) self-encouragement. Because social isolation and chronic loneliness trigger shame in many, these concerns are not always obvious at the start of treatment for later-life depression. Specific to promoting social relationships, this module helps patients identify who functions as “chosen family” in their life along with any individuals who share their personal values. In the materials to support treatment goal setting, patients are provided suggestions for when and how to share clinical materials and their therapy goals with others who are most likely to be in the position to provide support. The practice of completing a very brief written summary at
the end of each session is linked with an exercise to explore “Is there anyone in my life who can support me as I work on ______ this week? What would I like to ask them for help with?” Similarly, in the ongoing use of a brief session preparation form, there is a question: “Did anyone help support me as I worked on ______ this past week?” These two strategies are repeated throughout treatment, with therapists’ continued sensitivity to when they may trigger shame reactions. Over time, these processes can help reduce perceived loneliness for some patients, as they share some therapeutic activities with friends and/or family (e.g., daily activities that relate to personal values and strengths, cultivation of positive emotions). These questions are also key in helping patients and therapists collaboratively identify when social isolation and/or reducing loneliness should be added as a specific therapy goal.

When social isolation is a concern, these strategies then prompt the clinician to implement specific interventions to promote social connectedness (e.g., enrolling patient in Institute of Aging’s Friendship Line calls https://www.ioaging.org/services/friendship-line, and/or exploring Covia’s Well Connected program of telephone and internet group activities https://covia.org/programs/well-connected/participate/). Those two referrals also help clinicians avoid falling into “friendly visit” and primarily emotional support roles with lonely, socially isolated older adults. Once a patient is receiving weekly emotional support and general life problem-solving conversations with an interpersonally skilled and trained lay volunteer, psychologists are better able to stay working at the top of their scope of practice (i.e., provide therapeutic interventions that go beyond supportive counseling). Altogether, five of the Learn Pages and seven Practice Forms in Skills for Getting Started directly encourage patients to consider when and how they may wish to share aspects of their depression treatment with important other individuals in their lives. Especially when withdrawal from social activities has been a part of their depression, this is often a first step towards reconnecting with others and reducing perceived loneliness.

The other Core Modules within the workbook also specifically include materials to foster social connections. In Skills for Feeling, for example, the psychoeducation about emotions and emotional literacy skills is combined with exercises in cultivating and savoring positive emotional experiences, including those linked to social activities. In Skills for Doing, particular attention is paid to applying behavioral activation and problem-solving skills to social activities. Behavioral activation (BA) is recommended for use early on in treatment with all depressed middle-aged and older adults because there is strong empirical support for BA as an effective strategy on its own to treat depression across the lifespan and with culturally diverse individuals. Because BA is a practical, individually tailored treatment that emphasizes one’s values and preferences, it is inherently culturally sensitive. Any activities that are experienced as positive (i.e., rewarding, valued, meaningful) and that increase a sense of connection with others are useful in combating depression and reducing loneliness in older adults (Solomonov et al., 2019). This can include any activities done with and for others (e.g., calling friends after their health appointments to see how the visit went), as well as activities that encourage the patient to feel more connected to others (e.g., posting a favorite family recipe on Facebook to share with a grandchild). Even in the context of the COVID-19 pandemic, there are many strategies available to older adults to promote social connections and reduce loneliness (Van Orden et al., 2021). We link work on behavioral activation to use of the California Older Person’s Positive Experiences Schedule-Revised (COPPES-R; Rider et al., 2016) to aid in the identification of rewarding and meaningful activities (now available for use within or between sessions as a pdf or online administration; https://www.optimalagingcenter.com/assessments/coppes-r/).

Within the Skills for Thinking core module, we have been mindful that the experience of shame is a common reaction to both social isolation and loneliness. For that reason, we include self-compassion strategies (Gilbert, 2017) ahead of work on cognitive reappraisal skills, which can then be used to target socially relevant cognitions. Thoughts about others that are in fact self-referential are particularly helpful to identify and work with (“she won’t find me interesting” = “I am not interesting to others”). Patients who say “I feel lonelier when I am with people” are especially likely to need repetition in applying both self-compassion and cognitive reappraisal skills.

Although all the personalized modules include resources for promotion of social connections and decreasing loneliness, Skills for Relating, Skills for Living with Loss, and Skills for Caregiving have especially strong links to promoting social relationships. The Skills for Relating module may be helpful for lonely and/or socially isolated patients; sometimes even small changes in social connectedness can decrease loneliness and reduce the risks associated with social isolation. In Skills for Living with Loss, the module includes attention to a common pattern of withdrawal from others following bereavement, along with clarification of personal preferences for sharing grief reactions. Grief-related cognitions that create or reinforce social isolation are the most important to prioritize and address. Patients may have a range of thoughts and beliefs about their interactions with others since the death, leading to increasing withdrawal and social isolation. We recommend prioritization of these thoughts that interfere with social roles and relationships along with thoughts that involve not fitting into social networks anymore. These
have a strong likelihood of influencing daily activities and social functioning. If it becomes clear that there is a need for detailed work on loss and grief-related thoughts, the therapist can transition to the *Skills for Thinking* module and use those skills to question and re-appraise the most salient loss-related thoughts that interfere with relationships (i.e., within the *Skills for Thinking* module, stay focused on grief- and loss-related unhelpful thoughts). Individuals involved in a range of caregiving roles are especially prone to being socially isolated and lonely. In the *Skills for Caregiving* module, clinical materials facilitate a variety of skills, including replacing self-criticism with self-compassion and kindness, managing unhelpful thoughts about caregiving, asking for help from others, behavioral activation for the caregiver and care recipient, along with strategies to protect caregiver and care recipient well-being. There is a common ‘vicious cycle’ in which caregivers try to “do it all”, find they cannot, unsuccessfully ask for too much from one person, become depressed and withdrawn, and are increasingly likely to ask for assistance. A helpful tool for identifying options is the Atlas CareMap ([https://atlascaremap.org](https://atlascaremap.org)) which provides a systematic way for caregivers to identify their needs, support network, and where the gaps are in support (e.g., emotional, instrumental, financial, respite). We have used this within a session with caregivers and found the process to be helpful both in terms of immediate needs as well as determining if additional community services are needed.

Within the health-related personalized modules (*Skills for Brain Health, Skills for Healthy Sleep, Skills for Managing Chronic Pain*), social connections are also prioritized in various Learn and Practice pages. Positive social interactions support brain health while also reducing depression; the cognitive stimulation that accompanies social activities is important in preventing dementia (Livingston et al., 2020). Physical and social activities are also an important part of keeping daytimes sufficiently filled with positive experiences and preventing unplanned naps and dozing (Tighe et al., 2016) and are also a vital part of engaging in daily positive and rewarding experiences, despite the presence of chronic pain.

