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Dear Colleagues,

In the December, 2018 issue of *The Specialist*, I outlined five priority areas aimed at enhancing ABPP’s ability to better achieve its organizational mission “to serve the public by promoting the provision of quality psychological services through the examination and certification of professional psychologists engaged in specialty practice”. Additionally, I had noted that realizing this mission would require significant growth in both the number of ABPP-certified specialists and the administrative capabilities of the organization.

Although considerable work remains to be done, I am pleased to report that we are making notable progress in each of the five priority areas, as listed below.

1) Improve the internal collaboration, communication, working relationships, functioning, and best practices of the component parts of ABPP:  The Strategic Governance Task Force is scheduled to lead a half-day breakout session at the Mid-year BOT meeting in a continued effort to operationalize and implement previous communication and functioning recommendations, which were generated through surveying various governance groups.

2) Seek greater efficiency through identification and adoption of best practices and enhanced standardization, where appropriate, of Board and Academy functions:  In light of the ongoing transition of Marketing/outreach oversight from the Council of Presidents of Psychology Specialty Boards (CPPSA) to the BOT, CPPSA has voted to dissolve. This dissolution, to be completed this summer, will reduce the size of the BOT and allow for a more centralized approach to Marketing.  ABPP will, of course, continue to value the contributions of, and work closely with, the ABPP Academies.  Among other projects, ABPP governance is also working with Specialty Boards to develop standardized procedures for managing practice sample-related Protected Health Information (PHI).

3) Continue to grow and improve our financial position in accordance with best practices and fiscal responsibility:  So far this year, under the auspices of the Finance committee, we have successfully completed an external financial audit and reduced investment costs by moving our portfolio to Vanguard. We expect our balance sheet will further benefit from the recent attestation fee increase – the first in 14 years – and an anticipated reduction in ongoing costs as we move from development to implementation of our new technology platform.

4) Increase the Diversity of ABPP membership/governance and attention towards multiculturalism at all levels:  Under the leadership of Dr. Joel Frost, the Diversity committee will conduct a diversity training for attendees at the Mid-year BOT meeting this summer. Earlier this year, the Executive Committee voted to incorporate gender inclusive language in all ABPP documents and communications.  A formal proposal on this topic will be presented to the BOT for discussion and vote at the Mid-year meeting.

5) Continue to expand our ongoing Marketing initiative with a focus on enhanced messaging and targeted outreach to candidates, employers and other stakeholders:  In collaboration with the Marketing/Outreach committee and BOT, the Reis Group has developed and tested new messaging regarding the value of ABPP certification with a nationwide group of representative psychologists. As this messaging is finalized, work will soon begin on a dissemination plan tailored to key market segments. We are also working to expand incentives for conference attendees as well as scholarship opportunities for early career and diverse applicants.
The accomplishments described above represent only a small portion of the tremendous dedication and effort that many of you, have given to ABPP over the first half of this year. Realizing the full potential of our organization to advance the profession of psychology and address the needs of those we serve will require ongoing contributions from each and every one of us.

How can you help? 1) Raise awareness by noting ABPP status on all of your professional communications, including email signature, written materials, presentations, etc.; 2) Reach out to colleagues and let them know that ABPP specialty certification provides a valuable opportunity to distinguish themselves professionally, demonstrate expertise among peers and the public, and stay on top of advances in the field; 3) Remind professionals considering board certification that by completing the ABPP certification process they will earn 40 CE hours.

Thank you for the opportunity to serve as your president. 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
I hope everyone's year is off to a good start! I want to take just a moment to share with you some of the items that you will be hearing more about in the coming months.

ABPP is in the process of the final stages of a technology update that will permit us to have Practice Samples uploaded to our system for processing by specialty board reviewers. As you read this you may expect the roll-out of the system within weeks, assuming all goes as hoped for in the final stages of testing. This is a big step for which ABPP has worked hard, and we hope it facilitates the process for candidates, reviewers, and specialty board personnel alike. When the system is ready to use, each specialty board will receive instructions and training. I am looking forward to this!

On behalf of ABPP, I am working with representatives of the Council of Specialties and Proficiencies in Professional Psychology (CRSPPP) and the Association of State and Provincial Psychology Boards (ASPPB) to plan and co-facilitate the 4th Summit on Specialty, Specialization, and Board Certification. The Summit will occur in June and the plan includes participation once again by most of the major organizations in psychology. We anticipate that the upcoming Summit will put in place a plan for increased integration of specialty, specialization and board certification into the professional pathway. The group is looking at this on the continuum from education and training, accreditation, licensure and board certification as a specialist. Much more to come in future updates.

I recently returned from Washington, D.C. where I attended the APA Council of Representatives (COR) meeting. At the COR meeting, the COR took action on the new APA strategic plan of integrated structure of the 501(c)3 (educational/charity entity) and 501(c)6 (business/profession entity), received a report on the issue of accrediting Master's degree programs in psychology, adopted guidelines on depression, updated policies on psychopharmacology training and passed a resolution on physical discipline of children. There was also a significant meeting on the process of merging into the new APA structure the activities that had previously been completed by the Committee for the Advancement of Professional Practice (CAPP). CAPP had been the guiding entity for what was previously known as the APA Practice Organization. With the new structure, CAPP activities are initially going to be addressed largely by the APA Board of Professional Affairs (BPA).

Serving as our liaison to the American Psychological Association (APA) and other organizations, I have a couple of busy months coming up. In the coming months I will be representing ABPP at the Consolidated Meetings which includes many boards and committees. Specifically, I attend to the business of BPA, the Board of Educational Affairs (BEA) and any other boards/committees that have agenda items that intersect with the interests of ABPP. I will also be in attendance at the Practice Leadership Conference, which includes psychologist leaders and executive directors from state, provincial and territorial psychology associations (SPTAs). This is always a good opportunity to engage with the SPTA leaders as well as many leaders from other psychology organizations. I will also be present as the Commission for the Recognition of Specialties and Proficiencies in Professional Psychology (CRSPPP) meets to review its processes including items such as subspecialty and the APA Taxonomy. Finally, the ASPPB meeting will be our opportunity to interact with the member licensing boards as they hold their spring meeting. I will provide updates from each in my next column. Until then, always remember that you can count on our excellent Central Office staff to assist you in any way they can.

David R. Cox, PhD, ABPP
Executive Officer, ABPP Board of Trustees
Editor’s Column
By Kristine T. Kingsley, PsyD, ABPP

As Editor of the Specialist, I have been greatly impressed by the quality of submissions we received during our last blast announcements. Decisions of which stories to include and in what format can be sometimes agonizing- we thank all the authors for their patience and flexibility to work within the guidelines and objectives of this newsletter.

In this issue there are several articles, covering a broad spectrum of themes: from business news & updates of the BOT to topics pertaining to forensics, systems theory, military psychology, ethics in religion as well as ethics, social media & psychology. Additionally, we have had the pleasure of highlighting the accomplishments of a number of specialists.

