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The Specialist Editor: Kristine Kingsley, PsyD, ABPP
Dear Colleagues,

I’m pleased to report that 2018 has been a busy and successful year for ABPP. Our achievements, whether gained through new initiatives or daily diligence, reflect the effort and dedication of countless individuals working to increase the number of board certified psychologists and promote the provision of quality psychological services to our clients and patients. Space doesn’t allow me to list all the achievements of this year, but I’m happy to start with a strong kudos to Dr. David Cox (Executive Officer) and Nancy McDonald (Associate Executive Officer) for their successful efforts to increase the number of APA-approved CE for passing the board certification exam to 40 hours. For most of us, these 40 hours represent two full years of required CE which can more than outweigh the cost of the exam process!

Strategic Governance Planning. The SGP Task Force, led by Dr. John Northman, has been productive in pursuit of the goal to enhance the efficiency and effectiveness of “internal” governance in order to facilitate ABPP taking a more active role in addressing broader issues facing the field of professional psychology. As I noted in my prior column, four target areas have been identified for enhancing internal efficiency and effectiveness: (1) enhanced communication, both across specialty boards and specialists (e.g., horizontal), as well as between the BOT, specialty boards, and specialists (e.g., vertical), (2) increased engagement of specialists and specialty board members across all aspects of the ABPP, (3) improved messaging/outreach to expand the number of applicants, raise the public and professional profile of ABPP, and grow revenue sources to support the growth of the organization, and (4) increased administrative support for the specialty boards and Central Office to manage all of the above. Specialty Board presidents have provided valuable feedback about these recommendations and shared information with each other on topics such as exam structures, outreach/advertising practices, and cross-board communication strategies. At our just completed Year-end meeting, the BOT approved a motion tasking the SGP task force with identifying and implementing the most promising recommendations from each of these target areas. The BOT also began discussing approaches for targeting external entities, including other psychological organizations, employers (hospitals, universities), insurers, and governmental/regulatory agencies relevant to increasing demand and incentives for board certified psychologists.

Marketing/Outreach. The strength of our voice in the broader field is positively correlated with the size of the organization. Unfortunately, growth in the number of new specialists has been relatively flat the past few years. To address this, we have enlisted The Reis Group (thereisgroup.com), a health and social cause-focused public relations agency, to help us develop and better disseminate more effective messaging about the value of ABPP certification. We believe that this new marketing/outreach program will not only increase the number of professional psychologists seeking specialty status, but also enhance the professional and financial considerations available to existing specialists.

Finance. Under the leadership of our treasurer, Dr. Sylvia Marotta-Walters, ABPP continues to be financially healthy. However to address the expenses associated with our comprehensive technology update and new marketing initiative, the BOT voted in May to increase the annual attestation fee from $185 to $210. This increase – the first in 11 years! - will provide the financial flexibility for these and other projects designed to grow the organization and enhance the value of ABPP certification.

Affiliation. The Affiliation Committee been communicating with a number of special interest groups (SIGs) interested in developing proposals for new subspecialty boards. Several of these proposed boards will be cross-cutting, that is subspecialty certification can be achieved through one of multiple sponsoring “parent” specialty
boards. This represents uncharted territory for ABPP, and work by the Affiliation Committee to fully articulate the complexities of cross-cutting subspecialty board structure and function is ongoing. The Addiction Psychology SIG is farthest along, having received BOT approval for their Brief Proposal – the first step in the process.

**ECP.** In clear recognition of the contributions of early career psychologist involvement, the BOT voted to create a permanent ECP trustee position on the Board and has elected Dr. Leo Caraballo to this position. We are extremely indebted to Dr. Veronica Bordes Edgar for her tremendous work as first ECP trustee and chair of the ECP committee.

**Diversity.** Under the direction of Dr. Joel Frost, findings from the Diversity Committee 2016 demographic survey were published in *The Specialist* with a second manuscript being prepared for submission to a broader journal. This committee is also completing a review of diversity-related content from all 15 SB examination manuals with the goal of creating model language and greater uniformity across the boards.

**CPPSA.** Over the past several years, several specialty boards have assumed the functions of their academies, including marketing and outreach, in lieu of continuing these academies as separate entities. Reflecting this development as well as the initiation of the recent ABPP marketing initiative, CPPSA has voted to dissolve itself for the sake of efficiency. A Task Force, chaired by Dr. Lloyd Berg, 2019 CPPSA president, and made up of representatives from both CPPSA and the ABPP BOT, is expected to complete the dissolution by the end of 2019.

**ABPP Governance.** Of course, none of this work would be possible without the hard work of the BOT, EC, SBs, Academies, Liaisons, and our partner organizations. I would especially like to acknowledge the Executive Committee and Central Office. As members of the Executive Committee, Drs. Chris Pietz - president-elect, Michael Tansy - past-president, Joel Frost - secretary, and Sylvia Marotta-Walters - treasurer each put in countless hours every month in support of ABPP and have provided valuable support and guidance to me over the course of my first presidential year. We are also very fortunate to have such a knowledgeable and dedicated central office staff led by Dr. David Cox (EO) and Nancy McDonald (AEO) with support from Diane Butcher, Lanette Melville and Kathy Holland. Our staff is a clear strength of the organization and I hope you join me in sharing your appreciation with them as opportunities arise.

**2019 Priorities.** In May of this year, we approved a new organizational mission statement which now reads: “The American Board of Professional Psychology serves the public by promoting the provision of quality psychological services through the examination and certification of professional psychologists engaged in specialty practice”. Although a laudable aspiration, achieving the full public service impact of our mission will require a significantly higher penetrance rate than our current 5% of licensed psychologists. Achieving this growth is a critical driver of our strategic planning and much of work described above.

In the service of moving our mission from aspirational to actual, I would like to offer the following priorities for your consideration for 2019: 1) improve the internal collaboration, communication, working relationships, functioning, and best practices of the component parts of ABPP, 2) seek greater efficiency through identification and adoption of best practices and enhanced standardization, where appropriate, of board and academy functions, 3) continue to improve our financial position in accordance with best practices and fiscal responsibility, 4) increase the diversity of ABPP membership/governance and attention towards multiculturalism at all levels, and 5) continue and expand our ongoing marketing initiative with a focus on enhanced messaging and targeted outreach to candidates, employers and other stakeholders.

**How can you help?** First, raise awareness by noting ABPP status on all of your professional communications, including email signature, written materials, presentations, etc. Second, volunteer to represent your specialty board at local, regional or national meetings. Third, become involved with your specialty board or academy by volunteering for committee work or running for office.
Finally and most importantly, I encourage each of you to reach out to one or more non-specialist colleagues and ask them to consider pursuing board certification through ABPP. If each of you succeed, that will represent a doubling of membership! And don't forget to mention that this pursuit will very likely yield 40 CE hours!

Thank you for the opportunity to serve as your president in 2018. ABPP is only as strong as its membership, and I welcome any comments or suggestions you might have. Please feel free to contact me directly at: jpiacentini@mednet.ucla.edu.

Best,

John Piacentini, PhD, ABPP
President, ABPP Board of Trustees
BIG NEWS!!

ABPP has a long-standing tradition of granting CE credit for passing the board certification examination. As part of our renewal for being an APA-approved sponsor of continuing education, we had to complete a new application specific to “Home Study.” We were instructed that the study and preparation aspect individuals go through while pursuing board certification was covered under that application and that in order to continue granting APA-approved CE for passing the board certification exam, we would need to complete that application. In preparing to complete the application, I surveyed our board-certified specialists. I got an amazingly large, and rapid, response. Within 24 hours or so, over 1100 people responded. The survey indicated that in excess of 70% of people spent at least 40 hours preparing for the ABPP exam. This included studying, preparing practice samples, etc. SO.....in the application, I indicated we will be increasing the CE credits to 40 for passing the ABPP exam. Late this summer, we got the news that our application had been approved. Those of you “in the pipeline” will be granted 40 CE credits upon passing the oral examination. In many jurisdictions, that meets or exceeds the total number necessary for your license renewal. Caveat: don’t forget, though, that you may have specific content areas in which you must earn CE in some jurisdiction. Nonetheless, this is sure to be a nice addition to the completion of your ABPP process!

2018 Special Initiatives

2018 has been a year in which we have created several targeted initiatives to encourage ABPP applications from specific groups.

Training Directors Initiative – ABPP has instituted a waiver of application fee for directors of training at APA accredited doctoral programs, internships, and postdoctoral residency programs. Specific details may be found at https://abpp.org/Applicant-Information/5-Types-of-applications/Educators-Trainers.aspx. In addition, the ABPP Foundation has begun giving scholarships to training directors to help offset the expenses of becoming board certified. Interested parties may obtain information from ABPPFoundation@abpp.org. The ABPP Foundation indicated that there were many more applications than scholarships available and that they intend to increase the availability in 2019.

APA Division Board Members Initiative – In addition to the Training Directors Initiative, ABPP is encouraging board certification among APA Division leaders by waiving the application fee for board members of APA Divisions. The program will provide a waiver of the application fee for individuals that serve as an officer on the board of an APA Division. Thanks to Jan Tackett, ABPP in Rehabilitation Psychology, for providing this idea to us!

Early Career Psychologists Initiative – Finally, ABPP initiated a discounted application fee ($65) for those individuals who earned their doctorate no more than 10 years ago. We rolled out this initiative in July and have had a very good response so far.

David R. Cox, PhD, ABPP
Executive Officer, ABPP Board of Trustees
The Holiday Season is once again upon us, a perfect time for reflection and new resolutions. We have had an exciting and productive year with great initiatives aiming to increase the visibility of our board subspecialties and to cultivate relationships and establish more effective communication pathways across boards and among members (please see President’s column). Alliances & networks are being built to support ABPP’s mission. Each volume of the Specialist strives to inform our readership about the latest updates, share news about innovative projects and enhance a sense of affinity and belongingness. We are forever trying to identify ways in which our newsletter can be attractive and user friendly. In 2019, we are hoping to expand by increasing the number of volumes per year and by allowing for more flexible submission guidelines with respect to length. This will come truly handy for some of you great authors out there interested in submitting your ideas, so what are you waiting for?