In *Skills for Wrapping Up*, the termination process includes consideration of when aging patients should be referred to community resources for continued support. For example, encouraging them to find local “support groups” for coping with chronic illness can promote continued well-being long after formal therapy is over. A listing of a wide variety of national resources is included in the appendix to both the workbook and the clinician guide for appropriate follow-up services. Because finances are often an issue for older patients, being able to provide specific information about free or low-cost services is usually very much appreciated. It also helps to ease the termination process and conveys the message that ongoing support is “out there” and may be worth considering to help with maintenance of gains.

In summary, our efforts in this second edition to *Treating Later-Life Depression: A Cognitive Behavioral Therapy Approach* (Steffen et al., 2021a, 2021b) were aimed at staying true to the original RCT-tested studies, while reflecting the evolving science and practice. There are many strategies available in this approach for working with culturally diverse middle-aged and older adults, including those who are lonely and/or socially isolated.

Ann M. Steffen, PhD, ABPP
American Board Certified in Behavioral and Cognitive Psychology & Geropsychology
Professor,
Department of Psychological Sciences, University of Missouri-St. Louis
steffena@umsystem.edu

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Ann Steffen’s research, teaching and clinical interests are focused on advancing best practices for training behavioral health clinicians to work with older adults. She teaches undergraduate and graduate courses in clinical gerontology and doctoral courses for the UM-St. Louis PhD Program in clinical psychology. Dr. Steffen is dual board certified in Geropsychology, and in Behavioral & Cognitive Psychology by the American Board of Professional Psychology. She provides clinical supervision and has a small psychotherapy and professional consultation practice at the UMSL Community Psychological Service.
Group Telehealth for Older Adults: Learning from the COVID-19 Pandemic.

Branden Schaff, BS; Rachel Weiskittle, PhD; Michelle Mlinac, PsyD, ABPP

During the early months of the COVID-19 pandemic, virtual and telephone visits rapidly replaced most in-person care to reduce the virus spread. Many mental health providers had limited experience delivering telehealth services prior to the pandemic, and few resources were immediately available to help guide this widespread shift in care. Providers of older adult and medically compromised individuals faced additional clinical concerns. Their patient populations were among the most vulnerable to negative effects of COVID-19, and, as such, were also more susceptible to pandemic-related anxiety and loneliness.

In March 2020, Drs Michelle Mlinac and Rachel Weiskittle developed and disseminated the “Telehealth Support Group for Socially Isolated Older Adults During the COVID-19 Pandemic” in response to the urgent need for remotely-delivered mental health treatments for older adults. This evidence-based group intervention, deliverable over telephone or video conferencing, was compiled in written manual form and disseminated to geriatric mental health clinicians via national geropsychology email listservs, ResearchGate, and is freely available at the web-based geropsychology resource hub GeroCentral.org (https://gerocentral.org/clinical-toolbox/covid-19-resources/). Although the group intervention was primarily aimed at home-based primary care (HBPC) and other outpatient geriatric care services, it was also intended to be flexibly adapted by clinicians according to their local needs over time. The authors received feedback from all over the world at the manual’s utility across care settings.

The manual drew from three commonly used evidence-based treatments for older adults: Acceptance and Commitment Therapy (ACT) approaches to facilitate anxiety management, Problem-Solving Therapy (PST) to address social connectedness tactics, and Cognitive Behavioral Therapy (CBT) to promote behavioral change. Because at the time many clinicians were new to telephone and virtual groups, the manual was designed to be easy and efficient to implement quickly as the pandemic unfolded. For example, information on the ethical and practical considerations of telehealth with older adults was included, as well as educational information on geriatric-specific considerations of the outbreak.

In the fall of 2020, 21 clinicians who had implemented a support group using the manual completed a web-based feedback survey. Responses indicated high acceptability and feasibility beyond the early pandemic period, with the majority of respondents describing the group intervention as “very” or “extremely effective” in addressing both social isolation and pandemic-related worry. Many reported that they were continuing to offer the group, and all (100%) respondents reported that they would be interested in a modified version of the manual for telehealth services post-COVID. In fact, the authors have received many requests to update or create a new version of the manual that is less focused on COVID-19 anxieties and more targeted towards longstanding loneliness and isolation. This shouldn’t necessarily be surprising – one in three community-dwelling older adults experience loneliness, and notably this figure doubles for those residing in long-term care settings. The older adult population experiences a unique breadth and prevalence of factors that elicit feelings of emotional distance from support systems, such as spousal bereavement, declining physical health, functional impairment, and residential facility relocation. Given our understanding of the harmful effects of loneliness and social isolation on physical and mental health, what should perhaps be more surprising is the paucity of manualized clinical interventions for loneliness, particularly for older adults.

The authors are currently working on developing a version of the manual that addresses social isolation outside the parameters of the current pandemic, with plans to pilot the group intervention across multiple cohorts of older adult participants by the end of 2022. Following promising preliminary results, this new resource will be published open source for accessibility and adaptation per local needs. In the meantime, clinicians are welcomed and encouraged to continue using the original manual. Though the authors did not anticipate the original manual’s COVID-19-centric content to remain relevant in 2022, virulent variants and ongoing associated risks continue to contribute to elevated health anxieties and social distancing measures.
Telehealth has also remained more relevant than ever. Despite pre-pandemic misgivings, telehealth interventions are not only demonstrably efficacious but also help diminish health service inequities. Factors that can make it difficult to access in-person care are the same factors that place individuals at higher risk for loneliness and social isolation – limited mobility, frailty, rurality, and lower socioeconomic status. Older adults have been disproportionately affected by COVID-19 and continue to experience service limitations due to these risk factors. Social connection doesn’t have to be in person to be powerful. Technology continues to be a lifeline for many older adults who remain socially isolated but seeking of interpersonal interaction.

Michelle Mlinac, PsyD, ABPP, is a staff psychologist at VA Boston Healthcare System and an Assistant Professor in Psychiatry at Harvard Medical School. For the past ten years, Dr. Mlinac has worked in HBPC at VA Boston, providing clinical services to home-bound older adults and their families. She supervises graduate students, interns, and fellows in geropsychology practice. Dr. Mlinac is board-certified in clinical geropsychology and serves on the executive board of the American Board of Geropsychology. Her research has been in the areas of decision-making capacity, integrated care, and geropsychology training.
A Bridge for Others

Tim Daugherty, PhD, ABPP, Blanca Martinez, PhD, and Juan Meraz, MBA, PhD.