As in previous issues, I have been fortunate to work with a number of dedicated colleagues who comprise ABPP’s Communications Committee: Drs. Ellen Snoxell, Stanton Marlan, Katherine Hart, Anne Dobmeyer and our newly minted Associate Editor, Stacy A. Ogbeide. I owe them a huge thank you for their astuteness when dealing with “gray areas” of content and editing. I am also grateful to ABPP’s Main Office colleagues, especially to Nancy McDonald for her endless logistical support and Dr. David Cox, Executive Officer, for his unparalleled sagacity and guidance.

Please do not hesitate to contact me: thespecialist@abpp.org with feedback and suggestions for future issues. For the Submission Guidelines, please click https://abpp.org/News-Events/Newsletter-Online-CE-Exam/Submission-Guidelines-the-Specialist.aspx

Lastly, 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.

Respectfully,

Kristine T. Kingsley, PsyD, ABPP
Editor, the Specialist
ABPP Communications Officer
Requiring Board Certification in Your Workplace: An Interview with Thomas Burns, PsyD, ABPP of Children’s Healthcare of Atlanta

By Catherine Deering, PhD, ABPP

Thomas G. Burns, PsyD, ABPP is an Adjunct Clinical Professor at Emory University School of Medicine. He is also the Practice Director of Neuropsychology and Chief of the Psychology Section at Children’s Healthcare of Atlanta. He is board certified by the American Board of Professional Psychology (ABPP) within the specialty of Clinical Neuropsychology and Clinical Psychology and a board-certified subspecialist in Pediatric Neuropsychology.

CD: Why did you decide to require your psychology staff to attain board certification?

TB: ABPP was the best measure of excellence for treating the children at Children’s Healthcare of Atlanta. Peer review not only reflects a level of self-discovery and initiative but it enables the clinician to "fill in the gaps" from training and enable them to work at their best potential. This has also set a precedent so that there was continuous learning and fulfillment with regard to our psychologists’ professional identity. We feel as though the board certification was a significant factor in obtaining higher qualified trainees as well.

CD: How have you implemented the requirement to become board certified?

TB: In 2010, we required specific criteria for our Psychology section to conduct neuropsychological evaluations. This was consistent with the guidelines set forth from the American Academy of Clinical Neuropsychology - which required this as well. This helped the identity of our neuropsychologists and propelled our training program (APA Internship - 1 year & APPCN Fellowship - 2 years). Over the course of time, we received attention from our Credentials department and we were moved from the "Allied Health" designation to a full (voting) member of the Professional Medical Staff in 2015. With this adjustment came a pay increase for all psychologists, voting and membership privileges for our organization, and equal benefits to our physician counterparts. On the other side of the fence, we were required to provide a call schedule and board certification as our physician colleagues do. The call schedule was easy, but the board requirement was more difficult. After researching the various board certifications (including many "vanity boards"), we elected to require ABPP board certification in one of the specialty areas within 7 years after being hired by our organization after January 1, 2015. Anyone employed prior to that date was grandfathered in and, while encouraged and supported to pursue ABPP, it was not required.

CD: What has been the response to this requirement from the psychology staff?

TB: The neuropsychology staff was receptive, as we had a formal mentoring program and CEU program already in place to help train our fellows and to support junior faculty in their desire for board certification. The clinical psychologists struggled more because our hospital does not have a single department and many of the psychologists were located in a service line that did not have education and training with regard to board certification. One of the factors that helped push this change was (1) paying for the process of board certification
at the system level (similar to how the MD's are reimbursed for the DEA license), and (2) a 5% increase in salary and title of "senior psychologist" or "senior neuropsychologist" was added.

CD: You were initially board certified in Clinical Neuropsychology and the Pediatric Neuropsychology Subspecialty through ABPP. What made you decide to attain an additional board certification in Clinical Psychology?

TB: I chose to pursue board certification through Clinical because I felt as though our hospital was supporting Neuropsychology and there was a great need for pediatric psychology as well. I continue to carry some cognitive remediation and psychotherapy cases so I decided to take the Clinical examination, so that I would set an example to those that are hesitant on our medical staff about taking the exam. We have set up a formal mentoring process within the department and are trying to work towards a more unified pediatric psychology section.
Early Career Specialist Message by Outgoing Board of Trustees Member

By Veronica Edgar Bordes, PhD, ABPP

There has been a lot of change in the American Board of Professional Psychology (ABPP) in the past 5 years. Starting in 2010 with the advent of the Early Entry Option for application by unlicensed students, fellows and trainees as well as a 2012 ABPP Survey highlighting that boarded specialists were predominantly white, male, and senior in career, the ABPP Board of Trustees (BOT) began making strides towards encouragement of more diverse psychologists applying for board certification. One of the largest groups of focus was Early Career Psychologists (ECPs). This group is made up of individuals who are within 10 years of graduation. In 2014, the BOT created an ECP position on the board that was meant to be a “pilot” for the next 4 years.

In December 2014, I was elected by the board to be the first ECP Trustee on the ABPP Board of Trustees. Before I take you on the journey of the last 4 years, I would like to take a step back to discuss my board certification journey. As an immigrant from Mexico when I was a young child, I always lived in a world where I fluctuated between two languages and three cultures (Mexican, Mexican-American, and White American). I was frequently told that I could not do something including get in to graduate school, get a postdoctoral fellowship in neuropsychology or become board certified. In the end, I did not listen to the negative comments but used them as fuel to challenge the status quo. I began working towards board certification as a newlywed and shortly after beginning my first job. I eventually became board certified in Clinical Neuropsychology in 2014 during the course of which I had a child. I jokingly say my daughter learned a lot of neuroanatomy as she was my study partner and I would often read to her from textbooks or flashcards while rocking or nursing her to sleep. Less than 6 months later, the ECP Trustee position was announced and I decided to take another chance.

When I took the ECP Trustee position in January of 2015, I had no idea what to expect. Board certification is largely a given in neuropsychology and something you “must do” in order to succeed in the field. There is a very clear path and process towards achieving board certification in neuropsychology so I naively assumed that all specialties would be similar. I learned very quickly the diversity of different specialties from their size to their proportion of ECPs as well as the process for and culture of certification in each specialty. This made my task as ECP Trustee challenging and exciting. I also had to quickly learn about board politics and procedures. Several BOT members helped to mentor me through this process but especially Dr. Alina Suris. Not only did I learn, but the BOT also had to learn about working with an ECP juggling multiple career and family commitments including my near absence at my first BOT meeting (I was 33 weeks pregnant) and watching that child grow as he attended nearly all of the semi-annual board meetings. I share all of these personal things to that other ECPs are encouraged by this and are not afraid to be open about the challenges of the attempt at “balance”, which in the end is always more of a temporary juggling act.