Moving forward I am pleased to announce that the newsletter has a new Associate Editor. Please allow me to welcome Stacy Ogbeide, MS, PsyD, ABPP. Dr. Ogbeide is Board-Certified Clinical Health Psychologist and serves as a Primary Care Behavioral Health Consultant as well as an Assistant Professor within the Family Medicine Residency, training family medicine residents at UT Health San Antonio. She holds a doctoral degree in clinical psychology with concentrations in primary care psychology and chronic pain management. She is a prolific writer and presenter, having participated in numerous scientific meetings. Dr. Ogbeide will begin her three-year appointment as of January 2019 and will be an active member of the Communications Committee.

Our most recent volume features a number of interesting updates from our President, our Executive Officer, and our subspecialty boards. Furthermore, we are publishing some exciting updates on the role of competency and how to identify benchmarks at the readiness for practice level, as well as a feature on resolving ethical dilemmas in the world of neuropsychology. Our colleagues in neuropsychology are engaged in a most interesting conversation regarding cultural competence, to our colleagues at the Department of Defense and the Department of Veterans Affairs share with us some interesting initiatives in keeping their staff healthy and disease free. In this volume, you will also find an exquisite piece on the perils of innocence, a piece on how US service members face stressors in combat situations that can produce persistent mental health symptoms post-deployment associated with fear, or moral injury- the inevitable question of what is fair in war? Admittedly some may regard this article to be a bit of a deviation from our usual content. A Veteran’s daughter myself, the message resonated with me, as I have witnessed the “struggle” in my own family member.

Consider logging on to our Facebook page where we are posting material frequently about ABPP and its activities. Our Facebook page is located at  https://www.facebook.com/getABPP/?ref=ts.

If you desire to submit an article for the Specialist, do not hesitate to send us an email at thespecialist@abpp.org. We will be happy to answer any of your questions, before submission.
Below are the standing Specialist submission guidelines.

1. The theme and content of submitted articles should be consistent with ABPP interests and issues: specialization, credentialing, board certification, identification, and development of specialty areas, etc., or to the specific interests of ABPP-certified specialists.

2. The BOT, Editor, or Communications Committee may solicit or invite contributions from individuals and organizations.

3. Submissions may be of any length but are typically between 5 pages (excluding references) of word-processed text.

4. Submissions may be in any manuscript style appropriate to the content. APA Publications Manual style need not be followed.

5. Submissions should be made by e-mail attachment in Word to the Editor’s attention at thespecialist@abpp.org. The submission attachment document itself should clearly identify the author(s). Please consider submitting a short bio and photo of your preference, to accompany your story. Remember, humans, are often “visual”.

6. Article submissions will be subject to review by members of the Communications Committee. Authors may be asked for revisions based on the review or to consider publishing their story in a different outlet.

7. Submissions or letters to the Editor with particularly controversial content may be referred through the Communications Committee to the Executive Officer and the BOT for possible further recommendation or action.

I would like to extend once more my deepest gratitude to Drs. Ellen Snoxell (Rehabilitation), Anne Dobmeyer (Clinical Health), Stanton Marlan (Psychoanalysis), & Kathleen Hart (Clinical Child & Adolescent): you have been an immense source of wisdom and guidance. I would like to thank Ms. Nancy McDonald, whose fantastic organizational / tracking skills have allowed me to navigate tons of details with much efficiency. I would like to thank the members of the main office, Diane Butcher, Lanette Melville and Kathy Holland for all their hard work and support. Above all I would like to express my deepest appreciation to Dr. David Cox who is always able to provide me with a swift and most accurate response to any question, at any time.

Lastly, I wish to you and yours festive holidays and Happy, Healthy, and Prosperous 2019.

Sincerely,

Kristine T. Kingsley, PsyD, ABPP
Editor, Communications Chair
The American Board of Clinical Psychology (ABCP) works hard to make board certification exams available to psychologists throughout the country. We have six Regional Directors who coordinate exams in the Northeast (Dr. Lindsay Phillips), Mideast (Dr. Mark Paris), Southeast (Dr. Corey Arranz), Midwest (Dr. Karen Farrell), Intermountain Region (Dr. Gloria Emmett) and West (Dr. David Mather). These Regional Directors are members of the ABCP Board, elected to four year terms that are renewable for one additional term. Each of our Regions has a cadre of trained and experienced examiners who we rely on to volunteer their time and expertise. We are also continually recruiting and training new examiners throughout the country.

We give a set of exams at each of our Spring and Fall Board Meetings, and we select our meeting locations based on the need for newly trained and updated examiners in an area where demand for exams is high. We also give exams at the annual American Psychological Association meeting. We use these blocks of exams to train and update examiners, to calibrate our exam scoring, and to maintain interrater reliability. We carefully monitor the quality and performance of our examiners and select psychologists to serve as Exam Chairs only after they have served on at least three exam committees and been trained by our Regional Coordinators who mentor them as Exam Chairs.

Most our exams are given in cities that serve as hubs where we have a critical mass of trained examiners and the location is accessible to our Regional Directors. In addition to these existing exam hub cities, we are pleased to report that our Regional Coordinators have recently developed several new examination sites across the country. Our current exam locations are as follows:

**Northeast Region:** Philadelphia, PA (hub); Scranton, PA; Boston MA

**Mideast Region:** Washington DC (hub); Fort Meade, MD; Norfolk, VA, Durham, NC; Fort Bragg, NC

**Southeast Region:** Atlanta, GA (hub); Columbia SC, Fort Lauderdale, FL

**Mideast Region:** Chicago, IL (hub); Minneapolis, MN

**Intermountain Region:** Dallas, TX (hub)

**Western Region:** San Diego, CA (hub); San Francisco, CA; Seattle, WA

Developing new exam sites is time and labor intensive, but it has many benefits for our specialists in clinical psychology. It allows us to bring in new examiners to expand our resources and provide a more efficient and timely exam process; it provides opportunities for local examiners to be actively involved with ABPP and with their professional community; and it reduces the cost of travel and time away from work for many candidates. At times when the demand for exams is high, candidates may choose to travel to a conference or board meeting...
outside of their Region to expedite the scheduling of their exams, but we always seek to provide as many opportunities as possible for candidates to take their exams in their local Regions. We also have many military psychologist candidates who travel from distant deployments to take their exams, and we seek to provide their exams in the Regions most convenient and desirable for them.

Dr. Mark Paris, Director of the Mideast Region of ABCP notes that, “Mideast Region ABCP candidates include psychologists working in a broad range of organizations, including military hospitals and clinics, VA hospitals and clinics, civilian teaching hospitals, and private practices. Having test sites representing such entities increases the probability of ensuring that an exam team will represent the background, skills, and professional interests of candidates across the professional spectrum. It also ensures greater geographic proximity of exams to candidates as close as possible to their homes or places of work.”

Of course, developing new exam teams and sites would not be possible without the dedication and generosity of our many examiners who volunteer their expertise in the time consuming process of reviewing written practice sample materials and videotapes, giving oral exams, and participating in training. We extend our deepest appreciation to all of our examiners! We enjoy meeting and working with you and value your active participation in ABPP and ABCP.

If you are board certified in clinical psychology, would like to serve as an examiner, are willing to volunteer your time, and can donate your travel expenses to one of our exam locations within driving distance near you, please reach out to your Regional Director. Giving exams is a stimulating and rewarding experience that allows us to grow our numbers of board certified clinical psychologists and promote excellence in our specialty.
Liability Insurance Follow-up Article for Specialist

By The Examiner Liability Task Force

In a recent issue of The Specialist, ABPP Executive Director, David Cox, PhD, ABPP, authored an article discussing liability insurance options for specialists who volunteer with ABPP by participating in credentialing reviews and examinations (Risk Management: Information You Should Know, The Specialist, 2017; Volume 37) and other work of ABPP. Because several specialty boards had additional questions, the Board of Trustees created an Examiner Liability Task Force at the December 2017 meeting to explore liability coverage options for board examiners not otherwise covered and to share this information with Board of Trustees and interested specialists. Ellen Snoxell (chair), Shelley Pelletier, David Corey, and David Cox volunteered to serve on this Task Force.

Please note that there is no record of any specialist being sued in the greater than 70-year history of ABPP for being part of the credentialing process. In addition, many examiners already hold personal policies that include coverage for their activities as examiners for ABPP (specialists are encouraged to contact their individual professional liability insurance providers to verify this is the case for their particular policy). On the other hand, some examiners do not carry insurance apart from that which their employer provides for their jobs which may not extend to volunteering for ABPP as an examiner or other non-work activities.

The “obvious” solution would be for ABPP to obtain insurance to cover all examiners and other psychologists participating in the credentialing process; however, this option is not feasible for several reasons. Most insurance policies require the names of specific individuals covered in advance to issue the policy and this is not a practical option for our organization which relies upon an ever-shifting pool of volunteers in any given year. Members of the Task Force identified only one company that was willing to issue a policy that didn’t specify the individuals covered and this policy would cost ABPP an estimated $22,846 per year, plus 20% of the claim after a $150,000 deductible. The Task Force members unanimously agreed this was not a cost-effective or sustainable option.

One of our member Boards, the American Board of Rehabilitation Psychology, reimbursed its examiners in 2017 for purchasing Research and Academician Liability insurance which the issuer indicated would cover liability for examinations. The cost of this is relatively low ($70 per individual) per year and must be renewed each year the psychologist serves as an examiner. The volunteer examiners would need to obtain “tail” coverage for potential claims brought against them if they allow their policy to lapse but wanted continued coverage for any potential claims that might arise from their term of service.

To quote Dr. Cox from the aforementioned article, “Each of us should consider risk management in the context of our individual needs.” The Task Force recommends that psychologists who volunteer their time and expertise as part of the ABPP credentialing process consider a range of options which includes verifying that any professional liability policy you currently possess covers being an examiner or part of the credentialing process, checking if you might be covered for volunteering through any general umbrella policy on homeowners or other insurance, and considering purchase of Research and Academician Liability insurance through a professional insurer. Alternatively, individual Boards might consider reimbursing their examiners for the purchase of limited liability coverage.
The American Board of Geropsychology has had a very productive fall so far. A number of structural changes to organization will allow the Board to enhance its examination process and services provided to our specialists. The Board added an Inclusion committee to promote diversity within ABGERO and to better meet the needs of diverse specialists. To help clarify those needs, ABGERO specialists were surveyed, with the findings published in Clinical Geropsychology News (Mlinac, M.E., Bush, S.S., Molinari, V.A., & Badana, A.N.S., 2018). The Board also added an Outreach committee to improve publicity and marketing efforts and facilitate communication between the Board and ABGERO diplomates. The Outreach committee will use both technology (e.g., social media) and more traditional means to disseminate information and communicate with the public, ABGERO diplomates, and the broader psychology community. An Immediate Past-President position was also added to the Board of Directors, with Victor Molinari, PhD filling the position.