Many ABPP specialists work in academic settings where competencies related to relationships, diversity, consultation, and scientific methods can be applied to vexing modern challenges. Colleagues’ job satisfaction may be necessary for the fulfillment of higher education’s promises, and evidence points toward falling job satisfaction in the professoriate (Russell, 2010). Faculty attrition during the tenure and promotion process reduces overall scholarly output, interferes with curriculum development and delivery, and incurs financial costs related to searching and competing for talent. Women and persons from historically underrepresented groups are at increased risk for academic job stress, low job satisfaction, and attrition (Seifert & Umbach, 2008).

With college matriculants growing more diverse than college faculty, many universities have invested in piecemeal upgrades to hiring processes (Cavanaugh & Green, 2020). However, without a culture of equitable practices (Liera, 2020), even sincerely sought search improvements may fail to produce stable excellence in a faculty body. Subtle stereotyping and biased institutional processes may push otherwise equally talented new faculty members along separate, unequal career trajectories (Deutsch & Yao, 2014; Webber & Rogers, 2018).

ABPP specialists are uniquely prepared for interdisciplinary collaborations with colleagues to assess needs, audit processes, consider differential effects of policies, and build a healthy culture. Even as large studies provide heuristic clues (e.g., Webber & Rogers, 2018), no single approach to faculty support and inclusive excellence should be expected to work in all institutions (Apfelbaum, 2016). Actionable understanding of an institution’s work culture depends on reliably and validly culling locally relevant data (Ryan, Healy, & Sullivan, 2012).

Briefly reviewing our experience at Missouri State University, we hope to encourage specialists to join similar interdisciplinary efforts on their own campuses. Bear Bridge is an innovative mentoring program with collaborative, local, data-driven evolution at its core. Connecting senior and junior faculty members across disciplinary boundaries in contextualized mentoring relationships may catalyze a virtuous cycle of positive culture development (for information about the potential salutary impact of expanded intra-organizational networks, see Warner et al., 2016). The program offers a slate of supportive training, designed to help faculty members understand their roles and related expectations, while developing skills for navigating the tenure-promotion process and maintaining life balance.

Denton, Baliram, and Cole (2021) recently argued for teaching principles from cognitive-behavioral therapy (CBT) to high school teachers to help them manage work stress and avoid attrition; similarly, the Bear Bridge program is collecting data from tenured faculty members nationwide to help identify examples of dysfunctional thinking for consideration by Bear Bridge participants in our programming based on CBT. “I am a failure if I am not just as productive and respected as the faculty who have been doing this for 30 years’ was, for example, identified as dysfunctional thinking liable to produce difficult emotion and to hamper behavior. That same (now successfully tenured professor) remembered the benefit of shifting toward, “They weren’t born this productive and, besides, I actually enjoy this and have no need of arbitrary comparisons.”

To assess performance-enhancing optimism in the academic setting, we have created a new revision of the revised Life Orientation Test (LOT-R; Scheier, Carver, & Bridges, 1994) and are collecting data now; the initial iteration of the six-item LOT-A instrument had an internal consistency of .68, but we already have clues to improving its reliability before employing it fully. Even now, we are exploiting the reactive nature of testing to discuss the nature of and contributors to faculty optimism.

In a qualitative survey, program participants identified work-life balance, service, and campus relationships as areas of greatest concern. Confidence appeared to be highest for progress toward teaching excellence and high-but-mixed for progress toward scholarship goals. Understanding the complexity of thoughts and emotions connected to scholarship may be important to effective mentoring relationships. As quantitative and qualitative data collection continues through the life of the program, we will be careful to address differential effects that are sometimes masked by aggregation (see Apfelbaum, 2016).

Demographic shifts among students (Grawe, 2018; Washington Post, 2022) make the satisfaction and retention of a fully diverse faculty body even more important. Specialists can partner with colleagues to help universities take
effective, proactive steps forward. To paraphrase famed diplomat Dag Hammarskjöld, Specialists might most fully experience their profession by joining with others- in the service of others- to become a bridge to success.

Dr. Tim Daugherty is Board Certified in Clinical Child, and Adolescent Psychology (2003) and is a Professor of Psychology at Missouri State University. Long active in diversity education and faculty development, Tim jumped at the opportunity to assist with the Bear Bridge Program.

Dr. Blanca (Judith) Martinez is an Assistant Professor of Modern and Classical Languages at Missouri State University. While serving as the university’s Diversity Scholar, Dr. Martinez recognized the need for an approach to supporting tenure-track faculty members that is theory-informed, data-driven, and flexibly-faculty-focused. She developed and continues to lead the Bear Bridge Program.
Dr. Juan Meraz is the assistant Vice President for the Division of Diversity and Inclusion at Missouri State University. Executive board member of MBAA International and past president of Minorities in Business, Dr. Meraz is a strong advocate for and leader in diversity education.

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Gender-Based Discrimination: A “forgone conclusion” that we should stop researching?

Danielle Terry, PhD, ABPP

A few months ago, feedback from my latest article submission popped into my inbox. I did what many of us do: my body tensed, I mentally crossed my fingers, and hoped for a revise and resubmit. I am not a particularly avid researcher, but I have published regularly in peer-reviewed journals since 2005. Topics I have explored have shifted over time, and in the past two years, I have found myself examining factors that impact women working in medicine, including patterns of discrimination and bullying, job satisfaction and gendered expectations that drive work-family conflict.

This article was a second attempt at submission. The first was abruptly rejected within a day. I had been startled, as the journal seemed like a good fit, the audience would be interested, and understanding factors that increase retention of women in medicine seemed like an obvious contribution. However, the gauntlet came down with a few simple words: “Your findings seem like a foregone conclusion.” Maybe I was wrong? Maybe my findings weren’t that interesting or as fascinating as I, or my collaborators, thought they were?

As I nervously scanned the latest feedback, I was startled again. One reviewer congratulated us for bringing up a valuable topic, another stated they only had “positive comments and it would make an interesting publication.” The third, stated that they were not sure how “useful” the information was.

Four weeks later, I received feedback on a different project, related to women being bullied in medical residency. The same pattern emerged. One reviewer said the project was a wonderful contribution. Another reviewer said the findings were “obvious” and not sure how “useful” they were. Concurrently, I was angrily refused a recruitment opportunity by a medical program director, stating that the study should have been prohibited and, “what if all the male residents chose not to participate and all the female residents did? [This] could be damaging to the interpersonal relationships of the group.” It is curious to me how my 10-minute, low-risk, paper and pencil survey had the power to incite such a reaction. It leads me to wonder, what are the factors that make something important to study, or call for valuative reactions of those around us?

In 17 years, I have never seen such starkly different, independent reviews on the same exact piece of work. I have never experienced overt judgements on the usefulness of a topic, or suggestions that a low risk, low effort, IRB-approved, research study using validated measures should be “prohibited.” Once we knew that smoking was a damaging health behavior, did we stop studying it, because it was obvious?

Isn’t the question supposed to be, is this a contribution to science? When something has been identified, is there a time where we should stop studying or learning about it? And if so, is now really that time?