As the ECP Trustee for ABPP my task was not only to be responsive to the needs of ECP specialists and be their voice, but also to represent future ECP specialists and assist in ways to increase ECP applicants. This was a trying task especially in light of knowing that my position would sunset at the end of my term if I did not succeed.
With the pending end of the ECP Trustee position, I, along with the ECP Task Force made up of other BOT members, got to work. Over the past 4 years, we accomplished the following:

1) Created an ECP Ambassador Program where specialists are chosen from each specialty to promote ABPP through presentations at the local and national level. This program expanded greatly with 14 of the 15 specialties now being represented.

2) Held focus groups in 2016 with a total of 37 specialists participating and representing 8 specialties (Clinical, Neuropsychology, Child and Adolescent, Health, Police and Public Safety, Rehabilitation, Forensic, and Counseling). These focus groups were instrumental in informing our efforts and are still providing assistance to our new marketing endeavors.

3) Generated multiple social networking events in conjunction with the ABPP Workshops and APA Conference geared towards promoting ABPP to ECPs. These were well-attended both by prospective applicants as well as boarded specialists across all specialties.


5) Helped reduce the application fee to $65 for the first 10 years post-graduation

6) Facilitated via outreach efforts, an increase in ECP representation on specialty and academy boards
   a. 42% of Specialty Boards have an ECP position and 67% have an ECP on their board
   b. 33% of Academy Boards have a formal position, but 83% have an ECP on their board

7) Conducted an analysis of oral examination (for board certification) pass rates comparing ECPs and those psychologists later in their careers. This was published in an earlier edition of the Specialist and a full article has been submitted for peer review in a journal.

Of all of the accomplishments, the greatest was our combined effort that resulted in a unanimous decision by the BOT to have a permanent voting position on the ABPP Board of Trustees for an Early Career Psychologist Trustee. In this step, ABPP BOT is affirming the desire by ABPP to attract psychologists earlier in their career. Throughout the time that I was on the board, the percentage of ECPs grew from 11% (2014) to 14.4% in 2018. ECPs now make up 600 of the total 4164 boarded specialists and this percentage is anticipated to continue to grow. As I pass the torch to the next ECP Trustee, Dr. Leo Caraballo, I know the future is in good hands.
A Message from our New Early Career BOT Representative:

By Leo Caraballo, PhD, ABPP

I am greatly honored to serve as the new Early Career Psychologist-Representative Trustee for the American Board of Professional Psychology. I also have the honor of serving as the At-Large Director of Academy Membership and Mentorship Coordinator for the American Board of Clinical Psychology. In addition to my service with ABPP, I am also the current President of the Arizona Psychological Association (AzPA). Prior to serving as President of AzPA, I also served as the Chair of the LGBTQ Committee, Co-Chair of the Membership Committee, and Membership Representative to the Governing Council. In all of these roles I have endeavored to increase the recruitment of students and early career psychologists. Furthermore, I believe the future and vitality of any organization is dependent on its ability to engage with members. As such, I consistently strive to enhance the engagement of ECPs and students with the profession of psychology.

In addition to my board service, I am a clinical psychologist at a VA hospital where I provide recovery-oriented services to Veterans in an inpatient mental health setting. I am also a LGBT Veteran Care Coordinator and a clinical supervisor for pre-doctoral psychology interns. I frequently provide trainings to staff and trainees focusing on LGBTQ-competent care and evidence-based practices for serious mental illnesses. Prior to my current position, I completed a postdoctoral fellowship with the Central Arkansas Veterans Healthcare System in clinical psychology focusing on psychosocial rehabilitation and recovery for serious mental illnesses. I received my doctoral degree in clinical psychology from La Salle University in 2013, following my pre-doctoral internship with Atascadero State Hospital.

My goals as the Early Career Psychologist-Representative Trustee are to enhance ECP recruitment, involvement, and retention in ABPP. I hope to facilitate collaboration amongst early, mid, and late career psychologists to better meet the needs of ECPs and students that wish to pursue board certification. I also plan to continue to advocate for the needs of ECPs and foster the pursuit of board certification as a widely expected career milestone. One such endeavor will focus on increasing the number of board-certified psychologists in the VA system. Many psychologists across the VA already recognize the value and importance of obtaining board certification by ABPP, but may have uncertainties about the process. I plan to help educate and encourage all VA psychologists, and particularly ECPs, to demonstrate their advanced level of competence and their status as a specialist by obtaining board certification.
The Disgruntled Examiner: Countertransference in the Forensic Setting

By David Pingitore, PhD, ABPP, QME

As forensic psychologists we are often confronted with examinees who elicit in us powerful emotions and cognitions. These examinees can be evasive, seductive, oppositional or even disorganized. Our psychological response to these persons can include, what in the psychoanalytic and psychodynamic traditions, is known as countertransference. First recognized and theorized by Freud as a barrier to effective treatment (Freud, 1912), our recognition and use of countertransference has expanded. It now includes understanding it as a natural response to a person's outrageous behavior, what Winnicott termed “objective hate” (Winnicott, 1947). It is also useful clinical data that aids in diagnosis (Kernberg, 1965). Understanding the role of countertransference will permit examiners to fulfill guidelines set by our profession regarding forensic practice (American Psychological Association, 2013).

Recently licensed or board-certified clinical psychologists may have been provided scant education and training in the tradition of psychodynamic theories and practice, including their use in forensic practice. The traditions may seem out of date and ill-suited for contemporary forensic practice. Yet, as the late Ernest Jones noted, psychodynamic and cognitive-behavioral therapies have more in common than not (Jones & Pulos, 1993).

Countertransference, simply put, is the experience of using another person for unconscious/out of awareness purposes (Stein, 1990). In the forensic setting this can emerge as private feelings of grandiosity in providing opinion on a complex and high stakes case, or feelings of boredom and disinterest when faced with routine and clinically insignificant test performance. It can also serve as a source of potential bias in forensic examinations. The legal requirements for admissible evidence in Frye and Daubert require that counter-transference and bias be effectively addressed by the examiner (Scott, 2013).

Examinees present with a variety of behaviors in a forensic setting. They do not take their prescribed medications on the date of the exam, they arrive late, and they are seductive, oppositional or even openly critical of the examiner. These behaviors can effectively be dealt with in psychotherapy. In contrast, the forensic examiner has one and usually only one appointment to understand the examinee’s behaviors and formulate a reasonable opinion.

Case Illustration

The case involves a 48-year-old female working at a superstore. She had worked at the site for many years; in fact, she was the oldest employee on the shop floor. Her longevity and experience contributed to her being highly regarded by her fellow employees; in my initial examination her Base Rate score on the Millon Narcissism scale (Millon et al., 2009) was highly elevated. Hence her self-image was likely dependent on her work image. Subsequent events would prove this self-image to be fragile.