Under the leadership of Andrew Heck, PsyD, AGBERO has also continued to develop regional oral examinations. The second regional oral examination was held at the APA convention in San Francisco in August 2018, and with the assistance of the ABPP central office, the process went smoothly. We look forward to continuing to train examiners, who in turn can provide regional examinations around the country. In part for his excellent work with the regional oral examination process, Dr. Heck was awarded the 2018 ABPP Geropsychology Specialty Board Award.
First, I would like to express my gratitude to staff at the ABPP office, the ABPP Board of Trustees and to the small army of ABCN and academy volunteers who are willing to contribute countless hours to assist with board certification in the specialty of clinical neuropsychology. Even after several years of repeatedly asking and receiving, I am still blown away by the remarkable commitment and generosity I observe every day.

Now for a quick overview of a few projects we have been working on:

- **Diversity Initiative**

  ABCN has been working on several diversity initiatives, one of which has been the deployment of a survey to our Puerto Rican colleagues.

  Our goal is to better understand our colleagues’ perspectives on neuropsychology in Puerto Rico, including training opportunities, supervision, the boarding process and possible barriers, and whatever else they feel it would be helpful for us to know.

  This initiative grew from informal discussions with colleagues who pointed out that there is an active neuropsychology community in Puerto Rico and there are a good number of neuropsychologists practicing in the mainland U.S. who are originally from Puerto Rico. It also was brought to our attention that with a population of over 3.5 million, PR is the 29th most populace state/territory, yet there currently are no specialists in neuropsychology listed as practicing in Puerto Rico in the ABPP directory.

  Following informal discussions, the ABCN credential committee and diversity committee began to explore how we might better appreciate these issues. Dr. Marc Norman, diversity committee chair, initiated conversations with numerous colleagues, including many who had a connection to Puerto Rico, and it was determined that a survey would be a useful first step for furthering our understanding and improving our outreach to our colleagues who trained and/or practice in Puerto Rico. The survey, developed in collaboration with the Hispanic Neuropsychological Society, was recently deployed. We hope to use information gained from the survey to further our engagement and outreach to our Puerto Rican colleagues.

- **Subspecialty in Pediatric Clinical Neuropsychology**

  In 2007, ABCN formed a study group to consider the merits of developing a subspecialty credential following attainment of board certification in Clinical Neuropsychology. Over several years of investigation the committee concluded that the advantages of an additional credential outweighed any disadvantages and recommended subspecialty development. The charge from ABCN was then extended to develop specific policies and procedures for the first ABCN subspecialty credential in Pediatric Clinical Neuropsychology. In 2013, the ABCN
and ABPP Boards approved this first subspecialty designation. Since that time, over 100 pediatric subspecialists have successfully attained this credential. The subspecialty certification process involves three distinct steps: 1) pediatric credential review, 2) written examination specific to pediatric science and practice, and 3) a pediatric practice sample submission in which the candidate demonstrates competent pediatric neuropsychological practice. Applications are steadily increasing as this additional qualification is accepted as further documentation of competence for neuropsychologists who evaluate preschoolers, children, and adolescents. Interested applicants can view information on the ABCN and ABPP websites, or contact Ida Sue Baron, PhD, Chair of the Pediatric Clinical Neuropsychology Subspecialty Committee, at isbaron@gmail.com.

**ABCN Written Exam Revision**

The last revision of the written examination was in 2013. In 2017, as part of our efforts for ongoing quality improvement, we began working with Alpine Testing Solutions to revise the written exam using up to date industry standard psychometric methodology. Through the herculean efforts of board members and many academy volunteers (you know who you are), we worked through a rigorous multi-step process of exam revision and launched the revised written exam in the summer of 2018.

*Thanks to Drs. Marc Norman, Ida Sue Baron and Brenda Spiegler for their contributions to this article.*

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**Strategic Governance Planning - Brainstorming Session: November 29, 2018**

J. Rick Day, PhD, ABPP (Organizational & Business Planning)

Veronica Bordes Edgars, PhD, ABPP (Early Career Psychologist)

Sylvia Marotta-Walters, PhD, ABPP (Treasurer)
The American Board of Clinical Child and Adolescent Psychology

By Elizabeth A. Gosch, PhD, ABPP

The Clinical Child and Adolescent Psychology Board has had a busy year! We have partnered with the Society of Pediatric Psychology (SPP: APA Division 54), the Society of Clinical Child and Adolescent Psychology (SCCAP: APA Division 53), and the Clinical Child and Pediatric Psychology Training Council (CCAPTC) on several endeavors consistent with our mission of promoting the field of clinical child and adolescent psychology. We were sponsors of the University of Kansas National Conference in Clinical Child and Adolescent Psychology and the Society of Pediatric Psychology Conference in Orlando. We also participated on a task force responsible for establishing Post-doctoral Residency Competency Domains in the Clinical Child Psychology Specialty, inclusive of Pediatric Psychology, with the APA Council of Specialties in Professional Psychology Commission on Accreditation (CoSCoA). The task force consisted of representatives from the specialty constituencies: SCCAP, SPP, ABCCAP and CCAPTC. As a part of this task force, we are currently in the process of drafting a petition for the Commission for the Recognition of Specialties and Proficiencies in Professional Psychology (CRSPPP) to continue recognizing Clinical Child Psychology, inclusive of Pediatric Psychology, as a Specialty. Geropsychology Specialty Board Award.

We have accomplished a number of noteworthy board initiatives over the past year. We expanded our foundational and functional competency domains to better correspond with those of the American Board of Professional Psychology. We have added the functional competency domains of Teaching, Advocacy, and Research/Evaluation to our current domains of Assessment, Intervention, Consultation, Supervision, and Management/Administration. We plan to begin implementing these new competency standards beginning January 1, 2019. In concert with the changes to competency domains, we have completed a comprehensive review of our policies and procedures. An updated examination manual, reflecting the results of this review, will be available shortly. This past year, we also changed our Stage 2 application process. We began using Box, a HIPPA-compliant content management platform, for submitting and reviewing Stage 2 applications including video practice samples. This content sharing platform enables us to manage our application and examination process with greater efficiency and security. We want to recognize Greta Francis and Wendy Ward, exam coordinators, for their exemplary contributions as we transitioned to the Box system.

The level of interest in board certification among Pediatric and Clinical Child Psychologists remains high with a steady flow of applicants that continues to grow. Stay tuned for future developments related to conducting webinars on board certification in our specialty area, administering examiner trainings at national conferences, increasing networking opportunities for specialists, and expanding our pool of examiners.
Counseling psychology is a general practice and health service provider specialty in professional psychology. It focuses on how people function both personally and in their relationships at all ages. Counseling psychology addresses the emotional, social, work, school and physical health concerns people may have at different stages in their lives, focusing on typical life stresses and more severe issues with which people may struggle as individuals and as a part of families, groups and organizations. Counseling psychologists help people with physical, emotional and mental health issues improve their sense of well-being, alleviate feelings of distress and resolve crises. Counseling psychologists also provide assessment, diagnosis, and treatment of more severe psychological symptoms. Specialized knowledge incorporated into the training and practice of Counseling Psychology includes a focus on healthy aspects and strengths of clients (whether being seen as individuals, couples, families, groups or organizations), environmental/situational influences (how cultural, gender and lifestyle issues shape people’s experiences and concerns), issues of diversity and social justice (e.g., advocacy), and the role of career and work in peoples’ lives. These areas of focus are evident in work with clients throughout the lifespan.

Board certification as a Counseling Psychologist means that a person has successfully demonstrated the foundational and functional competencies expected of a professional psychologist with a specialized focus on Counseling Psychology’s approach of promoting human functioning across the life span using preventative, developmental, and remedial strategies.

The Specialty Board of Counseling Psychology has been focused on creating a more streamlined organization regarding the examination process. We have considered setting dates and times for the exams as well as connecting the examination to a national conference (APA, ABPP, etc.). Additionally we are continuing to fine tune the examination process itself related to the number of examinees needed, as well as content in the sections. Of particular importance to our board are the questions related to Diversity and Inclusivity, which we continue to stress to our examinees. We are also looking for possible volunteers to serve as mentors and examiners.

During the past year the Board has also edited our by-laws, updated our manual, and continued to revise our website. We will be having a webinar on Wednesday, December 5, 2018 from 5:00 - 6:00 pm eastern time for Early Career Psychologists. We are very excited at the opportunity to connect with more potential professionals related to the value of obtaining board certification.

Most recently, Dr. Eric Neumaier for has been appointment to the American Board of Counseling Psychology. Dr. Neumaier sought board certification in Counseling Psychology by the American Board of Professional Psychology (ABPP) to demonstrate his clinical competencies and commitment to counseling psychology, lifelong learning, diversity issues, and social justice. As the Communications Chair, he will be encouraging board certification, liaising with numerous organizations, participating in governance, and assisting applicants in their board certification process.
Clinical Health Psychologists Serving Those Who Serve
By Ann S. Hryshko-Mullen, PhD, ABPP-CHP

What do you get when you combine the vastly diverse field of Clinical Health Psychology with the numerous opportunities of military psychology? Incredible possibilities and some of the most meaningful work you can imagine. The following is a sampling of what military clinical health psychologists are accomplishing for our nation’s Service Members.

Health Behavior Research with Military Personnel
By G. Wayne Talcott, PhD, ABPP-CHP

Military personnel have overall better health and fitness levels than the general population due to screening and retention standards. In other words, active duty military members are accessed into the military who meet weight, fitness, and medical standards. In spite of having established standards for maintaining fitness and health, a surprising disparity emerges where veterans tend to exhibit equivalent of worse health than a comparable civilian population (Agha et.al, 2000; Almond et al., 2008; Hoerster et al. 2012).