We know that there is systemic gender bias in the workplace, education, and medical system. Research has suggested that healthcare providers are not immune to implicit and explicit gender bias among their own colleagues and in the treatment of patients. Gender inequity and discrimination has a far reaching and damaging impact on our society as a whole. It is a risk factor for gender-based violence, worse physical health, and worse living conditions. It can result in dismissal of medical symptoms and increased medical errors and contributes to poverty and unemployment. These inequalities are further enhanced by race or ethnicity. But like the study of weight-related inequity, gender inequity and discrimination can fly under the radar and may be passable, sneaking in under the camouflage of a normative behavior. In many ways, the way in which we manage systemic inequity is as embedded and natural of a habit as speaking our native language. Perhaps the more important question to ask is why are some people content to pass on publishing data about inequity, while others think it is a valuable contribution?

When these issues exist, wouldn’t it make even more sense to study them, and understand them? How do we bring awareness of our own biases in science to allow us to continue to adhere to the basic tenets of the scientific process and review? It reminds me of my early graduate school training, and a mentor who encouraged me to begin with a statement of the problem and why it should be studied. But what if the problem is not considered valuable, in part, due to the invisible threat it creates by becoming visible?
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**Danielle L. Terry, PhD, ABPP** is the Director of Behavioral Science at the Guthrie Family Medicine Residency in Sayre, Pennsylvania. Prior to that time, she developed the psychology clinical training internship and served as the Program Director for the Bath VA Medical Center in Bath, New York. She is board certified in health psychology, and also serves as a mental health liaison for the Guthrie Breast Cancer Clinic. She has special interests in smoking cessation, anxiety disorders, home-based primary care, and physician wellness. She is a recent co-author and editor of the book, *Providing Home Care for Older Adults: A Professional Guide for Mental Health Practitioners*. Her recent publications relate to technology use among physicians, impact of the COVID-19 pandemic, and the intersection of gender, family conflict and well-being in rural medical providers.
Prisons, Psychology, and the Isolated Mentally Ill

By Stephen A. Ragusea, PsyD, ABPP

Mental health has been getting increasing attention since COVID changed our lives. But there’s not much focus on the mental health of a major segment of our population, the 2.12 million people in our prisons. Prisoners are lonely, isolated, and largely abandoned human beings. Our, counties, states and nation continue to participate in a quiet crisis that is devouring our youth, our mentally ill, and our tax dollars. As has been true for more than four decades, the United States incarcerates a higher percentage of its population than any other nation in the world. Think about that. Let that thought settle into your consciousness.

Of course, we should start by admitting that there are violent people, real criminals, who need to be locked up behind bars for life, to protect those of us who aren’t violent and aren’t criminals. Throughout my career, I’ve done a lot of work in prisons, and I’ve evaluated prisoners who I don’t ever want to see walking down my street! But it turns out that the number of violent offenders is less than half of our prison population. And violent prisoners are often released prematurely because our jails are so over-crowded.

Most of our prisoners are under the age of 30, and according to the Federal Bureau of Prisons, half are convicted of crimes related to substance abuse. Approximately 15% of the total are people who meet generally accepted criteria for a mental illness, and about half of that group are considered seriously mentally ill.

According to one report (ISBN: 1564322904) from the national organization, Human Rights Watch, “One in six U.S. prisoners is mentally ill. Many of them suffer from serious illnesses such as schizophrenia, bipolar disorder, and major depression. There are three times as many men and women with mental illness in U.S. prisons as in mental health hospitals.” One of the report’s authors, Jamie Felner, observed, “Prisons have become the nation’s primary mental health facilities.” Treatmentadvocacycenter.org currently estimates “that there are currently 356,000 inmates with serious mental illness in jails and state prisons.” To crystalize these estimates, the population of our nation’s prisons roughly matches the entire populations of Pittsburgh, Philadelphia, and most of central Pennsylvania. The number of mentally ill in American’s prisons is approximately equal to every man, woman and child in Cleveland or New Orleans or Corpus Christi.

How did we get into this mess? Some of it started when politicians decided that they could get elected and stay elected by being “tough on crime.” They voted for mandatory minimum sentences, taking discretion away from the judiciary. And, although approximately half of our prisoners were convicted of non-violent, drug related offenses, our elected officials decided to spend our hard-earned tax dollars on building more prisons rather than voting for funding to pay for alcohol and drug treatment.

In Pennsylvania, where I live, it costs approximately $42,000 to keep each prisoner behind bars annually, not counting the cost of the cell itself. Where does all the money for prisons come from? Taxes, of course. And, to a significant degree, the money for building prisons was stolen from our public mental health system. Part of John Kennedy’s vision for an American Camelot included a national system of well-funded community mental health centers that would serve the mentally ill in their own hometowns, thereby permitting the closing of a well-developed system of state mental hospitals that had been providing inpatient treatment for the severely mentally ill.
ill. Those of us old enough to remember the 1970s recall an era of widely available, well-funded, mental health care provided through local Community Mental Health Centers. Oddly enough, the systematic under-funding and disempowering of our Mental Health Centers coincided with the increase in funding of the prison system to support the “Get Tough on Crime” movement that spread like a well-intentioned plague from sea to shining sea.

Is there anything to be done about all this? Of course. And psychologists should be leading the effort!

For starters, we need to depend more on special judicial institutions, sometimes referred to as “Mental Health Courts” and “Drug and Alcohol Courts.” These new courts operate under a different set of regulations and expectations from our normal criminal courts. Provision is made to include mental health professionals, judges are given wide discretion, and the focus is more on rehabilitation and prevention than it is on punishment. These courts are a good place to begin. Then, we need to improve the funding for our mental health system and stop wasting billions on the largest prison system in the history of the world.

Tell your elected representatives. We need to do more than get tough on crime; we need to get smart on crime. We can do better. Psychology can do better.

Stephen A. Ragusea, Psy D, is a clinical psychologist in Lewisburg, Pennsylvania. He has over 40 years of experience with a doctoral degree in clinical psychology from Baylor University. He is a board-certified family psychologist.
Most of us are beyond puzzled when we hear of people who would rather die than change their mind. This is happening daily during the pandemic, and it visits tragedy on thousands of families across the nation. Resistance to persuasion or standard medical advice concerning vaccination is formidable and unyielding, often buttressed by challenges of the reality of the pandemic. If the reality of the disease is accepted, rival approaches to treatment of infected persons are pursued. The only thing that is consistent is that openness to advice is anathema, amounting to a loss of sense of self or even a surrender to evil.

In more ordinary times and in other circumstances, advice is accepted or even sought and paid for because of the advisor's expertise in a specialty area (legal, medical, financial, plumbing, etc.). But when advice is not solicited, even when it is offered by an authority, it is often negatively received. People feel harangued, patronized, insulted, or attacked. The typical reaction is to fight back or find a means of escape.