The examinee suffered a single fall on an icy and slippery concrete floor in which she first struck her back and then the back of her head. She suffered concussive symptoms for a period of time, then psychosomatic symptoms, including stuttering. Her treating primary care physician concluded that her speech and cognitive symptoms were greater than anticipated given her mechanism of injury. She underwent an MRI and a neurological exam and both
were unremarkable. She was referred to a psychiatrist for treatment who questioned whether she was malingering as a result of her poor response to antipsychotic medication. She was then referred to a neuropsychologist colleague who conducted a full assessment. He concluded that the patient had “good rehab potential.” Nonetheless, her memory was impaired. This neuropsychologist conducted scant effort and symptom validity testing as part of the examination.

In response to this clinical picture she was referred to me for a medical-legal examination. At the time of the examination she demonstrated further functional decline. At one point in the case there was a time lapse of one and a half years between my examinations. During that time, she was terminated from her psychiatrist’s office due to threatening behavior. She returned back to work in an accommodated fashion for a short period of time. However, conflict arose with a supervisor and there was threat of violence. The claimant announced to her treating neuropsychologist that she was going to “do violence” towards this man.” She was terminated from the job. She had major surgery for an intestinal blockage.

She then returned to me for examination. Her performance on assessment was abysmal. On simple questions from the WAIS-IV she demonstrated obvious poor effort if not exaggeration. For example, she reported that 30 seconds comprised a minute and did not know the correct year. Her story recall on Logical Memory was virtually nonexistent. At that point I was disgruntled and exacerbated by her performance. What was the reason she was behaving so poorly? Was she trying to confuse me or herself and what were the motives for such poor performance?

I began to ask myself what information my countertransference of disgruntlement if not disdain provided. Was this woman trying to induce me to do to her what was done to her by others - her psychiatrist, her parents who shipped her out in her teenage years to a private school or her former employer? That is, since they had “kicked her out” was she perhaps unconsciously “testing” me to see if I would do the same thing. It was also evident that the examinee had collapsed into a major depressive episode. When she was not permitted to return back to work, as her examining neuropsychologist remarked, “things went south.” Thus, my countertransference was a reenactment of some of the scenarios. If left unexamined I would view her as malingering. With some reflection and research, I conceived of an alternate formulation. The woman was presenting in a fashion that clinical neuropsychologists have termed a Cogniform Disorder (Delis, Wetter, 2007). The patient came to believe that she had more memory deficits than could be objectively caused by the original mechanism of injury. She was also acting out in a regressive manner in the face of the loss of her valued working identity. She was behaving in a manner to permit others to become angry at her rather than allowing herself to experience emotions related to the loss of her job.

Conclusion
We have at our disposal professional resources to address counter-transference. Psychological and neuropsychological test data can serve as an important corrective to the adverse effects of the countertransference. That is, the numbers typically “don’t lie” and an astute and competent examiner will use the clinical data, integrate it with the subjective experience of the examination and present a reasonable formulation. Personal education and training on bias is also an important resource at our disposal. Lastly, we should regularly consult with colleagues on cases to ensure that we have looked under all of the rocks related to a case so that our formulations and opinions are valid.

BIBLIOGRAPHY


The Ripple Effect and the Three Generational Cure

By Bryce Lefever, PhD, ABPP

An interesting man engaged my services to fulfill a requirement of his psychology internship. We will call him Ben and it was a privilege and a delight to work with him. There was not a lot wrong with Ben—he was bright, recently married and had a new baby. I worked with him on some of his issues and showed him how he could become a great therapist—not only by method, but by being an example of outstanding mental health.

As therapists, we can trace a genealogy of sorts regarding who influenced our education and who provided the most significant guidance, support, encouragement and direction. For example, my principal professors in college were Roger Tarpy (learning theorist) and Ernest Keen (existentialist, and whose intellectual parentage included Harvard University personality theorist Gordon Allport).¹

Between college and graduate school, I took 7 graduate courses at American University from such notables as Lanny Berman (former President of the American Association of Suicidology), Diane Chambless (agoraphobia and exposure treatments of anxiety disorders), and James J. Gray (perceptions of female attractiveness). During this time, I attended workshops from Thomas Stampfl (Implosive Therapy), A. Tim Beck (Cognitive Therapy), and from the pioneers in the study of suicide and self-destructive behavior—luminaries Edwin Schneidman and Norman Farberow.

During graduate school at the University of Illinois, there were two professors who most shaped my thinking. The first was I.E. Farber—a Hull-Spence trained drive-reductionist from Iowa—who inadvertently began the cognitive movement in 1963 when he used self-talk as a variable in an experiment entitled “The Things People Say to Themselves”. Secondly, and most notably, was Israel Goldiamond, who was a professor at the University of Chicago and under whom I received the majority of my clinical training. I learned an enormous amount from him intellectually, philosophically and from his life experience. Regarding the latter, at the age of 51, he was in an automobile accident which left him paralyzed from the waist down. He reported that he began his recovery immediately, and never became depressed. To me, this meant that emotional well-being was not directly tied to physical health or physical capabilities. Izzy (as he was called) was an inspiring teacher. He could draw and diagram beautifully on a chalkboard directly from his wheel chair. Among his many gifts were an optimistic spirit and he gave me a realization that psychology was a great profession in that it could be masterfully practiced even after illness, injury or the onset of old-age.

I realize that diving into a pool of memories might seem to some as interesting as a recitation of the Begats. However, beyond showing appreciation and gratitude, I do have a point to looking back. That is, each of my mentors, professors and major influences had the same benefit bestowed to them. Wisdom was garnered, gleaned and passed from generation to generation. I now had the same opportunity to give what I have learned to Ben and many others. I mention Ben, in particular, because as a burgeoning psychologist, how many lives was he going to touch? In this way, if I could guide and influence Ben, just imagine how many lives I will have indirectly touched, through him, for the good. One life touches and influences many others. This is the ripple effect. At the center, there are choices between health and disease, construction or destruction, good and evil. Each of us has, looking forward, these fundamental choices. After making a choice, the ripples begin to spread.

¹ Allport, G. W. (1955) Becoming: Basic Considerations for a Psychology of Personality.
² American Psychologist 18(4):185-197 · April 1963
I mentioned to Ben “the importance of our work.” He had shared the particulars and peculiarities of how he had been raised. He had overcome pain and obstacles. I encouraged him to continue in this process and go even further. There are many stories out there and mental health professionals are acutely aware of how profoundly child rearing practices can affect a person throughout the lifespan. Messed up adults beget messed up children. Our work was important not only for whatever changes Ben needed to make to be happier, more fulfilled, and successful. It was also important in that by becoming healthy, he had the opportunity to make a generational course correction. If he did not repeat the mistakes of his own care-givers, then his children would have a much better chance of being healthy. And, I pointed out that his grandchildren would have an even better chance of being healthy adults. This is “the three generational cure.” In this way, our work not only affects the person in our office, it affects a family system for generations. How many lives will each of us touch in this important way?