How can it be that military members, who are required to be in good health, fit and ready for battle, are vulnerable to poorer health? Changes in health status among military personnel appear to be influenced by risky health behaviors like tobacco use, physical inactivity, poor diet and alcohol misuse (Danaei et al., 2009; Fryar et al. 2016; Loef et al; 2012). In order to address this problem, Haibach et. al.,(2016) points out that the Department of Defense (DoD) and the U.S. Department of Veterans Affairs (VA) are making the promotion of healthy behavior a part of their healthcare missions. This emphasis on health promotion offers unique oppo the ties for military clinical health psychologists.

Wilford Hall Ambulatory Surgical Center, at Joint Base San Antonio, Texas, is collaborating with a team of researchers from the University of Virginia on five grants (four through the National Institutes of Health, and one funded by the Department of Defense) with aims to reduce tobacco use, alcohol-related incidents and overweight concerns of gestational women.

One randomized controlled trial (Mom’s Fit 2 Fight) is designed to help gestational active duty and civilian women entitled to military healthcare, to control weight gain during the pregnancy and then help new mothers with weight loss after delivery. This is particularly important for active duty women who have to be able to meet strict fitness standards between 6 months and 1 year after delivery.

Tobacco cessation efforts are effective in the military, and some evidence suggests that abstinence rates for cigarette smoking are significantly higher among DoD health care beneficiaries when compared to outcomes from civilian studies. Sadly, the majority of quit attempters still smoke at the end of these quit attempts. In fact, almost 70% of those participants who attempt to quit smoking, fail to quit. That is the focus of a current study trying to readdress smokers who for whatever reason, tried and failed to quit. This randomized controlled
trial provides a proactive, four session smoking cessation treatment with follow-up at three months after the quit attempts. Participants who were unable to quit are randomized to a “rate reduction”, “repeat treatment” or “choice” (they select either to try rate reduction or simply repeat the four counseling sessions). All participants are then followed at one year regardless of whether they choose to engage in another round to treatment.

Clinical health psychology research with military personnel provides an exciting opportunity to serve a largely underserved group of young women and men as well as to develop innovative and hopefully useful interventions for the larger population of military and civilians who suffer from alcohol misuse, tobacco use and overweight/obesity.

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Dr. Talcott has had an unconventional academic career having served 28 years in the United States Air Force as a Psychologist. During his Air Force career, he served as the Training Director of the Air Force’s Clinical Health Psychology fellowship program for nine years and was an Assistant Director of the Psychology Internship program. He also served on the headquarters staff of the Air Force Surgeon General’s Office where he was Chief of the Community Prevention Division. During his seven years on the Air Staff he was responsible for the Alcohol and Drug Prevention and Treatment Program, Suicide Prevention Program, Family Advocacy Program, Exceptional Family Member Program and was the Consultant to the Surgeon General for Psychology. Additionally, he was responsible for writing policy for the management of health risk behaviors in the Air Force, including the policy to increase the price of tobacco on all military installations.

Dr. Talcott deployed to Iraq where he served as the Deputy Commander at the 332nd Air Force Theater Hospital, Balad AB, Iraq. Over his career he received an Iraq Campaign Medal, Meritorious Service Medal with four Oak Leaf Clusters and a Legion of Merit. His active duty experience has been beneficial in establishing strong collaborative relationships with the Air Force. In 1993 he served as the Military Project Director for the largest Air Force tobacco cessation project, impacting over 30,000 Airmen.

Since his retirement from the Air Force in 2010, he joined the faculty of the University of Tennessee until CAPR relocated to the University of Virginia, School of Medicine. He has been an investigator in eight National Institutes of Health grants and one Department of Defense grant. He is a consultant to the Chief of Air Force Health Promotions and provides training in motivational interviewing to civilian and military health providers. In addition, Dr. Talcott volunteers and is a credentialed provider at the Wilford Hall Ambulatory Surgical Center where he provides treatment to military beneficiaries, supervises psychology interns and residents, and supports other important military research.
Clinical Health Psychologists as Agents of Change in Healthcare Systems

By Ryan J. Kalpinski, PhD & Daniel G. Cassidy, PhD

Clinical Health Psychology as defined by APA refers to the opportunity for health psychologists to play a role in improving the health system. As healthcare costs grow, the variety of healthcare models employed to date, have not achieved outcomes necessary to justify the abundant resource allocation. Such costs are particularly salient and problematic in the military, which has significant interest in the health of its population across time. The Defense Health Agency works diligently to optimize the delivery of healthcare services across Service branches. As an example, the Air Force Medical Service has sought to improve the quality of care delivered by adopting principles consistent with High Reliability Organizations (HRO). HROs require that every facet of the military health system emphasize behavior change among care recipients, providers, and support personnel in an effort to deploy highly effective process improvement tools.

Clinical Health Psychology staff and postdoctoral fellows at Wilford Hall Ambulatory Surgical Center work diligently to give away the best that behavioral science has to offer to the task of designing for behavior change at the benefit of those for whose care the military health system is responsible. One such example of this is clinical health psychology’s involvement in the 59th Medical Wing’s Gateway Academy. Within the context of an integrated, inter-professional team of medical personnel, the Gateway Performance System Management Model ensures consultation with health psychologists to refine process improvement strategies and to best effect change in the delivery of health care to an empanelment of 55,000 beneficiaries.

Clinical health psychologists shape the behavior of lab technicians to reduce the waste of patient samples, influence the instructions of nutritional medicine technicians to improve patient attendance, and leverage social norms to positively influence the culture of medical personnel. Clinical Health Psychology assists in refinement of such efforts to improve the experience and effectiveness of constituents throughout the military system of health. It is imperative that medical settings be designed for human operators and health psychologists are among the most well-equipped to ensure behavioral science is utilized effectively in this effort.

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Professionalism is a foundational competency that encompasses professional values, individual and cultural diversity, ethical and legal standards, and reflective practice (HSPEC, 2013). Although the professionalism competency cluster is relevant to all psychologists, debate continues about its essential components and behavioral benchmarks (Grus & Kaslow, 2014), which may vary by specialty. The American Board of Couple and Family Psychology has been engaged in the process of updating its manual to reflect the most recent competency conceptualization (HSPEC, 2013), identifying specific benchmarks at the “readiness for practice” level for candidates and examiners. This article considers professional values from the perspective of the couple and family psychology (CFP) specialty.

Competencies for CFP have been described in detail by Stanton and Welsh (2011) and updated to be consistent with those for health service psychology (Celano, in press). To demonstrate professional values, health service psychologists must: (a) behave in ways that reflect the values and attitudes of professional psychology; (b) value principles of safe, effective, patient-centered, timely, and equitable care; (c) value and communicate their identities as psychologists to the public and other health professionals; and (d) value collaboration with other health professions and team-based care (HSPEC, 2013).

Values and attitudes: Values and attitudes of professional psychology identified in the APA Ethical Principles of Psychologists and Code of Conduct (APA, 2010) are openness or freedom from bias, autonomy, integrity, equality, and justice. Essential components of the professionalism benchmark also include deportment, accountability, concern for the welfare of others, and professional identity (Fouad et al., 2009). Additional values relevant to CFP practice are (a) acceptance of ambiguity, (b) appreciation of complexity, (c) systematic in practice, and (d) flexibility. Acceptance of ambiguity refers to the ability to cope with the uncertain and multi-determined nature of presenting problems (Stanton & Welsh, 2011). Appreciation of complexity is embodied in the specialist’s recognition of the dynamic relationships between system levels and subsystem components that go beyond a linear cause-effect conceptualization (Stanton & Welsh, 2011). Systematic in practice means that treatment is approached in a thoughtful and planned manner, moving from comprehensive assessment to purposeful intervention (Thoburn & Sexton, 2016). Flexibility, important in all practice settings, is particularly relevant in health care organizations in which the CFP specialist is expected to meet both the patient’s and health care team’s needs. CFP specialists show flexibility in managing their time to accommodate interruptions, in coordinating treatment with other health care professionals, and in matching frequency and location of treatment to a fast-paced environment with unpredictable access to space and resources (McDaniel et al., 2014).

Patient-centered care: Patient-centered care has been defined by the Institute of Medicine (IOM, 2001) as care that is “respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions” (p. 3). Patient-centered care is a quality of personal, professional, and organizational relationships (Epstein & Street, 2011); the patient is considered in the context of his or her family, community, interactions with the health care team, and the health care system (APA, 2017). CFP specialists demonstrate patient-centered care when they: (a) consider how the intake process, provision of services, and clinic space and procedures are experienced by families; (b) ask individuals and family members if they accept and how they understand their diagnoses; (c) engage in collaborative treatment planning with families; (d) seek patient and family feedback about the treatment process; and (d) use patient feedback to improve health care in the specialty.
Professional identity and interprofessional collaboration: Given the importance of interdisciplinary team care to high quality and cost-effective health care (IOM, 2001), interprofessional collaboration and positive team functioning are foundational to CFP practice in health care settings. Professionalism requires a strong professional identity; the psychologist conveys to other health care professionals his or her skill sets (McDaniel et al., 2014), and appreciates the roles and skills of other health care team members. Interprofessional collaborative practice requires specific values/ethics competencies, including respect for the dignity and privacy of patients, and maintaining competence in one's profession (Interprofessional Education Collaborative Expert Panel [IECEP], 2011). Within CFP, a strong professional identity as a couple and family psychologist is conceptualized as a unique competency domain (Stanton & Welsh, 2011). Specialists are expected to understand the uniqueness of CFP, and how it is different from other specialties and from the modality of family therapy. They are also expected to articulate and communicate to the public and other health care professionals their identity as a Couple and Family Psychologist by continued clinical practice, service, scholarship, or teaching in the specialty.

Next steps: Now that CFP competencies have been defined and updated to be consistent with “readiness for practice” benchmarks for health service psychology, we can turn to the complex task of achieving consensus about the best ways to assess these competencies at the specialist level. Some evaluation methods are better suited than others to a given competency benchmark. The ABCFP Board will be considering assessing professional values and attitudes through multisource feedback (e.g., 360-degree evaluation) and an enhanced direct observation (e.g., in the oral examination) rather than simply relying upon the professional statement, work sample, and endorsement letters.