In the case of COVID vaccine refusers, fighting back has taken several forms. To name a few, there are: denial (not acknowledging the existence of the pandemic); seeking unorthodox medical treatments (hydroxychloroquine, ivermectin); preferring orthodox treatments focused on post-infection cure rather than prevention (vaccination).

There are myriad theoretical conceptualizations that could be cited to explain this resistance phenomenon. One that comes most readily to mind is Cognitive Dissonance Theory (Festinger 1957), which asserts that a person presented with two conflicting thoughts will find a means to reduce the conflict, or dissonance, by rejecting one of the thoughts or by modifying it significantly. While it is risky to speculate on the dissonant cognitions of the COVID vaccine rejecters, one possible example might be: cognition one--"I don't really believe COVID is that serious."; cognition two--"I'll wait it out, but if I get sick, I'll get monoclonal antibody treatment, which is very effective."

A second conceptualization that could be utilized comes from psychodynamic drive theory (Howell 2014). Howell cites that work of Ferenczi who posits that the abused child manages the confusion between caregiving and abuse initially through dissociation and then secondarily by identifying with the aggressor. This dynamic has been used to explain compliance among concentration camp inmates, hostage victims taking sides with their captors or citizens accepting the leadership of dictators. Would it be possible to regard rejection of life-saving vaccine as a choice consistent with these examples of self-defeat and self-sabotage?

A third theoretical approach offered by W.R.D. Fairbairn shows distinct similarity to Ferenczi, in that the notion of self-handicapping is very prominent (Clarke & Scharff 2014). But, whereas Ferenczi draws on classical analytic drive theory to illustrate identification with the aggressor, Fairbairn's theory is based on the premise of object-seeking quest for emotional nurturance and love. The patients who have experienced rejection in their pleas for love internalize these experiences as bad self-objects that are unworthy of love or relationship. Sometimes the “internal saboteur” prevents the person from experiencing anything like success. It could also conceivably block access to preventive health care.

All of the above psychological conceptualizations are efforts to explain phenomena that are self-handicapping, at best, and lethal, at worst. They attempt to make sense of the nonobvious, the counter-intuitive and the irrational. Yet, experience has shown the phenomena are real and, in themselves, are contagious, resistant to modification and often more powerful than religious creed.

Well-meaning persuaders, family, friends, and co-workers have used various methods to try and penetrate the concretized resistance. First among these is appeal to science, citing research in prestigious medical journals and hospital statistics in the news. These invariably fall flat because of perceived condescension and shaming. Another effort might invoke something like “common sense.” This is a more subjective tack and might link into society's broad experience accepting other vaccinations (flu, polio, rubella, etc.) without mishap. But this vaccine push seems different--because of the speed of its development or its endorsement by coercive government. A third attempt at persuasion might use moral authority, perhaps a suggestion that this is a way we can demonstrate “being our brother's keeper.” While some might be moved by this appeal, others might counter that strong faith and prayer will be sufficient to protect themselves and their families.
The last two appeals are unabashed in their invoking of emotionality, subjectivism, and authority of a higher power. By contrast, the first appeal relies on the naive hope that the accumulation of a sufficient amount of scientific data reported in peer reviewed journals will sway public opinion. However, for many of our citizens, this approach has the contrary effect of stimulating resistance and as noted previously, resentment over perceived condescension and superiority.

Perhaps anticipation of this kind of resistance to frontal attack using facts and data led Thaler and Sunstein (2008) to develop the notion of a nudge. A nudge can be used to get a little more room in a crowded subway car without generating too much protest from other passengers. But in the context of influencing people to make prosocial and personally more advantageous decisions, a nudge takes the form of modifying the choice environment to increase the likelihood of a more favorable selection being made. An example cited by the authors might be automatically including employees in retirement savings plans unless the employee actively opts out. Such a situation is described as choice architecture, i.e., an inclusion program that is assumed rather than mandated. This has been described as libertarian paternalism.

Another alternative to the frontal attack of data and scientific “elitism” is suggested in the psychoanalytic technique of joining. Whereas nudging represents subtle, noncoercive and easy default presentation of prosocial options, joining is understood as more actively affiliative. Perhaps it is less devious as well (Margolis 1994).

I understand the overall message communicated in joining as something like “I am like you in many ways.” Its closely related technique, mirroring, makes an even stronger effort to form connections with persons, many of whom have experienced rejection and alienation. Whether through mirroring or joining, the person using the technique is communicating a message that forms a bond (e.g., “I, too, am a...father, brother, sister, wife, etc.; I also want good things for me and the people I love.”). Similarly, through successful bonding an empathic linkage permits participation in the emotional experience of the other person, probably most often the emotions of anger and pain. When done effectively, alienating divisions are minimized.

I felt that movement towards joining occurred during a therapeutic retreat for returning combat veterans in Indiana. In the course of several days, veterans and their spouses/significant others participated in a variety of exercises to foster reintegration to civilian life and enhancement of their relationships. At wrap-up of the retreat, one of the vets said, “I found out that the doctors were pretty normal.” This actually felt like quite a compliment, suggesting that barriers to communication had been removed, and something like trust had been established.

The progress made during the four-day retreat was at best a baby step forward in encouraging the vet to trust enough to share a little of his experience with those who he is close to. In the same way that a veteran may be pleasantly surprised to discover the normalcy in the doctor, he may feel more reassured to be perceived as normal himself.

Perhaps it is absurd to compare therapeutic processes occurring in psychoanalysis or at a veterans retreat with arguments between friends who differ politically or on medical matters. On the other hand, when persuasion is successful in any of these situations it is probably because the person being persuaded feels befriended, or joined, rather than assaulted or alienated.

When people accept the tenets of persuasion through joining, they are, of course, moving away from the notion of an arena of conflict. They are not there to debate or score points. This will be a novel position for the experienced debater whose goal has always been victory. Resisting the lure of winning could be very difficult. It might feel unnatural to seek common ground with a person whom you are convinced is absolutely wrong, and it would probably require reminders along the way that victory is not the end game. People capable of transitioning from debaters to joiners are flexible and willing to change old habits.

The pitfall of needing to win, while requiring vigilance, may not be as problematic as that of frank dislike. In psychotherapy, this is often called negative countertransference, and its presence can complicate progress in treatment. The same can be said of persuasion. While persuaders might be inclined to deny disliking the persons with whom they are communicating, negative energy in their verbiage at times suggests hostility. Awareness of one’s own emotionality and feeling tone increases the likelihood of accessing the skill of joining and a possibly successful persuasion.