Dr. Bryce E. Lefever, received his Doctor of Philosophy in Clinical Psychology from the University of Illinois and joined the Navy in 1987. He was assigned to the Navy’s Survival Evasion Resistance Escape (SERE) School from 1990 to 1993, where he insured the safe training of high-risk-of-capture personnel undergoing intensive exposure to enemy interrogation, torture, and exploitation techniques. He served with Navy Special Forces from 1998 to 2003 and was deployed as the Joint Special Forces Task Force psychologist to Afghanistan in 2002, where he lectured to interrogators and was consulted on various interrogation techniques. Capt. Lefever has been deployed to many parts of the world during his career including Haiti, Panama, Israel, Afghanistan, Italy, Bahrain, Crete, Puerto Rico, Iceland, Antarctica, and Spain where he has lectured on Brainwashing: The Method of Forceful Interrogation and taught The Management and Treatment of Combat Stress.

Dr. Bryce Lefever is a leading authority on mental fitness, transitions, and suicide prevention. The mission of this work is to teach the principles leading to mental health in clear and accessible ways so they can be immediately practiced and incorporated into one’s life. He has given training throughout the United States and worldwide.
Greetings from the North Atlantic Treaty Organization (NATO) Role III Multinational Medical Unit in Kandahar, Afghanistan! In NATO parlance, a Role III hospital is a trauma-focused unit with specialist diagnostic resources (i.e., a radiologist with Computed Tomography capability), specialist surgical support (e.g., Neurosurgery, and Trauma and Orthopedic Surgery) and follow-on medical capabilities such as an intensive care unit. We typically receive coalition and Afghan combat casualties who are aeromedically evacuated to us from the battlefield or forward stabilizing surgical teams. We are the only combat Role III hospital for coalition and Afghan troops in southern Afghanistan. I’ve had the distinct privilege of being the Navy’s first psychologist to command a combat trauma hospital.

Now that I’m in what Navy medicine calls “Executive Medicine”, people sometimes ask me if I miss the practice of psychology with regard to individual patient care. I smile and say, “What? I use my clinical skills everyday with individuals and groups in virtually every meeting, in every team development, patient safety review or facility planning session, and in every mentoring encounter. I have just moved my intervention approach from the individual to the group or organizational level.” As a board-certified counseling psychologist, I see the military as a great fit with its focus on strengths-based interventions, team building, healthy populations, and life-span and career development perspectives. As a quick aside, I pursued my ABPP early in my career. I believe that having my board certification helped me to be selected for clinical and leadership jobs along the way in a variety of hospital and operational environments.

Our unit is composed of over 80 Navy medical professionals, both officer and enlisted, and taken from commands all over the United States and bases overseas such as Guam, Japan and Italy. In 2009-10, I served as part of the mental health team at this same Role III hospital when it was a tented facility. Now, the Role III is a 62,000 square foot hardened structure that is rocket resistant. With respect to layout, the hospital is well designed for trauma care with immediate access from the emergency room to the radiology or surgical suites and direct access from surgery to the intensive care unit. The hospital is staffed with three trauma teams, three surgical teams and a six-bed intensive care unit (usually for patients on ventilators) and a six-bed intensive care ward (usually for patients post-surgery who do not require ventilator support).
Additionally, in mass casualty events we integrate staff from other medical units stationed, here, on Kandahar Airfield.

While coalition presence in Kandahar has been significantly reduced since I was last here in 2010, our unit has been very busy throughout our deployment caring for battlefield casualties who have had gunshot wounds or blast injuries, as well as troops with non-battle related illnesses. In December 2018, we were honored to integrate a Romanian medical team into our hospital. They are involved in primary care support for Romanian troops, but also augment our mass casualty responses as litter bearers and medics.

The Role III hospital in Kandahar has a distinguished legacy of caring for people from all over southern Afghanistan and our team is proud to be part of the rich history of providing what our motto states as, “The Best Care Anywhere.”

One of our trauma teams describes its work during an emergency simulation to the Train Advise and Assist Commander- South, Brigadier General John Shanahan on the far right, an Australian Flag Officer based in Kandahar. I’m standing toward the center at the foot of the bed, listening to my team (U.S. Navy photo by Hospitalman 3rd Class, Gregzon Fontanilla/Released).

In the wake of the Kandahar Palace shooting in Oct 2018, our team took care of many senior leaders wounded from that incident. Pictured is the President of Afghanistan, Ashraf Ghani (center), receiving updates from U.S. military and medical leaders during a visit to the hospital (U.S. Army photo by SSG Neysa Canfield, Public Affairs/Released).

I received my PhD from the University of Kansas, Counseling Psychology program. I completed my APA-approved internship in Clinical Psychology at Naval Medical Center Portsmouth, VA in 1994 and have served for the past 26 years as a Navy Medical Service Corps officer. I received my ABPP in Counseling Psychology in 2001.

*The views presented in this article are those of the author and do not necessarily represent the views of DoD, its components, the U.S. Navy, or the NATO Role III Multinational Medical Unit.*
The Socratic Method of Psychotherapy (Overholser, 2018) proposes several new ideas that can help guide therapy sessions. The book attempts to integrate the ideals derived from ancient philosophy with the practical applications used in contemporary psychotherapy. The book derives from 30+ years of clinical practice, combined with assorted scholarly work in the field. Although the approach deviates from the current emphasis on evidence-based practice, the text presents a new framework for case conceptualization and treatment planning. The Socratic method of psychotherapy goes well beyond the use of a series of questions, and includes a respect for wisdom, a collaborative search for new information, and an attempt to cultivate virtue in everyday situations.

**The Clergy Sexual Abuse Crisis in the Catholic Church: What Board Certified Psychologist Specialists Should Know.**

By Thomas G. Plante, PhD, ABPP

Santa Clara University and Stanford University School of Medicine

The clergy sexual abuse crisis in the Catholic Church has been front page news yet again in recent weeks and months due to the summer 2018 release of the Pennsylvania grand jury brief, which reported on sexual exploits of high profile Church officials such as Cardinals McCarrick and Pell, the release of names of all creditably accused priests across the land, and an unprecedented global bishops’ conference on clergy sexual abuse held at the Vatican in late February. Even with constant daily press attention so much misinformation and myths about this issue continue to spread. Psychologists, among other health care professionals, should be better informed about these matters. After all, many may treat or evaluate those who are impacted by this story, whether they may be victims or perpetrators of abuse, family members of those abused or who have abused, or even engaged Catholics who are mortified and demoralized by what has happened with their Church. Additionally, when you think about it, most everyone has been touched by the Catholic Church given their wide network of primary and secondary schools, colleges and universities, hospitals and clinics, as well as numerous social service and charitable organizations. Certainly few topics elicit more emotion, rage, and strong opinions from the public, Catholic or not, than sexual abuse committed by Catholic priests. Yet with such strong feeling and views inevitably misinformation abounds.