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THE PERILS OF INNOCENCE

A war within myself: One Veteran's struggle for life after combat

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Abstract: US service members face stressors in combat situations that can produce serious psychiatric disorders post deployment. Some of these disorders are associated with fear, but others are related to moral injury. This article examines how innocence and avoidance can inhibit or prevent recovery from PTSD or moral injury. The potential benefit of self-disclosing narrative is discussed.

Key Words: innocence, moral injury, PTSD, resilience, disclosure.

The Dilemma

"The problem is I lost my innocence in Iraq," he said, "and I don't want her to lose hers." The young veteran was responding to a question asked to an audience of veterans and their partners participating in a weekend workshop whose goal was to foster communication and closeness in couples separated by warzone deployments lasting several months.

The question posed was," Since you are here to make even stronger the bond you have with your partner, what would it be like to tell her about the toughest thing you had to deal with on deployment?" I felt the veteran's response was eloquent and able to capture the sentiment of many of the other retreat attendees, who nodded in agreement. There was clearly high motivation to protect the partner from innocence-killing war experiences and to contain or extinguish these within oneself. Perhaps this is understood as part of the warrior's mission.

I attempted to frame the question as a logical extension to the stated goal of enhancement of communication and emotional intimacy with a veteran's partner. But this effort ignores the penchant for many service members to be selective about information shared--whether classified or not--even with one's intimate partner. It became apparent that there was common- if not universal, sentiment to shield the loved one and maintain the innocence.

In a philosophical inquiry, the question of the value of innocence looms large. In her 1993 article in the journal, Philosophy, Elizabeth Wohlgast cites two literary examples of how innocence can go awry. She quotes Herman Melville's description of the protagonist Billy Budd as "little more than an upright barbarian," to be compared with the Biblical Adam; his naiveté sets him up to be victimized by the villain, Claggart. In another example, Wohlgast notes how May Willand in Edith Wharton's Age of Innocence is a sheltered child, whose fiancé did not want her to have the kind of innocence that "seals the mind against imagination and the heart against experience." Finally, Wohlgast concludes that "being an innocent disqualifies one for moral understanding, and as understanding is a condition of virtue, being an innocent is a disqualification for virtue" (Wohlgast 1993). If the closeting of the innocent prevents her from gaining an understanding of genuine virtue, it also introduces significant barriers to communication with others who are co-conspirators in maintaining the state of innocence.
In clinical practice, it is common for the psychotherapist to encounter conspiracies to maintain secrecy--a kind of innocence--which prolongs severe pathologies within families, perhaps for generations. The sequestering of the family is similar to that which often occurs in a band of combat veterans, in the sense that the uniqueness of the group experience is thought to be so foreign to others as to be incomprehensible. Some would say that there is a separate lore, separate meanings, even a separate language that is spoken. Of course, the natural consequence of this is that everyone else is an outsider.

**Why the Soldier's Wish is Perilous**

Russell Carr in his article, Combat and human existence: toward an intersubjective approach to combat-related PTSD (Carr 2011), notes that men he treated in the field in Iraq referred to outsider civilians as the "normals," i.e. those who had not been subjected to the horrific life-changing experiences of combat. Perhaps in this context, the word innocent is interchangeable with normal.

When Carr was able to make an intersubjective connection with his patient, he got some validating feedback from the young Marine officer that he "got it" more than any other provider who had worked with him. It is likely that professionals who had previously worked with this young man did not lack for intelligence, training or effort, but the "getting it" was impossible because they were perceived to be normal and innocent, which is to say incapable of participating in the person's inner emotion. This separation is palpable, whether it is occurring between a veteran and his doctor or his spouse. Robert Stolorow, citing Martin Heidegger, uses the term, "the they," to illustrate how out of touch he/she is from society as a whole, or even one's loved ones. The term that Heidegger would choose to describe the courage required to overcome such separation is authenticity (Heidegger 1962).

It is accessed when the person has ceased to make use of repression or other means to bury the trauma in an inauthentic effort to fit in with those who have never been traumatized. Trauma is life-changing, and we say the soldier's wish to keep his wife in a state of innocence will also maintain permanent alienation from her and from others he cares about. Robert Stolorow describes this alienation as an excruciating singularity, a state of separation that is intolerable and drives one to isolation (Stolorow 2007). Alternatively, it can motivate the person to seek undoing of the alienation of false innocence.

The daunting challenge of facing one's alienation head-on is described by Karl Marlantes, a decorated Marine Corps veteran in Vietnam in his memoir, “What it’s like to go to War” (2011). He reports with complete candor the chaotic mix of emotions, including some that many people would find repugnant, that occur in combat. The excitement of warfare is seen by many veterans as addictive, something to long for years afterward. It is also something that is regretted, feared and denied years afterward, due to both fear and guilt. Marlantes invokes Carl Jung's archetype, the Shadow, to tap into the darkness in which the alienated veteran dwells. The Shadow embraces not only evil but also incompetence, immaturity, clumsiness and any other trait that a person would want to deny.

Other theoreticians have identified the same alienating darkness of Jung's Shadow but have chosen a slightly different language. Harry Stack Sullivan refers to the Bad Me and Not Me as self-identification to be feared and rejected (Sullivan 1953). British Object Relations writers, WRD Fairbairn (1951) and DW Winnicott (1989), write in the 1940s of "war neurosis", and the return of the Bad Object. At times, the negative self-identification is even regarded as a saboteur, capable of undermining the person's best efforts in a relationship. A soldier's wish for a return to innocence has a long and elusive history.
**Efforts to Address Fear**

Part of what has been destroyed in the soldier’s loss of innocence is freedom from fear. He/she carries the residues of combat in the form of hypervigilance, intrusive memories, irritability and other symptoms associated with Post Traumatic Stress Disorder (PTSD). Mental health professionals have become aware that PTSD symptoms are not inclined to disappear over time, but, on the contrary, they are maintained by the patient’s (in this case, veteran’s) preference to avoid thoughts or everyday experiences that remind her/him of the original trauma. Avoidance is a thoroughly normal response to traumatic experience, but it prevents the patient from discovering that the traumatic threat was in the past, not in the present, and, because of this, recovery is prevented. Ironically, for several years well-meaning but ineffective treatments for PTSD offered by the VA and other facilities encouraged avoidance as a means of helping veterans steer clear of "triggers" to anxiety. Within the last two decades, however, a significant shift in treatment philosophy has occurred—such that patients are now encouraged to revisit traumatic memories in an effort to eliminate their power to evoke fear in the patient. Two methods have been prominently used in the VA system, and both have been very successful.

Cognitive Processing Therapy (CPT) (Monson et al 2006) is based conceptually on Cognitive Behavioral Therapy (Beck 1995) in that it encourages the patient to understand that it is possible to get "stuck" on irrational beliefs about traumatic events that then lead to negative feelings about oneself; the process of challenging the negative beliefs is called Socratic questioning. The other method sanctioned by the VA is called Prolonged Exposure (PE) (Foa, et al 2007). PE utilizes the process of habituation, i.e. a systematic method of tolerating one’s fears through monitored exposure to fear-evoking stimuli from the present and the past. Both of these methods have well established scientific research documenting efficacy and are consequently referred to as evidence-based therapies. Other therapies are under consideration to be added to the treatment arsenal, but their scientific support is not yet established.

Both CPT and PE are therapeutic techniques designed to address existing fear-based PTSD. The possibility of taking a preventive approach to PTSD was introduced by Martin Seligman and his colleagues, who forged the Comprehensive Soldier Fitness Program (CSF) in 2011 (Seligman and Fowler 2011). The emphasis of the program was the development of resilience in the soldier through the use of the principles of Positive Psychology. Resilience was conceptualized as being factored into several enhancing traits, including optimism, effective problem-solving, faith, sense of meaning, self-efficacy, flexibility, impulse control, empathy, close relationships, and spirituality. Some researchers critiqued the urgency of the adoption of this program in the absence of adequate pre-evaluation (piloting), but this was thought, in part at least, to be driven by the alarming number of service member suicides that have been reported during and after deployments (Eidelson et al 2011; Steenkamp et al 2013).

**When the Problem is not Fear**

In 2014 Brett Litz offered some commentary on the question of resilience in the aftermath of war, and he suggested that a division into three broad categories would be most useful: (i) "Operational resilience is the ability to maintain occupational role functioning and psychological performance during operational deployments despite stressor exposures, and, perhaps despite internal distress and conflict; (ii) Post-deployment resilience, which may be defined as the ability to reacquire and maintain effective role functioning in largely non-military settings after returning from deployment, and thus to again be a productive member of a family and civilian society; and (iii) Long-term psychological resilience, which may be defined as the enduring ability to adapt physically, mentally and spiritually to combat or operational exposures without developing a significant mental disorder or behavioral problem" (Litz, 2014).
The temporal component of resilience (i), (ii), and (iii) seems critical to gaining an understanding of the complicated form of PTSD that is sometimes referred to as moral injury. The immediacy of response demanded by resilience (i) is possible because of excellent training, quick reaction time, rapid analysis skills, physical strength and devotion to the mission. On the other hand, resilience ii draws heavily of the soldier’s need for flexibility, to change gears from hypervigilance to relaxed trust, from insistence on military efficiency to tolerance of delay and occasional error. But perhaps resilience iii is the most challenging, since the passage of time permits reflection on one’s role in combat and the morality of the decisions the soldier has made. Jonathan Shay makes frequent mention of his Vietnam vets being tortured by not having done “what’s right” in a war that for many of them had been over for more than twenty years (Shay 1994). Some researchers have been inclined to believe that moral trauma resulting from perpetration, real or imagined, is not treatable with PE or CPT because the underlying assumption that fear is the primary problem is false. If the underlying emotional nexus for moral injury/ trauma is a mixture of guilt and shame rather than fear, then the habituation associated with repetition of the trauma narrative, as in PE, may be more hurtful than helpful. Similarly, if the fundamental assumption of CPT that the veteran’s feelings of guilt/ shame are unfounded or irrational when they are caused by acts of perpetration, then statements reframing guilt may seem hollow and untruthful (Jordan et al 2017).