In many respects, appreciation of the difficulty of persuasion is not difficult. It is not rocket science. Some would say it’s much harder than rocket science. But perhaps joining and other indirect, empathic techniques offer promise.
References


David Tarr retired in 2019 after a 37-year career as a clinical psychologist involving service in two VA facilities, one voluntary hospital, two private practices and one public health clinic. During one of the VA stints, he held adjunct faculty appointment at the Indiana University School of Medicine in the Psychiatry Department. He coordinated the PTSD Clinical Team (PCT) while at the Indianapolis VAMC. He now lives in the Charlotte NC area with his wife of 51 years- near the families of his two daughters, and four grandchildren.
Loneliness as a Reflector of Psychological Problems at Later Life

Brad Lian, PhD, Ian Yeager, DO, & Lee Hyer, PhD, ABPP

Social relationship quantity and quality are critical to development across the lifespan. Such relations have been linked to better mental health, physical health, health behavior, and thus lower mortality risk via a variety of psychosocial and physiological pathways (Umberson & Montez, 2010; Lim, Holt, & Badcock, 2020). A recent Cigna (2018) study equated the health impact of loneliness to smoking 15 cigarettes a day, making it more dangerous than obesity.

Unfortunately, social isolation and feelings of loneliness are on the rise in the US, and especially so among the elderly, with recent estimates suggesting between 25-55% of older adults experience such feelings (Victor 2012; Berg and Morley 2020). Indeed, aging is often accompanied by a reduction or disruption in social relationships (e.g., deaths of loved ones, children leaving the home, relocation) and opportunities (Hughes et al., 2004) and an increase in solitary living arrangements. The COVID-19 pandemic has only exacerbated loneliness issues among older adults—a form of collateral damage (Beridze et al., 2022)—because they are most at-risk and vulnerable to such viruses and so have been subject to social isolation policies and lockdowns earlier and longer than other segments of the population (Holaday et al., 2021).

Previous research conceptualized loneliness as a stable trait, focusing mostly on the amount of social contact. Importantly, there is now consensus that subjective accounts of isolation also matter (Hughes et al, 2004). In short, loneliness is now best considered as part of a constellation of socioemotional states (e.g., mood, anxiety, optimism, fear, social skills and supports, dysphoria, etc.) (Hughes et al., 2004).

Study Purpose

We address loneliness as it relates to age and age-related variables. We do this during the height of Covid-19. Our interest is in the relationships among perceived loneliness and a variety of other psycho- and socio-emotional states and the extent to which loneliness may be a pan-psychological variable.

Data and Methods

Our data come from a larger study comparing the relative influences of cognition and behavior on daily functioning, based on a convenience sample of 140 residents from several assisted living facilities in two cities in Georgia. Participants completed a questionnaire covering attitudinal, problem behaviors, and psychosocial concerns (e.g., worries, sleeping, anxiety, mood, and meaning), as well as sleep and health. The loneliness scale was included. Cognition was assessed on-line (memtrax). Subjects were also asked if they had been treated for depression or anxiety and whether they actually lived alone (see Aquadro et al., 2022).

The loneliness component in the questionnaire contained four yes-no items from the widely used UCLA Loneliness Scale (Russell, 1996): feeling in tune with the people; lacking companionship; having no one to turn to; and having someone who understands me. We created a loneliness scale with a range of 0 – 4, where 0 equals no indication of loneliness and 4 equals a high likelihood of loneliness (alpha was .8). We ran correlations between the loneliness scale and the other scales and data set items. We also created a dichotomized measure (0 = little or no loneliness and 1 =loneliness) and ran some t-tests. Finally, we ran a multiple regression, where the scales and items were regressed on the loneliness scale. Doing so allows us to account for and examine the relationships among variables simultaneously in a single model.
Results

Descriptive data showed that 41 percent of subjects responded as not lonely and 59% had a loneliness reaction. The average (and variability) of the scales were: MBI = 6 (0-45), memtrax = 74 (34-100), functional problems = 1 (0-4), worry = 5 (0-21), mood = 3.7 (0-18), meaning = 5.6 (1-7.5), and sleep = 1.3 (0-3). In general scores reflected lower levels of problems; memtrax reflected scores in the mild cognitive impairment range.

First, we conducted a correlation matrix between loneliness and the other variables. Loneliness is evidently a complex but consistent construct. Several variables were significantly related to loneliness: health (-.31), depression (.41), anxiety (.28), functional problems (.27), meaning (-.36), and MBI (.30). Those who received previous treatment for depression or anxiety had loneliness scores significantly higher than those not having treatment, M (SD) = 1.23 (1.16) and 0.80 (0.91), respectively (t(133) = 2.41, p = .017). Those reporting living alone also had higher scores on loneliness than those reporting otherwise, M (SD) = 1.06 (1.05) and 0.52 (0.83), respectively (t(132) = 2.57, p = .011).

Secondly, when loneliness was dichotomized, general health, living alone, MBI, anxiety, depression, and function were significant in the direction expected; the high group had more problems. No statistically significant gender, race, or age differences were found between the groups based on t-tests. Finally, the results of our regression analysis found statistically significant relationships for four of our independent variables; education (higher scores more protective), living alone, mood, and sense of meaning (higher scores accounting for more loneliness). The model had an adjusted R2 of .27.

Discussion and Conclusions

We assessed the construct loneliness in a sample of older adults during Covid-19. Based on our three analyses, loneliness appears to be a pan-psychological variable. It is related to mood and anxiety, health ratings, meaning, behavior problems, function, as well as education level and whether one actually lives alone or has had previous treatment for depression or anxiety. In general, subjects had lower cognitive scores (in MCI range), were protected, and were generally coping well during Covid-19 (staff reports). Loneliness appears to be connected to many negative conditions, possibly leading to hopelessness and suicide, depression, self-medication and drug use, and poorer self-regulation.

This was a small sample of convenience assessing older adults. The variability and correlations among study factors were low. Despite these limits, we can be reasonably exporting that loneliness needs attention at late life. These findings occurred during the pandemic, a situation exacerbating loneliness. While results may be limited to the pandemic, research indicates the pervasive negative influence of loneliness. Clinically then, loneliness seems as much a problem (or a moderator of problems) as any of the negative pathological problems measured in psychology. Loneliness may be considered a pan-psychological variable. The extent of this problem requires further study.
Notes and Comment:

UCLA Loneliness Scale: Developed by psychologist Daniel Russell (1996), the UCLA Loneliness Scale (Version 3) is a 20-item measure that assesses how often a person feels disconnected from others. Using a 4-point rating scale (1= never; 4 = always). **20 = typical/average; 25 = high level, 30 = very high.**

1. How often do you feel that you are “in tune” with the people around you?
2. How often do you feel that you lack companionship?
3. How often do you feel that there is no one you can turn to?
4. How often do you feel alone?
5. How often do you feel part of a group of friends?
6. How often do you feel that you have a lot in common with the people around you?
7. How often do you feel that you are no longer close to anyone?
8. How often do you feel that your interests and ideas are not shared by those around you?
9. How often do you feel outgoing and friendly?
10. How often do you feel close to people?
11. How often do you feel left out?
12. How often do you feel that your relationships with others are not meaningful?
13. How often do you feel that no one really knows you well?
14. How often do you feel isolated from others?
15. How often do you feel that you can find companionship when you want it?
16. How often do you feel that there are people who really understand you?
17. How often do you feel shy?
18. How often do you feel that people are around you but not with you?
19. How often do you feel that there are people you can talk to?
20. How often do you feel that there are people you can turn to?