As a psychologist who conducts empirical research in this area, evaluates and treats both clerical abuse victims and perpetrators, conducts psychological screenings of applicants to Catholic seminaries, and has served on child protection committees for the Church at national, regional, and local levels for over 30 years, it is important, in my view, to highlight some of the most common misperceptions about clergy sexual abuse in the Catholic Church that psychologists should know.

1. The percentage of Catholic clerics who have sexually abused minors is not higher than other groups of men who have access to and power over children (e.g., clerics from other faith traditions, teachers, coaches, scout
The best research data available from the well-known John Jay College of Criminal Justice (2004, 2011) studies among others reports (Plante, 1999; Plante & McChesney, 2011) suggested that 4 percent of Catholic priests sexually violated a minor child during the last half of the 20th century with the peak level of abuse occurring in the 1970s and dropping off dramatically by the early to mid-1980s. The recent Pennsylvania grand jury report offered two cases of abuse in the past dozen years that were already known and dealt with by authorities (thus this blockbusting grand jury report was about historical issues going back 70 years and not about current problems of active clerical abuse). Putting clergy abuse in context, research from the US Department of Education (Shakeshaft, 2004) found that about 5-7 percent of public school teachers engaged in similar sexually abusive behavior with students during the same time frame. While no comprehensive studies have been conducted with most other religious traditions currently available reports and studies find similar percentages. And when examining the general population of men, the Diagnostic and Statistical Manual (DSM-5; American Psychiatric Association, 2013) reports that about 5% of men are likely to meet the diagnosis of pedophilia.

Certainly one would expect much better behavior among clerics than non-clerics but the bottom line is that somewhere close to 5% of men likely have predilections towards sexually victimizing minors regardless of their religious engagements or associations.

2. Clerical celibacy doesn’t cause pedophilia and sex crimes against children.

Psychologists well know that many people, regardless of religious engagements or vows, are celibate. Many people can’t find an appropriate sexual partner, some have poor relationships with their current partner and haven’t engaged in sexual activities in years or decades, and some people have medical or psychiatric troubles that prevent them from satisfying sexual encounters and relationships. We know that if you can’t or don’t have sex with a consenting partner, children don’t automatically become the object of your desires. Additionally, if public school teachers have levels of sexual victimization of their students at levels higher than Catholic clerics during the same time frame that data was collected then one can’t simply blame celibacy for the sexual victimization of children. Finally, we know that the majority of sex offenders are men who do not profess celibacy. These men are typically married or partnered, with most victimizing their own family members.

3. Homosexual priests aren’t the cause of pedophilia in the Church.

As psychologists, we know that homosexuality and pedophilia are very different things. Yet, much of the public easily confuse them. Research from the John Jay College (2004, 2011) has found that about 80 percent clerical sex abuse victims are male and thus many interpret this problem as an issue of homosexuality. While research does suggest that the percentage of Catholic priests who are homosexual are much higher than among men in the general population, we know that sexual orientation is not a risk factor for pedophilia. Homosexual men are sexually attracted to other men, not children. Research has found that most of the sexual abuse perpetrators didn’t consider themselves homosexual at all but were “situational generalists” (John Jay College of Criminal Justice, 2011; Terry & Ackerman, 2008) (i.e., they abused whomever they had access to and control over and in the Church, especially during the mid to late 20th century, that was boys).

4. The Church has used best practices to deal with this issue since 2002.

The incidents of clerical abuse in recent years (i.e., since 2002) are down to a trickle according to all reports and particularly by the independent auditing firm hired to keep track of these incidents (US Conference of Catholic Bishops, 2018). There have been 5 new cases in the past 5 years in the USA. Many of the newer abuse cases since 2002 have been perpetrated by visiting international priests here on vacation, studies, or sabbatical who have not gone through the extensive training and screening that American clerics now go through. The famous Dallas
Charter and Essential Norms (US Conference of Catholic Bishops, 2002a, 2002b) as well as other subsequent Church reforms have resulted in a number of industry standard and even groundbreaking policies and procedures to keep children safe in Church-related activities and keep abusing priests permanently out of ministry. All dioceses and religious orders, as well as the US Conference of Catholic Bishops, have lay review boards with judges, lawyers, psychologists, social workers, human resource professionals, law enforcement officers, and so forth reviewing all cases of reported clerical problem behavior. All church workers, including clerics and lay volunteers, must participate in safe environment training that focuses on signs and symptoms of abuse and details policies and procedures for keeping children safe and reporting clerical misbehavior to both civil and Church authorities. An independent auditing firm conducts yearly audits to ensure that all dioceses follow these guidelines and then make their findings publicly known. A zero-tolerance policy is now in effect such that any credible accusation of abuse is reported to law enforcement, the offending party is removed from ministry and evaluated, and if accusations are found to be credible then the offending party never returns to ministry ever again. Things are very different in the Church post 2002 than before 2002 and the outcome in terms of new cases is proof that these measures are working (Plante & McChesney, 2011).

Conclusion
Keeping children safe from abuse should be everyone's priority. Tragically, data suggests that whenever men have access to and power over children and teens, clerics or not, a certain small percentage of them in the neighborhood of 5% will violate that trust and sexually abuse these minors. This is true for Catholic and non-Catholic clerics as well as lay teachers, coaches, tutors, choir directors, scout leaders, and so forth. The best way to deal with this reality is to develop evidence-based best practices that create environments where children are safe and where these men are carefully screened and evaluated. Certainly, some people fall between the cracks when policies and procedures are not followed carefully. The recent scandals with Penn State football and with US Gymnastics are good examples. And so, more work is always needed to plug these holes to be sure that best practices and industry standards are followed at all times and by everyone.

The good news is that progress is being made to ensure that children are safe but vigilance is always needed and good data and reason needs to take precedent over emotion and hysteria if we truly want to keep children and families safe from abuse in the Church as well as in all institutions, religious or not, where adults and children interact.

References:


Dr. Plante is the Augustin Cardinal Bea, S.J. University Professor, professor of psychology and, by courtesy, religious studies, and directs the Applied Spirituality Institute at Santa Clara University. He is also an adjunct clinical professor of psychiatry and behavioral sciences at Stanford University School of Medicine. He recently served as vice-chair of the National Review Board for the Protection of Children and Youth for the U.S. Conference of Catholic Bishops and is past-president of the Society for the Psychology of Religion and Spirituality (Division 36) of the American Psychological Association (APA). He has authored or edited 23 books including, Graduating with Honor: Best Practices to Promote Ethics Development in College Students (2017, Praeger), Do the Right Thing: Living Ethically in an Unethical World (2004, New Harbinger), Sexual Abuse in the Catholic Church: A Decade of Crisis, 2002-2012 (2011, Praeger), and Spiritual Practices in Psychotherapy: Thirteen Tools for Enhancing Psychological Health (2009, American Psychological Association). He is editor of the APA journal, Spirituality in Clinical Practice. He has published over 200 scholarly professional journal articles and book chapters as well. He teaches courses in abnormal psychology, health psychology, the psychology of religion and spirituality, and professional ethics and maintains a private clinical practice as a licensed psychologist in Menlo Park, CA. He is best reached at tplante@scu.edu
Benefits of Board Certification in Clinical Psychology: Diverse Roles and Settings

The American Board of Professional Psychology was created in 1947 to establish, implement, and maintain specialty standards and examinations by its member boards. Currently it provides board certification in 15 specialties. Board certification in Clinical Psychology is the “practice of psychology that connotes special competency acquired through an organized sequence of formal education, training, and experience.” Below are few personal stories of board-certified clinical psychologists and their interest in promoting competent practice.