Dave Grossman’s book, On Killing, amply illustrates the soldier’s anguish when ordered to fire his weapon in heavy combat. His examples are drawn mostly from ordinary military engagement where there is no evidence of crime or atrocity, yet soldiers in large numbers fail to fire. Grossman cites one researcher reporting that several rifles were retrieved from a Civil War battlefield with many rounds tamped down on top of another simply because the soldier faked shooting when the order was given. Fast forwarding to World War II, one researcher gave an estimate of 15 to 20% of the infantrymen actually firing their rifles during a battle. This informal estimate alarmed military commanders, who called for more rigorous training in boot camp. The result was that the efficiency of firing rose to 55% in the Korean Conflict and then up to 90-95% in the Vietnam War. Grossman maintains that the demonstrable aversion to killing suggested in the anecdotal and statistical data gleaned from conflicts from the Civil War until World War II necessitated actual psychological conditioning programs in basic training to improve efficiency in firing (Grossman 2009). The increase in shooting (and killing) efficiency reported in Korea and Vietnam attests to the success of the conditioning program.

A number of researchers have begun to probe whether there is a relationship between killing and proneness to psychiatric symptoms in service members and veterans. Initially, there was an interest in studying the relationship between killing and PTSD symptoms, in particular. Shira Maguen and her colleagues discovered that “killing was a significant predictor of PTSS (prodromal PTSD)” among Gulf War veterans in spite of the brevity of that conflict (Maguen et al 2011). This study was followed by an examination of the relationship between killing and post-traumatic stress symptoms in Iraq and Afghanistan veterans, and again a strong relationship was found (Maguen et al 2013).

In addition to concerns associated with the generation of PTSD symptoms following experiences involving killing, formal evaluation of the risk of suicidal ideation was done. A retrospective study of Vietnam veterans revealed that veterans with “higher killing experiences had twice the odds of suicidal ideation compared to those with lower or no killing experiences” (Maguen et al 2012). A more recent study conducted with Iraq and Afghanistan veterans found that “firing/ killing were associated with suicidal ideation of the full sample (e.g. men and women) and men alone” (Tripp et al 2016). These findings add support to the notion that moral injury is a real phenomenon that is separable from, and, for some service members, more damaging than the effects of fear-based PTSD. Certainly, the alarming reality that the US military loses more troops to suicide than to combat in any given year makes it impossible for us to ignore killing as a high probability contributor to these deaths (Maguen et al 2012).
**If You Can't Go Home Again (To Innocence), Where Can You Go?**

The veteran who nostalgically mourned the loss of his own innocence and who hoped to preserve his wife's- was well aware of how much he had changed. He may have started to isolate himself from old hometown friends, realizing how out-of-touch he felt. He may have shown some self-handicapping behaviors like driving too fast or drinking too much. In darker moments, he may have even started to wonder if life is worth living.

In her article, Recovering Lost Goodness: Shame, Guilt, and Self-Empathy (Sherman 2014), Nancy Sherman focuses on the emotional and moral wounds that military personnel sustain, but she also proposes a therapeutic approach that differs from therapies that are fear-based. She notes that the challenge of healing is the "emotional fixity of stubbornness" that confirm the negative self-evaluations attendant to shame and guilt. It is this fixity that holds the soldier or veteran in self-handicapping or self-defeating behavior patterns. Little progress is possible if the same self-condemning mantras are recited with every recollection of the trauma (e.g. "I should have gone with the squad." "I shouldn't have fired on the vehicle.")

Sherman asserts that the "working alliance" with the therapist fosters self-empathy through a reconstruction of events, an introduction of a new interpretation that is less self-condemning. In a sense, a greater distance is taken that permits an alternative view. Citing Aristotle's notion of self-love (or self-friendship), she notes that this is what promotes moral growth and feelings of good will; this is the substrate for the growth of virtue, wisdom, and maturity.

Finally, Sherman credits Peter Goldie (2004) with what amounts to a suggestion of technique for the generation of self-empathy. Goldie discusses creating a "narrative sense of self" which involves changing perspective and "seeing oneself as another," thus permitting the kind of empathic response one feels when viewing a friend, or even a stranger, in difficulty. It is Sherman's belief that self-empathy goes to a far greater depth than self-forgiveness because it retains some degree of attunement to the original conflicts and emotions that were problematic (Sherman 2014). To the degree that the patient constructs a full, honest and empathic narrative, she/he is permitting healing to go forward that does not depend on a return to an innocent state. Hopefully, too, one is released from self-isolation, self-handicapping and self-destructive behaviors that have served as maladaptive means of coping.

The notion of narrative construction is essential to the manualized program of therapy designed by Brett Litz and his colleagues. The program, called Adaptive Disclosure (Litz et al 2016), addressed many of the concerns Litz cited in his monograph of 2014, which, as stated earlier, delineated the three types of resilience necessary for successful readjustment following combat exposure. In essence, Litz believed that existing evidence-based therapies concentrated far too much on fear-based PTSD and ignored the psychic pain associated with guilt and shame. In many respects, Adaptive Disclosure appeals to the suffering soldier's sense of fairness as he/she imagines a compassionate, non-judging authority inviting a more even-handed interpretation of events, or even imagining the soldier herself suggesting to a comrade that he should not condemn himself forever, that even heinous perpetration can be let go when post-traumatic growth occurs.

The technique of dialog and narrative generation has been an effective tool in various therapeutic antecedents to Adaptive Disclosure. Fritz Perls, the founder of Gestalt Psychotherapy, promoted the notion of dialoguing with a psychologically problematic person seated in an empty chair in the consultation room (Perls 1969). This technique permitted the patient to suspend inhibition and repression sufficiently to release unrecognized affect and hopefully achieve healthier ego integration. A self-generated narrative is also crucial in Imagery Rehearsal Therapy (IRT), where patients are coached to rescript a problematic recurrent nightmare in a way that it becomes unthreatening.
A growing body of research is demonstrating that trauma survivors can benefit from restructuring and rehearsing dreams to take the place of terrifying nightmares that had been dominant for years (Balliett et al 2015, Casement and Germaine 2014, Casement and Swanson 2012).

It would appear, therefore, that therapeutic techniques are available to address the injuries of fear-based and guilt/shame-based trauma. Patients have responded to treatments that promote re-scripting, reassessment and self-empathic interpretation of events. The challenge for the therapist is to persuade the person to commit to the therapy. Some resistance can be attributed to skepticism that it would be possible to heal by imagining comfort provided by a trusted authority or to think it possible to re-write the narrative of a nightmare or trauma. But it is also true that much of the resistance is the result of the internalization of negativity and belief that one is not worthy to experience psychological relief and healing. A veteran told me he was convinced that he was going to hell, even though pastors had tried to convince him of God’s mercy.

If the benevolent efforts of a Christian clergyman are unsuccessful in persuading a veteran that he is worthy of grace and forgiveness, what might be tried to release him from disabling guilt and shame? It occurred to a number of theorists (e.g., Litz & colleagues) that a warrior might have more willingness to be merciful to another comrade than to himself. Through narrative and creative role play a shift from subject to object is at first contemplated and then affected. It is the self-empathy that Nancy Sherman (2014) strongly recommends but which is so difficult to accomplish within a toxically shamed and self-condemned person. So to imagine lessening the burden of guilt and shame on a buddy who was stuck in a situation, not of his own making may permit transfer of relief to the self. And this might occur even if acts of criminal perpetration have occurred.

It will be recalled that Sherman prefers the concept of self-empathy to that of self-forgiveness. She believes the notion of empathy captures more of the complexity and long-term emotional work that is needed to fully accept but also integrate the reality of wrongdoing and goodness residing in the same person. By contrast, Sherman regards self-forgiveness as risking superficial and quick-paced resolution which papers over the reality of culpability and pain of transgression. Self-empathy permits the individual to say "that was me, but this other self is also me, and I will keep vigil to maintain the goodness of this other self."

It should not be a surprise to anyone that therapies addressing PTSD and moral injury encourage the soldier/veteran to cease secrecy and denial, first and foremost to himself. Not every soldier has a calling for literary expression (Karl Marlantes, 2011; Tim O’Brien, 1990), but it is true that a great many soldiers have a story to tell. And it is in the telling of the story that she/he is liberated from the obligation to shelter civilian society from the pain that leads to self-loathing and shame. To move forward to tell the story, one is proceeding with the expectation that it is safe to do and also that it will be believed. Insistence on keeping society (even one’s own partner) innocent prevents communication and reinforces doubt within the service member that he/she has credibility or value. The challenge for many of us is to muster the courage to self-disclose and shattered innocence. When this occurs, one surrenders the need to return home to naivete and innocence because there is greater comfort in wisdom. When innocence is lost, it can do no more damage.

**Philosophical Postscript**

In a time when one’s basic understanding of guilt, shame and innocence is in a state of flux, it can be seen as an opportunity for reconstruction of one’s self and one’s belief system. It seems to me that this is the situation faced by the person suffering severe moral injury. Loss of innocence has occurred, and one may feel adrift on a sea of uncertainty. It is in this fluid state that Albert Bandura (2001), who had become disenchanted with over-determined views of personality, contended that subjective, agentic personality is possible, where choice and
planfulness are put into play by the individual. To be agentic (i.e. to be one who makes things happen) is consistent with being able to write a self-empathic script that is self-disclosing and oriented towards healing.

Another perspective useful in finding a foundation for re-writing one’s script or personal narrative is that of Hans Vaihinger. He was a German neo-Kantian philosopher who introduced what he called the philosophy of As If (German: Als Ob). The essential premise of this thesis is that there is distinct value in society proceeding as if various stated or unstated assumptions are true simply because a significant benefit (social, religious, scientific, etc.) derives from this belief. Some have described this as a hypothetical approach to reality. Yet, in an effort to overstate his case, Vaihinger went so far to say that some beliefs that are demonstrably false should be maintained if they yield a positive social good. As the agnostic son of a clergyman, he may have been thinking of religion most especially in making this assertion (Vaihinger 1924, 2000, 2001).

Curiously though, when Vaihinger first introduced his “As If” thesis in his doctoral dissertation in 1877, some important hypotheses in physics were as yet speculations. It was not until the work of Niels Bohr in 1911 that the existence of the atom became proven, although it was cited by Vaihinger as a valuable “as if” assumption much earlier.