References


**Brad Lian, PhD**, is an Associate Professor in the Department of Community Medicine and the Director for the Rural Health Sciences PhD Program in the School of Medicine at Mercer University. His research interests revolve around poverty and human development. He has been the lead evaluator for a HRSA-funded Healthy Start Program and an Investigator or Co-PI on several CDC- and NIH-funded programs.

**Ian Yeager** is a fourth-year medical school at the Philadelphia College of Osteopathic Medicine. He is currently doing a rotation at Gateway Behavioral Health Psychiatry Program. He will start his internship in psychiatry at Walter Reed National Military Medical Center this July, with an interest in consult liaison and interventional psychiatry. He is a graduate of the University of Georgia where he acquired his undergraduate degree.

**Lee Hyer, PhD, ABPP** is the author of over 300 articles and book chapters, as well as five books. He has also had over 50 grants from all sources, government, and industry. Now he is in Savannah at Gateway Behavioral Health Psychiatry Program directing psychotherapy and assessment. He is also Professor of Psychiatry at the Mercer University School of Medicine. He is member of several professional organizations, where he is a fellow at the American Psychological Association and the Gerontology Society of America, and a member of the American Association of Geriatric Psychiatry and the National Association of Neuropsychology.
The Psychologists in Public Service Ad Hoc Committee (PPS) continues to determine a mutually beneficial way to promote board certification of Public Service psychologists by providing an opportunity for discussing the pros and cons of becoming board certified and creating a forum for continuing advanced training for interns, fellows, and early career psychologists across the Department of Veterans Affairs, Bureau of Prisons, and the Department of Defense. The PPS is collaborating with these agencies to develop a pathway to ABPP. Many psychologists in these agencies have already become board certified, e.g., 70% of Navy psychologists are board certified, and others benefit from being “asked to join” and provided with a pathway to board certification.

This work of PPS has grown out of our original focus as the VA Task Force. This fall, for instance, we will tell their stories and highlight their contributions in a Special Edition of the Specialist. Stay tuned. In the meantime, we have expanded our efforts with the VA to include the DOD and BOP. In time we will reach out to the psychologists in other government agencies as well. We are pleased to partner with the senior psychologists in these agencies to meet these objectives and honored that they view ABPP as a critical certification for their colleagues. We are also continuing with our core programs:

**Ambassadors**

Borrowing from the success of the Ambassadors Program created by the Early Career Psychologists Ad Hoc Committee, we have designated Ambassadors of our own. ABPP has an untapped resource among board-certified psychologists in public service. Ambassadors are points of contact for other psychologists who might be interested in pursuing board certification. They share information about 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 seven Ambassadors serving in the VA across the country. We are seeking additional nominations for Ambassadors in order to build this program.

**Webinars**

The webinars are continuing and available for all psychologists in the VA and we are expanding them to the DOD and BOP. Each month we highlight one of ABPP’s specialties, provide critical information, and answer questions about eligibility, the application process, foundational and functional competencies, and benefits. The webinars are well received and serve as a primary form of outreach.

**Early Career Psychologists**

Early Career Psychologists (ECPs) represent a cohort that has demonstrated great interest in board certification. We are collaborating with ABPP’s ECP Task Force to find ways to engage ECPs in public service and discuss the value of board certification. Given that finances are often a barrier, we are working with ABPP’s Foundation to provide scholarships to ease some of the financial burden. Further, the observations that online oral exams are effective provide the opportunity to study the value of continuing online exams for ECPs 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 they complete their formal training. They have opportunities to discuss the value of board certification over the course of their career. We are creating a network of directors at all levels of public service to encourage them to discuss the importance of board certification not only for the individual psychologist but for the field of psychology as a whole. In the end, we are encouraging postdoctoral training programs to actively promote board preparation activities and to enhance ABPP’s appeal to potential applicants.
We are pleased that the BOP and DOD are partnering with us and our alliance with the VA grows stronger through our collaboration with Dr. Stacey Pollack, National Director of Program Policy Implementation in VA's Office of Mental Health and Suicide Prevention and the VA's lead psychologist based in Washington, D.C. We continue to see the number of VA applications increase and in time, we hope to report the same with the BOP and DOD. ABPP has considerable recognition and respect among psychologists. We have found that psychologists only need a pathway to their desired specialty and then many are willing to begin the process to become board certified. If you would like to join us, please let me know at sjames@srjames.com.

Samuel R James, EdD, ABPP (Chair)
Brenda Spiegler, PhD, ABPP
Chris Pietz, PhD, ABPP
Catherine Deering, PhD, ABPP
Leo Caraballo, PsyD, ABPP
Michael West, PhD, ABPP
Jeremy Jinkerson, PhD, ABPP
Kate Morris, PsyD, ABPP
Natalie Heidelberg, PhD, ABPP
Stacey Pollack, PhD
After a few false starts resulting from the pandemic, members of the American Academy of Forensic Psychology are looking forward to the organization’s first annual meeting, which will be held in Chicago, November 2-4, at the Doubletree Magnificent Mile. *All psychologists are heartily invited to attend this 3-day continuing education event.*

The program will begin with a brief welcome and awards session, followed by a plenary address on false confessions which will be delivered by attorneys Steven Drizin and Laura Nrider, both of whom are members of the Northwestern Law School faculty who represented one of the defendants in the case that was the focus of the Netflix documentary, *Making a Murderer.* In addition to a mock hearing, program offerings include half-day continuing education workshops on a diverse range of topics. A sampling of these topics includes:

- Offering effective expert testimony
- Bias in forensic evaluation practice
- Managing Daubert and Frye challenges
- Considering and addressing issues of diversity in forensic practice
- Understanding HIPAA and forensic psychology practice
- Assessment of response style
- The neurobiology of violence
- Managing a forensic practice
- Habits of the master forensic psychologist
- Distinguishing false beliefs and delusional beliefs
- Assessing defendants’ capacity to waive counsel and represent themselves

A variety of other activities are planned to include two hosted social hours, a competitive episode of *Forensic Jeopardy,* optional “Brown Bag Lunch & Learn” sessions, and organized dinner rounds that will facilitate after hours fellowship. Complete program and registration information will be posted on the AAFP website. Make sure to register early.