J. Kim Penberthy, PhD, ABPP

I am a clinical psychologist and an endowed professor in the Department of Psychiatry and Neurobehavioral Sciences at the University of Virginia School of Medicine. I sought board certification due to two compelling reasons. The first was that I felt that board certification would be important for me to ensure promotion in an academic setting. Being at a large University Hospital and academic setting where the majority of physicians are required to be board certified in their specialty, I think it only fitting that I demonstrate my knowledge and competency by also being board certified in my specialty. Being a psychologist in a medical setting can be daunting and often involves proving that you are “on par” with other professions. The second reason I became board certified is more personal and is related to my belief that ongoing education and growth is necessary in the career of a clinical psychologist.

Uche Chibueze, PsyD, ABPP

I currently serve as the Chief Psychologist for the Harris County Juvenile Forensic Department (HCJPD). In addition, I am a primary supervisor for our APA-approved internship program and Postdoctoral Juvenile Forensic Fellowship. I chose to pursue a board certification specifically in clinical psychology because I perceive myself as a clinical psychologist who performs forensic evaluations. Despite the forensic emphasis in my role with HCJPD, the nature of juvenile forensic work is inherently very clinically oriented. Additionally, I conduct full psychological evaluations that are used for diagnostic clarification and to identify appropriate treatment recommendations. As a result, attaining board certification in clinical psychology has been very instrumental in helping ensure I maintain a high level of clinical competence. In addition, the board certification credential has also increased my credibility as an expert witness in juvenile cases. My role as a supervisor and mentor to students and early career clinicians also made achieving board certification an important personal goal. I know that I have been availed the honor and responsibility to serve as a role model to a wide range of trainees who complete our training program; consequently, I personally felt it was important to set a high standard for myself and that my students would be inspired to emulate. In addition, I believe the goal of increasing the number of board-certified specialists is best realized if trainees actually see board certification as an attainable goal and are able to witness firsthand the benefits of board certification. Having direct access to a board-certified supervisor/clinician has been a very beneficial resource for our students who are interested in going through the process in the future.
Vladimir Nacev, PhD, ABPP

In late 1980 and early 1990’s there was a second wave of clinical psychologists, mostly military psychologists, who became board certified by the ABPP. I started my process about eight years post licensure in the early 1990’s and became board certified few years later. At that time, a movement was started in the Department of Defense (DoD) to get clinical psychologists in parity with physicians, particularly when it came to clinical privileges. To sweeten the outcome, the DoD gave a financial incentive to those psychologists in uniform who were specifically board certified by the ABPP and not by other private organizations also offering certification. For me, achieving board certification had several functions. One, professional recognition and the ability to meet a standard that was above and beyond the basic level. Second, demonstrating to my patient population that I attained certification and a standard that was recognized by my profession. Third, I also believed that board certification was the way of the future, especially for those who were interested in getting promoted and assigned to teaching hospitals that had APA-approved psychology internships. Lastly, it also had a personal importance, an accomplishment that I am very proud of. For several years now, I have served on the ABPP examining committees for board certification and for the past two years have been a mentor for those seeking certification in clinical psychology.

Melissa Boyd, PsyD, ABPP

In 2016, I started a mentoring program for active duty Army clinical psychologists. The focus of the program is to foster mentorship, encouragement and supportive communication between potential and current candidates, and those who have already achieved board certification in hopes that applicants be best informed about expectations of the board certification process and receive guidance as to how to best prepare for the examination. Board certified Army clinical psychologists mentors are matched with mentees based on interests, geographical location, and specialty – with the majority seeking certification in clinical psychology, with a few others interested in Organizational, Forensic, and Neuropsychology. Thus far, over 20 mentees have been matched with ABPP mentors and the psychology branch consultant is considering making board certification one of the criteria for certain military assignments.
People are consuming and interacting with the media at increasingly high rates. Generally defined as a means of mass communication (“Oxford Dictionaries,” n.d.), the media includes radio, television, film, published written content, and the internet. According to 2017 data from Statistica (www.statistica.com) the average U.S. adult spent over 12 hours a day engaging with media, with television being the most consumed medium (“Average Time Spent”, n.d.). Furthermore, recent data from the Pew Institute suggests that 73% of U.S. adults use YouTube and 68% use Facebook (“Social Media Use in 2018”, 2018).

As people increasingly interact with the media, psychologists encounter unique opportunities for engagement (“Reflections on Media Ethics”, 2008). Not only do we use it in our personal and professional lives (e.g., individual Facebook page, advertising a private practice), but are often asked to share our expertise with the public through various communication venues. For example, psychologists may write an ongoing blog, be asked to promote their latest research findings on social media sites, deliver a video-recorded talk, host a radio or television show, publically promote a political bill or policy, or be filmed as an expert on a news station (McGarrah, Alvord, Martin, & Haldeman, 2009).

My personal investigation of media ethics intensified in 2014 after giving a TEDx talk (Warren, 2014). After the talk was posted on YouTube, I received many media requests to offer expert commentary on news channels, podcasts, and even films. For the first time in my career, I received opportunities for mainstream media interaction but struggled to find clear guidelines about how psychologists (clinicians, in particular) should interact with the media to maximize benefits and reduce the likelihood of ethical and legal conflicts. Consequently, I consulted various legal groups to understand some of the key benefits and challenges psychologists face when engaging with the media.

**Key Benefits of Media Engagement**

Primary benefit engagement is that it provides us with a powerful platform to educate and inform the public about our field its practical application to the world. Psychologists offer expertise in many arenas—from mental health to methodology, to cultural/social behavior, to organizational performance enhancement, to forensic investigation—which can be shared with the public in meaningful ways. For example, psychologists can comment on current world events that are challenging for the public to process and understand (e.g., political strife, mental health issues, natural disasters). Additionally, psychologists can use media to advocate for causes relevant to mental health, policy, and social change (DeAngelis, 2018). Media platforms can also help disseminate our scientific work to a wider audience and promote public interest about a given topic (e.g., “Giving Away Psychology”, n.d.).