Could it be useful to the mental health practitioner to introduce the notion that the traumatized or morally injured person can move forward “as if” healing is taking place? Actually, this is clearly implicit in treatments that entail the risk-taking of self-disclosure and the acquisition of self-empathy. When one is willing to take the point of view of a benevolent, non-judgemental authority (as in therapeutic Adaptive Disclosure), one is operating “as if” it is possible to resume a life free of disabling guilt and shame—but also as a beneficiary of the wisdom resulting from one’s traumatic experience.

REFERENCES


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**Cultural Competence as a Foundational Neuropsychological Competence**

By Tedd Judd, PhD, ABPP-CN

When *The ABPP Specialist* put out a call for papers including personal stories regarding specialization, credentialing, board certification, and the functional and foundational competencies, I realized I had a story to tell, although perhaps not a conventional one. I hope it may raise some awareness of what ABPP has been, is, and, hopefully, will be.

For most of my career, ABPP has had a reputation “on the street,” that is, in the profession of psychology broadly, as an organization of, by, and for old white men. I have nothing against old white men; in fact, I am one. I got certified in 1989. Thereafter, I did some work sample reviews for ABCN. In my direct experiences I found ABCN to be shockingly weak on ethnic and gender diversity in membership and practice. I considered advocacy work within ABCN, but judged that it would probably be frustrating and fruitless. Worse, I heard disturbing reports from colleagues of having received what they experienced as rude and racist treatment from ABCN. I felt embarrassed and pained for my esteemed colleagues and decided that I did not want to associate myself with the organization, and so I quit ABCN. I remained in ABPP, for which I had no such specific reports.

When I was President of the Hispanic Neuropsychological Society (HNS) in 2010, I received reports that candidates preparing their work samples for ABCN certification were being advised in the community not to present cases of Spanish-speaking clients, even when that population was the candidate’s strongest skill-set, because ABCN was not prepared to evaluate such cases competently. Around that same time I noticed that there were no ABPP specialists in any specialty in Puerto Rico. I spoke with my Puerto Rican colleagues and learned about their barriers to certification and some possible solutions. Puerto Rico has an enthusiastic but struggling neuropsychology community, with at least 13 universities offering courses and one university offering doctoral training in neuropsychology. It could be a valuable partner for reciprocal training from the mainland to mutually enhance cultural competence. I began lobbying ABCN on these issues a bit and received slow but modestly-encouraging results.
More recently, my disillusionment with AACN has slowly turned around after observing hard-won changes, especially with the initiation of Relevance 2050. I am encouraged by the fact that this movement has made substantial progress in recognizing AACN’s cultural and linguistic provincialism and in laying out the long road to incorporating cultural competence into the profession of neuropsychology in North America. Relevance 2050 has multiple working committees that are addressing issues of cultural competence at all levels of the neuropsychology profession and community. They (I should now say “we”) held a joint summit in conjunction with both AACN and HNS at the 2017 conference. These efforts have been embraced by the AACN board. All of these changes and efforts are heartening…so a few months ago I rejoined AACN.

I am particularly pleased that the name, “Relevance 2050,” reflects the demographic realities that neuropsychology as a field and all neuropsychologists as individuals not only should but really need to develop cultural competence in order to be relevant (employed) by 2050. I always enjoy working with my diverse colleagues and welcome them in AACN.

But that is only part of the hard work ahead. We cannot count on recruitment of minorities as the only strategy for addressing an increasingly diverse North American client population. All of us need to improve our cultural competence, even old white men. Participating in Relevance 2050 has given me the opportunity to collect in one place my experiences in teaching cultural competence in neuropsychology through a multicultural practicum, mentoring, listserves, and in teaching courses and workshops in many different conferences and countries. I have now mentored students speaking at least 10 different languages, and so have also had the opportunity to experience some of what it takes to train students to become clinically competent in their heritage language. Relevance 2050 has given me the opportunity to participate in drafting what basic cultural competencies are, how to teach them, and what it may take to be considered a specialist in a particular language/cultural group. And we have been able to envision some of the infrastructure that organized neuropsychology needs to develop in order to support a profession that is culturally competent.

Those of you who know me might say I’m a dreamer. I look forward to this work seeing the light of day soon. I look forward to seeing a cohort of ABPP-CN’s from Puerto Rico. I look forward to when AACN is ready to routinely provide culturally-competent review of non-English speaking cases as work samples and exam questions. I look forward to watching our profession grow and mature into the consideration of all kinds of brains in their contexts, and to treating all brain-impacted clients with professionalism, competence, and fairness. I'd like to be able to see it in 2050 (OK, I’m old, but not that old), but I’d love to see it sooner.

Tedd Judd, PhD, ABPP-CN, is a clinical and forensic neuropsychologist, and cultural generalist with 38 years of experience. He has evaluated clients from about 90 countries and has taught neuropsychology in 24 countries. He is Past President of the Hispanic Neuropsychological Society. He teaches a practicum in non-English cross-cultural psychological assessment and is the academic co-director of Central America’s first Master’s degree in neuropsychology at the Universidad del Valle, Guatemala.
Cultural Competence as a Foundational Neuropsychological Competence: Commentary

By Anita Sim, PhD, ABPP & Marc Norman, PhD, ABPP

With changing demographics, the American Academy of Clinical Neuropsychology and American Board of Clinical Neuropsychology support new assessment methods, training models, clinical strategies, and cultural competence to meet the needs of the shifting population. Dr. Judd’s positive commentary on Cultural Competence as a Foundational Neuropsychological Competence allows ABCN and AACN to highlight the important initiatives, progress, and aspirations to meet these needs.

As Diversity Chairs, we have seen tremendous commitment of the ABCN and AACN Boards of Directors for a vision of cultural competence, and we are enthusiastic about the tangible changes within the last several years. As noted by Dr. Judd, AACN’s Relevance 2050 is an initiative to improve access and service delivery for our increasingly diverse patient populations. The multi-dimensional initiative focuses on research, education, and training. As highlighted in the Spring 2018 issue of The ABPP Specialist, the AACN formally awarded a $10,000 grant award to help support the development of an interactive platform for multi-cultural/multi-linguistic norms for open access cognitive tests. To increase the pipeline of culturally competent neuropsychologists, the Relevance 2050 Student Pipeline Subcommittee (SPS) has engaged in initiatives focused on promoting mentorship and recruitment of under-represented trainees and providing early education on board certification via intra-/inter-organizational efforts. The SPS student and trainee members have developed a pathway for students from under-represented groups to be included in AACN’s governance structure, and this group has successfully sponsored free and highly popular webinars and presented workshops at AACN. Since bringing under-represented minorities into the pipeline is only the start of the process, the AACN Board Certification Promotion Committee successfully applied for and received a grant from the Council of Presidents of Psychology Specialty Academies to help defray the cost of board certification for ten ethnic minority applicants. We have received positive feedback by highlighting neuropsychologists from under-represented backgrounds, emphasizing the benefit of visualizing inclusivity in our profession.

Since its inception, the Relevance 2050 Committee has also worked closely with the AACN conference programming committee in order to offer quality workshops on multi-cultural topics at each year’s annual meeting. In 2018, we were pleased to offer, select, and provide an award to the best poster presentation on a diversity related topic, and will continue to do so for future meetings. We were quite pleased that Dr. Judd himself contributed to a rich 2018 program, by offering a workshop on the best practices in forensic neuropsychological assessment of non-English speaking clients. Also in 2017-2018, the Relevance 2050 Peer Consultation Network Subcommittee successfully constructed and disseminated a survey to APPCN neuropsychology postdoctoral training directors to determine their perceived competencies and teaching/supervision practices regarding multicultural issues in an effort to better inform AACN’s efforts towards enhancing multicultural competence.

In addition to these tremendous gains, the ABCN and AACN found an opportunity to address possible concerns and perceptions by our colleagues in Puerto Rico. While it is unfortunate that individual experience may not have been positive in the past, we were interested in understanding current perceptions, training opportunities, supervision, interest in and possible barriers to becoming boarded. An initiative was undertaken by ABCN and AACN in collaboration with the Hispanic Neuropsychological Society to survey those trained and/or working in Puerto Rico. We recently gathered information about training, language, and perceptions about the boarding
process, including perceptions about examiner and reviewer cultural competence. The results are now being analyzed, but initial findings suggest that negative experiences are the exception, and there is a positive regard toward engaging and addressing training in Puerto Rico. The survey has been enlightening, and we are encouraged by the engagement and desire for a board certification initiative. This has been a rewarding collaboration, and we hope to broaden the feedback and learning to a wider range of LatinX neuropsychologists. The ABCN board continues to be engaged in considering non-English practice samples, but the issues are complex and nuanced beyond culturally competent practice sample reviewers. The ABCN has continued to make concerted efforts to assess cultural competency across the written and oral examinations. The ABCN Diversity Committee has traditionally reviewed oral exam Ethics Vignettes, and the ABCN has undertaken analyzing and implementing additional cultural competency assessment within the written and oral exams.

We applaud Dr. Judd for his re-engagement with AACN and leading-edge thinking about the importance of inclusive training and cultural competence in providing services and share a similar vision. Like Dr. Judd, we are excited by positive changes, and we look forward to new and exciting Relevance. Together, AACN and ABCN share a unified vision of increasing diversity and cultural competence and are excited about the vision, engagement and steps we have undertaken. We should all value and work towards providing culturally competent care and encouraging diversity within the profession.

Dr. Anita Sim is a staff neuropsychologist at the Minneapolis VA Health Care System. She is the primary neuropsychologist within the Department of Physical Medicine & Rehabilitation where she provides neuropsychological assessment services to both veteran and active duty service members on the inpatient and outpatient services. She is also actively involved in the training and supervision of pre-doctoral interns and residents in neuropsychology and rehabilitation psychology. She completed her PhD in Clinical Psychology at the University of Nebraska Lincoln. She was a neuropsychology pre-doctoral intern at the University of Oklahoma Health Sciences Center prior to completing her two-year postdoctoral residency at the University of Virginia School of Medicine. She attained board certification in 2011. Her clinical and research interests include sports-related concussion, mild traumatic brain injury, performance and symptom validity, and multi-cultural/diversity issues. She has authored or co-authored multiple papers and book chapters and is an ad hoc journal reviewer for The Clinical Neuropsychologist and the Archives of Clinical Neuropsychology. Dr. Sim is also actively involved in APAs Society for Clinical Neuropsychology, including past service on the Ethnic Minority Affairs, Program, and Women in Neuropsychology subcommittees.