[www.aafpforensic.org](http://www.aafpforensic.org)
New Board-Certified Specialists/Subspecialists
December 1, 2021-March 31, 2022

Behavioral & Cognitive Psychology
   Amara Brook, PhD
   Lisa S. Elwood, PhD
   Kallio Hunnicutt-Ferguson, PhD
   Kimberly A. Kroeger-Geoppinger, PsyD
   Audrey Sessions-Spezzacatena, PsyD
   Jordan N. Soper, PsyD
   Talia Wiesel, PhD

Clinical Child & Adolescent Psychology
   Jasmine Ghannadpour, PhD
   Yasuko Y. Landrum, PhD
   Sarah R. McCarthy, PhD
   Sheila Z. Modir, PhD
   Emily C. Mudd, PhD
   Jocelyn Stokes, PhD
   Amy E. West, PhD

Clinical Health Psychology
   Valerie J. Keffala, PhD
   Jane Liu, PhD
   Jenna N. Oppenheim, PsyD
   Mona A. Robbins, PhD
   Georgeann L. Russell, PhD
   Soumitri Sil, PhD
   Michelle L. Smith, PhD

Clinical Psychology
   Justin C. Baker, PhD
   Audrey A. Cleary, PhD
   Noah Epstein, PhD
   Michael B. Finegan, PhD
   Alexis N. Fletes, PsyD
   Elise L. Gibbs, PsyD
   Christopher R. Glowacki, PsyD
   Jodi L. Johnson, PsyD
   Donna LaPaglia, PsyD
   Robert Miranda, Jr, PhD
   Anne T. Murphy, PhD
   Stephen R. Russell, PsyD
   Brianna E. Staley Shumaker, PhD
   Tracey L. Smith, PhD
   A. Jordan Wright, PhD

Counseling Psychology
   Seth Green, PhD
   Claire E. Haedike, PsyD
   Shavonne J. Moore-Lobban, PhD
   George T. Stegeman, Jr, PhD
   Melanie M. Wilcox, PhD
Couple & Family Psychology
  Caroline Daravi, PsyD
  Heather K. Poma, PsyD

Geropsychology
  Eric H. Berko, PhD
  Angela D. Coriano, PsyD
  Candice M. Daniel, PhD
  Erin R. Kube, PhD
  Lauren G. Masuda, PsyD
  Jesse A. McPherron, PhD
  Steven C. Pote, PhD
  Nicole M. Reynolds, PsyD
  Kristy D. Shoji, PhD

Group Psychology
  Abby K. McCabe, PhD

Organizational & Business Consulting Psychology
  Joseph S. Pachman, PhD

Pediatric Neuropsychology Subspecialty
  Vilija Petrauskas, PhD
  Gregory Witkin, PhD

Police & Public Safety Psychology
  Christopher Sbaratta, PhD

Psychoanalysis
  Daniel P.C. Knauss, PsyD

Rehabilitation Psychology
  Abigail S. Hardin, PhD
  Chelsea M. Kane, PsyD
  Charlotte A. Sykora, PhD

School Psychology
  Jonelle D. Ensign, PhD
In Memoriam

Thomas John Vaughn, Jr., PhD, ABPP

Dr. Thomas John Vaughn, Jr. died on April 17, 2022, after a courageous battle with cancer. He was born to Alice Katherine Wagner Vaughn and Thomas John Vaughn, Sr. on October 26, 1943, in Oklahoma City, Oklahoma.

Tom grew up in Oklahoma City, graduating from John Marshall High School in 1961. Tom went on to attend the University of Central Oklahoma, where he was an active member of the Alpha Tau Omega Fraternity and graduated in 1967. He taught psychology at John Marshall High School.

Tom developed a deep concern for human rights and the wellbeing of others early in life. After high school, he selflessly risked bodily harm participating in Freedom Rides and voter registration efforts in the American South responsive to the Movement for Civil Rights. His commitment to taking action led to his rapid development as a political organizer and thrusted him into nationally important roles in the presidential campaigns of Eugene McCarthy and George McGovern, where he also joined efforts to end the Vietnam War.

Tom established a lasting and impactful career in psychology where he specialized in working with children who had experienced trauma. He held a private practice in Oklahoma City, then Shawnee, and joined medical staff at the Shawnee Regional Hospital. He served as Director of the Clinical Psychology Internship program at the Health Sciences Center and held a faculty appointment at the University of Oklahoma. Tom contributed greatly to the field of psychology throughout his career, holding leadership and committee roles of local, regional, and national organizations, including the Oklahoma State Board of Examiners of Psychologists, Oklahoma Psychological Association, the American Psychological Association, and the Association of State and Provincial Psychology Boards. For his efforts, he received multiple recognitions and awards, including being honored with the Karl F. Heiser Award by the APA, the Norma P. Simon Award and Asher R. Pacht Distinguished Service Award by ASPPB for his advocacy and extraordinary contributions to psychology, and received the distinction of being certified by the American Board of Professional Psychology. Tom’s legacy of dedication will continue to benefit Psychology for decades to come.

Tom deeply enjoyed the outdoors and recreation. He fostered that appreciation for being outside in those around him and could often be found at a national park or on a golf course. He was also actively involved in the Canadian River Cruisers car club, and frequently displayed his cherry red 1955 Chevy 150 at area car shows in the service of raising money to support social uplift programs.

Tom is survived by wife, Susan Vaughn, known professionally as Dr. Susan McCurdy; brother, Don Vaughn and his wife Sarah Vaughn; daughter, Laura Vaughn and her husband Justin Lincks; son, Ryan Vaughn and his wife Laura Lussier-Vaughn; step-daughter, Candice Clark and her husband Bradley Clark; step-son, John McCurdy and his wife Annemarie Raizman; grandchildren, Jacquelyn Vaughn and Elizabeth Vaughn, Jordan Simmons and
husband Jake, Jacob Sheehy, Kaitlyn Reynolds and husband Joey, Abby Sheehy, and Savannah McCurdy; great-grandchildren, Noah Simmons and Maebry Simmons. In addition to his parents, he was preceded in death by his uncle, Bill D. Wagner.

In the spirit of Tom’s service, if you would like to make a donation to the charity of your choice, or many of the organizations Tom supported, please consider Food and Shelter for Friends, City Rescue Mission, or the American Cancer Society. The family would like to express gratitude to the OU Health Stephenson Cancer Center and Heartland Hospice.

A Memorial Service was held on Monday, April 25, 2022, at Goodrich Memorial United Methodist Church. Online condolences may be shared at: www.havenbrookfuneralhome.com.

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