Furthermore, engaging with the media can be an enjoyable and rewarding experience, as well as provide additional sources of income to professionals. The American Psychological Association’s Public Action Campaign serves as an excellent example of how psychologists can engage with the media in ways that meaningfully benefit the public (“Public Education Campaign Overview”, n.d.).
**Key Ethical Challenges**

Despite the important advantages of media engagement, psychologists are bound by ethical principles and legal regulations set forth by licensing boards and professional organizations making interactions more challenging (American Psychological Association, 2017). As such, it is essential to critically consider some key ethical challenges prior to engaging with the media.

1) **Knowing and Conveying Your Role**

One of the most important issues when engaging with the media is knowing and conveying your role to the audience, particularly if it may look clinical in nature. Clinical work is generally described as any work involving a clear doctor-patient relationship (“Medical Definition of Clinical”, 2018). In psychology, we often describe a client-therapist relationship as one that 1) exists because a service is being requested; 2) is a one-way fiduciary relationship; 3) requires informed consent; 4) is confidential; 5) involves payment to the psychologist for professional services provided to the client; 6) is focused on a goal that the client hopes to achieve through the work (Corey, 2009).

Given that treatment is confidential, psychologists must consider whether their appearance in the media is or “looks” clinical in nature. Often, the public may misconstrue what “therapy” entails, so they may perceive you to be a “therapist working with a patient” which in turn can be legally and ethically problematic.

2) **Commenting on an Issue versus a Person**

Media outlets often want psychologists to comment on public figures. For example, when a celebrity is dealing with a mental health or personal issue, psychologists are often called upon to comment on that figure’s emotional well-being or mental condition. This was a topic of great discussion when President Donald Trump was elected into office (Basken, 2016). Yet, according to the Goldwater Rule (Levin, 2016), psychologists cannot ethically comment on public figures or people whom they have not clinically evaluated. As such, mental health providers cannot comment on a specific person or public figure in the media.

That said, commenting on an issue or topic that emerges because of a figure's status is one of the best ways psychologists can inform the public. For example, in the face of a mass shooting or suicide, psychologists can offer expert information on these general topics without saying anything about a specific person.

3) **Separate Professional Media from Personal Media**

Many psychologists interact with the media in their personal lives (e.g., a personal Facebook or Instagram page). In addition, personal and professional information about most people—including psychologists—is readily available online (e.g., family information, home address, professional website, Yelp reviews). Although challenging, psychologists must consider how to handle media overlap between personal and work-related relationships. For example, do you accept “friend” requests from current or former students? How do you network and manage collegial relationships online? In general, separating personal from professional information to the degree possible in the media possible is desirable.

4) **Competence to Comment**

When considering a media opportunity, psychologists must consider whether or not they have sufficient education, knowledge, and training to comment. As a representative of the field, psychologists should ensure they are competent to offer expert commentary on the topic requested.

5) **Conflicts of Interest**

In response to any media request, psychologists should disclose conflicts of interest that may exist. This is particularly important to maintaining credibility. For example, if you are promoting a new brand or business through the media, it is important to state whether you are receiving compensation for your media engagement.
Conclusion
Despite the many important benefits media engagement offers to professionals and the public alike, psychologists face key ethical dilemmas that are highly complicated. Given my increased interaction with the media over time, it was important for me to explore and understand what I could do to benefit the public while protecting current and former clients, colleagues, students, and the profession at large. Consequently, I formulated a Professional Media Policy that outlines my conceptual framework, rationale, and policies related to work conducted in the media (Warren, 2018a). This policy is licensed under a Creative Commons Attribution-Noncommercial-Share Alike 3.0 United States License, which means that any mental health professional is welcome to copy or adapt these policies to suit their professional needs with proper citation (see https://creativecommons.org/licenses/by-nc-sa/3.0/us/). In addition, I wrote a Digital Media Policy for Current and Former Clients, which is specific to digital media policies in a clinical context (Warren, 2018b).

My comments here are by no means an exhaustive list of the benefits and challenges of media engagement. That said, psychologists will likely continue to receive media requests. As we increasingly accept these requests, I hope these documents bring increased dialogue and clarity to the topic of ethical media engagement.

References


Dr. Cortney S. Warren is a former Associate Professor of Psychology at the University of Nevada, Las Vegas (UNLV) and an Adjunct Clinical Professor of Psychiatry at the University of Nevada School of Medicine. After earning her bachelor’s degree at Macalester College in 2000, Cortney received her Ph.D. in clinical psychology from Texas A&M University in 2006 after completing a clinical internship at McLean Hospital/Harvard Medical School.

Raised traveling the world as the child of two professors, Cortney has a unique perspective on human nature. She is an award-winning expert on eating disorders, addictions, self-deception, and the practice of psychotherapy from a cross-cultural perspective. With over 45 peer reviewed journal articles, 7 book chapters, and one book, Cortney’s work appears in some of the field’s top journals, including the *International Journal of Eating Disorders*, *Appetite*, and *Obesity*. Cortney has won some of the most prestigious awards in her field, including the 2015 Early Career Achievement Award from the American Psychological Association Minority Fellowship Program; the 2011 Theodore H. Blau Early Career Award for Distinguished Professional Contributions to Clinical Psychology; and the 2010 Samuel M. Turner Early Career Award for Distinguished Contributions to Diversity in Clinical Psychology.

Although Cortney received tenure from UNLV in 2012, she formally retired from academia in 2014 to pursue a career that would allow her more time with her family and more interaction with the general public. In her book, *Lies We Tell Ourselves: The Psychology of Self-Deception*, and a TEDx talk, Cortney described her decision to retire from academia and her view that self-deception is our biggest obstacle to life fulfillment. Cortney currently works as a consultant, public speaker, and expert commentator for various media outlets. For more information on public speaker, and expert commentator for various media outlets. For more information on her work, see ChooseHonesty.com.
Newly Certified Specialists  (Dec 2018 – Feb 2019)

Behavioral & Cognitive Psychology
Marina Gershkovich, PhD
Timothy Ralston, PhD

Clinical Child & Adolescent Psychology
Chelsea M. Ale, PhD
Rachel Busman Rosen, PsyD
Rebecca M. Denning, PsyD
Kat T. Green, PhD
Alessandra C. Shapiro, PsyD

Clinical Psychology
Claudia W. Allen, PhD
Tyson D. Bailey, PsyD
Marc A. Browning, PsyD
Carolina M. Garcia-Leahy, PhD
Ryan McDonald, PsyD
Rebecca Stinson, PhD
Eanah M. Whaley, PhD

Counseling Psychology
Kim S. Baldwin, PhD
Amileah R. Davis, PhD
Changming Duan, PhD
James L. W. Houle, PhD
Matthew C. Johnson, PhD
Leah M. Rouse, PhD
Mary Schwendener-Holt, PhD
Jerry V. Walker, III, PhD
Aaron S. B. Weiner, PhD

Couple & Family Psychology
Stacy J. Cecchet, PhD

Group Psychology
D. Thomas Stone, Jr., PhD

Rehabilitation Psychology
Alicia F. Hegie, PsyD
Abbey J. Hughes, PhD
Kimberly L. Paul, PsyD