Dr. Norman received a PhD in clinical psychology, emphasizing in neuropsychology, from Brigham Young University. He completed the UCSD/VA Medical Center Psychology Internship program in 1995. Following an NIH funded research postdoctoral internship, Dr. Norman became an Assistant Clinical Professor of Psychiatry. He earned a Diplomate from the American Board of Professional Psychology, specializing in Clinical Neuropsychology and is a Board Examiner. Additionally, he was elected as a Fellow of the National Academy of Neuropsychology. Dr. Norman is active in disaster mental health and is past chair of the American Red Cross San Diego/Imperial Counties chapter Disaster Mental Health Team.
Achieving Sound Ethical Solutions: A Forensic Neuropsychology Case Illustration

By Shane S. Bush, PhD, ABPP

Introduction

Effective psychological services are guided by a commitment to upholding high standards of ethical practice. Psychologists who aspire to such high ethical standards strive to anticipate the ethical issues that are relevant in their practice context and to structure their practices in a manner that meets and exceeds minimum ethical requirements. Such efforts help practitioners avoid many ethical dilemmas that would be experienced by someone less focused on ethical issues. However, despite best efforts, ethical challenges inevitably emerge over the course of a career and must be addressed. This process of anticipating ethical issues, avoiding ethical missteps, addressing ethical challenges, and aspiring to high standards of ethical practice has been referred to as the Four A’s of ethical practice (Bush, 2018).

Ethical decision making is conceptualized better as a process than an event. As with clinical decision making, the ethical decision-making process involves multiple steps that lead to a sound solution or recommendation. Unlike clinical decision making which occurs on a daily basis for most practitioners, the ethical decision-making process is a less common occurrence and, as such, is likely to be much less automatic. For this reason, use of a structured ethical decision-making model can facilitate the process, ensuring that all key steps are completed, thereby increasing the likelihood of reaching a well-reasoned, evidence-based, helpful, and defensible solution. Many ethical decision-making models have been proposed in the ethics literature. Although some differences exist among the models in the number and wording of the steps, considerable overlap exists. Attempts have been made to tailor some models to the needs of specific psychological specialties or to word them in a way that facilitates the use of a mnemonic that can facilitate recall of the steps (e.g., Bush, Allen, & Molinari, 2017). The following psycholegal issue, as illustrated by a forensic neuropsychology case, showcases the use of a model described by Bush, Connell, and Denney (in press) for use in forensic practice.

Psycholegal Issue

In Ford v. Wainwright (1986), the Supreme Court of the United States (SCOTUS) addressed competency to be executed. It determined that the execution of the insane was a violation of the Eighth Amendment (i.e., cruel and unusual punishment). The court argued that the insane lacked the mental capacity to understand the nature of the death penalty and the reason it was imposed. In 2007, the SCOTUS again addressed this issue in Panetti v. Quarterman. The court contended that inmates in capital cases needed a rational understanding of the reason for their death sentence, which was beyond just a factual understanding. However, the court failed to outline the specific competency criteria or guidelines. Thereafter, state courts have struggled with applying this ruling, with varying definitions, which has complicated the assessment process for psychologists. This issue is particularly important for older adults who have been given the death penalty. With aging, comes increased risk of progressive neurocognitive decline, which could result in incompetency to be executed over time. To date, the SCOTUS has declined to hear any case that addresses the constitutionality of capital punishment for older adult prisoners with diminished capacity (Allen et al., 2018).
Case Illustration

A 55-year-old man is convicted of murder and sentenced to death. The conviction and sentencing are subject to lengthy appeals. Over the years during which the appeals take place, the man, who was in good health and cognitively intact at the time of his conviction, gradually begins to show signs of cognitive decline. By the time the appeals have been exhausted and the execution is scheduled to occur, the man is showing signs of possible cognitive deficits and some functional impairment. A neuropsychological evaluation is performed at the request of post-conviction habeas counsel, and the man is diagnosed with major neurocognitive disorder due to Alzheimer’s disease. The neuropsychologist opines that the man no longer understands why he is incarcerated or why he will be executed. The neuropsychologist states in his report that the death penalty is inappropriate for older prisoners with diminished capacity. In addition, he advocates for the defendant to be granted compassionate release so that he can receive appropriate care and supervision in the home of a family member for his few remaining years. A second neuropsychologist is retained by the state attorney general’s office to review the report and test data obtained by the first neuropsychologist. She finds that the initial neuropsychological evaluation selectively used cognitive tests to highlight deficits. In addition, she finds that the first neuropsychologist has extensively written on his opposition to the death penalty and only conducts evaluations for the defense, with similar conclusions. Moreover, the second neuropsychologist thinks the test data are most consistent with a mild neurocognitive disorder. She believes that the first neuropsychologist overpathologized the defendant’s condition because of his personal bias against the death penalty. She believes such behavior is professionally inappropriate and considers what to do about it.

Case Analysis

A structured and systematic decision-making process is used to determine the neuropsychologist’s course of action. It is typically valuable to understand not simply that certain practices are unethical, but rather why they are unethical, as well as how to address them. The mnemonic CORE OPT can help clinicians follow the seven ethical decision-making steps and arrive at a sound solution.

Clarify the ethical issue. The second neuropsychologist is concerned that personal bias influenced the first neuropsychologist’s test selection, presentation of results, and recommendations, which could have significant implications for justice. Such bias could lead to information and recommendations that, rather than being of value to decision-makers in the criminal justice system, are harmful to the process.

Obligations owed to stakeholders. The second neuropsychologist has a primary obligation to the court to provide objective and impartial input, which can be used in the pursuit of just legal decisions, even though she is hired by the attorney general’s office.

Resources - ethical and legal: The APA Ethics Code states, “Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of their competence, and the limitations of their expertise do not lead to or condone unjust practices” (American Psychological Association, 2017; General Principle D, Justice). Additionally, “Psychologists’ work is based on established scientific and professional knowledge of the discipline” (Ethical Standard 2.04, Bases for Scientific and Professional Judgments), rather than on personal opinions and preferences. Similarly, according to the Specialty Guidelines for Forensic Psychology (APA, 2013), “When conducting forensic examinations, forensic practitioners strive to be unbiased and impartial, and avoid partisan presentation of unrepresentative, incomplete, or inaccurate evidence that might mislead finders of fact” (Guideline 1.02, p.9). Psychologists strive to avoid harmful actions and outcomes (Ethical Standard 3.04; General Principle A, Beneficence and Nonmaleficence) and are better positioned to avoid harm when basing their conclusions and recommendations on evidence-based procedures and knowledge. In the context of competency for execution assessments, Zapf (2009) described the importance of practitioners maintaining objectivity throughout the
evaluation process. Cunningham (in press) noted specifically, “Evaluations of competency for execution require a strong commitment to objectivity and an absence of bias regarding the death penalty or its imposition.” Professional guidelines exist for the evaluation of competency for execution (Zapf et al., 2003).

Examine personal beliefs and values. The second neuropsychologist believes while personal biases are a natural part of the human experience, psychologists practicing in the legal system have an obligation to strive to understand their biases and to minimize their impact on their work; she does not believe that the first neuropsychologist made such efforts.

Options, solutions, and consequences. The second neuropsychologist considers the following actions regarding her colleague's apparent biases and their impact on his work: (1) do nothing, let the adversarial legal process reveal any problems with the expert's services; (2) contact the colleague directly to discuss her concerns informally and ask that he reconsider his conclusions and provide an addendum with a corrected diagnosis and different recommendations; or (3) file a complaint with the state licensing board and relevant ethics committees. Option one may suffice for this case, but the colleague could continue to practice in this manner in the future. Option two, consistent with Ethical Standard 1.04 (Informal Resolution of Ethical Violations) is commonly a good option in clinical practice contexts but not in forensic practice. It could be viewed as witness tampering. Option 3 is also not advisable in the course of a forensic case because it can be viewed as a tactic intended to discredit an opposing expert. Sweet (2005) advised the following: “If ethical concerns that arise within a forensic context remain salient after the case has concluded, then it is appropriate to consider whether any action is necessary” (p. 55).

Put the plan into practice. The second neuropsychologist decided to take no action at the time. She elected to let the legal process play out for the current case and to wait until the matter was settled before considering whether her concerns remained at a level that would warrant a formal complaint.

Take stock, evaluate outcome, and revise as needed. The decision to execute the man was upheld. The second neuropsychologist remained concerned about the first neuropsychologist's bias regarding test selection, presentation of results, and a recommendation beyond the psycholegal issue. She decided to discuss the matter with the first neuropsychologist post-trial/appeal, as outlined in Standard 1.02 of the APA Ethics Code. During that discussion, the first neuropsychologist acknowledged that the issue raised during cross-examination was very detrimental to his credibility and professional integrity. He reported that he no longer planned to conduct these evaluations.

Conclusions:

When anticipating or confronting ethical challenges, multiple resources are available to guide decision making and behavior. A structured approach to ethical decision making can facilitate the process. The present article highlighted such a model, which can assist in addressing ethical dilemmas. This model consists of the following components (CORE OPT): (1) Clarify the ethical issue, (2) Obligations owed to stakeholders, (3) Resources—ethical and legal, (4) Examine personal beliefs and values, (5) Options, solutions, and consequences, (6) Put plan into practice, and (7) Take stock, evaluate outcome, and revise as needed.

Despite best efforts, ethical challenges inevitably emerge over the course of a career and must be addressed. Adherence to the Four A's of ethical practice can prepare psychologists to meet and exceed ethical requirements and to address dilemmas when they occur. Effective psychological services are guided by a commitment to upholding high standards of ethical practice. Psychologists who aspire to such high ethical standards strive to anticipate the ethical issues that are relevant in their practice context and to structure their practices in a manner that meets and exceeds minimum ethical requirements. Such efforts help practitioners avoid many ethical dilemmas that would be experienced by someone less focused on ethical issues. However, despite best efforts,
ethical challenges inevitably emerge over the course of a career and must be addressed. This process of anticipating ethical issues, avoiding ethical missteps, addressing ethical challenges, and aspiring to high standards of ethical practice has been referred to as the Four A’s of ethical practice (Bush, 2018).

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