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The Specialist Editor: Kristine T. Kingsley, PsyD, ABPP
Associate Editor, Stacy A. Ogbeide, PsyD, ABPP
Dear Colleagues,

We are living in unprecedented times. With the ongoing spread of COVID-19 (coronavirus), and the incredible speed at which things are changing around us, the ABPP is continually adapting our operations and business to accommodate specialty boards. Many Specialties have reached out to Central Office and the Executive Committee seeking guidance on how to proceed. Some Specialty Boards are continuing to conduct business while others are seeking guidance on how to continue.

OPTIONS FOR MEETINGS

For the past two years, the Executive Committee has used Zoom to conduct their monthly meetings, and the Executive Meeting has found Zoom to be an effective platform for conducting business. Other ABPP committees have used telephone conference calls to conduct business, and some recently started using Zoom. Given the ongoing concerns related to COVID-19, many boards are cancelling their in-person meetings and opting for conference calls and / or Zoom meetings. For those of you wanting to continue to do board business, the ABPP offers three options:

1. **Ooma Office**- for up to 10 attendees; free to Specialty Board, but there may be a charge to attendee(s) if they do not have an unlimited plan.

2. **Capitol Conferencing**- for over 10 attendees; free to attendees, but a charge can be attached to specialty board depending on # of attendees and length of call.

3. **Zoom videoconferencing**- https://zoom.us/; ABPP has a pro account and accommodates up to 100 attendees (no charge to attendee or Specialty Board).

Please contact Nancy McDonald nmcdonald@abpp.org to help coordinate these meetings.

REIMBURSEMENT FOR CANCELLATIONS

Some of you already scheduled travel to attend Board meetings or ABPP meetings. ABPP does not have a policy regarding reimbursement to board members/examiners in the event of cancellation. Many airlines have indicated that they will refund airfare, as have hotels. Ultimately, the financial impact falls on the Boards and Academies, given that the reimbursements for those individuals that do / don’t travel, comes out of the Specialty Board, Academy, or Central Office budget.

OPTIONS FOR CONDUCTING ORAL EXAMINATIONS

Given the unprecedented public health crisis (COVID-19) the ABPP Executive Committee discussed the issue of using synchronous audio/video (e.g., Zoom) for oral examination. Because of the current extenuating circumstances permission is granted to temporarily conduct examinations via using synchronous audio/video. It is required that the candidate sign an agreement to proceed with their oral examination via synchronous audio/video (e.g., Zoom), and that they be notified that ABPP will not uphold an appeal, should one occur.
that is based on a claim that this method of examination is a deviation from procedure. We recommend this language be included in the signed agreement:

“I have requested and/or consented to have the ABPP Oral Examination conducted using synchronous audio/video. I understand that this procedure is being used due to the extraordinary circumstances arising out of the COVID-19 situation and is a means to proceed while protecting the safety of those involved. I understand that neither the Specialty Board nor ABPP will consider an appeal, should one occur, that is based on a claim that this method of examination is a deviation from the normal procedure.”

This is only an acceptable procedure during the COVID-19 crisis. Once the pandemic situation settles, ABPP Executive Committee will reassess this as an acceptable platform for oral examinations. The EC, will also consider seeking clarification via a Declaratory Statement from the Florida Board of Psychology regarding this issue.

Another option is for the Board to accommodate the candidate with an extension of timeline, as deemed appropriate. We encourage Boards to consider alternatives for conducting oral examinations.

BOARD BUSINESS

These unparalleled times require us to consider alternatives to conduct business. If a Board chooses not to hold examinations, meetings, and / or PCRs, there will be no penalties imposed by the ABPP. We encourage Specialty Boards to heed to this same policy for candidates applying for Board Certification.

Christina A. Pietz, PhD, ABPP
President, American Board of Professional Psychology

THE ABPP SPECIALIST

Volume 45 | Spring 2020
ABPP, and the World, on Hold

I hope you are healthy and stay safe; things seem to be changing by the hour these days. The crisis brought about by COVID-19 is undoubtedly unprecedented. The World, not only ABPP’s World, seems to have at once slowed down to a crawl, while at the same time becoming so volatile— that predicting next month, much less “the long-term future” seem impossible.

One thing we can predict with some certainty is that it will be weeks, if not months, before we can return to “normalcy”; Dr. Pietz’ President’s Column provides some information about the temporary “adaptation” during this pandemic, which allows Specialty Boards and Candidates interested in completing the Oral Examination process, to use synchronous audio / video methods. As the situation continues to evolve, matters will be reassessed by the Executive Committee.

Our Mid-Year Board of Trustees meeting, which had been scheduled for June in San Diego, will now be conducted via video conference format. Fortunately, we have avoided cancellation fees with the hotel, as we successfully negotiated to hold the June 2021 meeting at the same location.

In the meantime, ABPP Central Office continues to be in full operation; staff members have the capability to work remotely for almost all tasks, and we routinely do so. That said, children home from school and other factors may interfere temporarily with some response time. Thank you in advance for your understanding and please be assured that we will respond.

On Other Fronts—

Be sure to spread the word about the following ABPP scholarships and discounted applications:

• Early Entry Option and Early Career Psychologist Applications – A significant percentage of applications to ABPP are Early Entry Option (pre-licensure) and Early Career Psychologists. Combined, these excess 60% of the applications in any given year. Information on the process as well as the reduced application costs for these applicants may be found at the Early Entry Option application page: https://abpp.org/Applicant-Information/5-Types-of-applications/Early-Entry.aspx and the Early Career Psychologist application page: https://abpp.org/Applicant-Information/5-Types-of-applications/Early-Career-Psychologist.aspx

• Training Director Waivers and Scholarships – Training directors at APA/CPA and APPIC sites may have the application fee waived when applying for board certification: https://abpp.org/Applicant-Information/5-Types-of-applications/Educators-Trainers.aspx

• The ABPP Foundation (ABPPF) additionally, has available scholarships, which can reimburse some of the expenses incurred during the board certification process to those who successfully become board certified. More details can be found at: https://abpp.org/Foundation2/ABPP-Foundation-Funds/Training-Director-Awards-(1).aspx
**Continuing Work from Specialty Summit 4.0** – The Summit, via a very active Outreach and Communication Committee, has been working on infographics regarding the Taxonomy, as it may be perceived by various sectors (e.g., public, students, Psychologists). Materials are “not quite ready for prime time”, yet close. There is also a movement to develop an app, which would facilitate Programs’ ability to describe themselves using the Taxonomy.

**Current status of Specialties & Subspecialties**

In December of 2019, ABPP members of the BOT heard from two new specialty / subspecialty groups.

a) *Addiction Psychology* (AP) presented a proposal as a Subspecialty. The presentation was favorably received; however, the group was encouraged by the ABPP BOT, to redesign the proposal and submit an application instead for Specialty consideration. Included in that recommendation, was a strong suggestion that AP should also apply to CRSPPP for Specialty recognition.

b) The *Serious Mental Illness Psychology* (*SMI*) group, also presented to the ABPP BOT in December. That group- already recognized as a specialty by CRSPPP- was encouraged to continue with the affiliation process.

There is an ongoing consideration of efforts for a Forensic Neuropsychology Subspecialty to form. No official action has taken place yet by ABPP regarding this proposal; two Specialty boards (Forensic Psychology and Clinical Neuropsychology), which were scheduled to meet in mid-April for further discussion had to postpone the event due to the given restrictions on travel.

**ABPP Liaison Activities** –
ABPP continues to maintain important relationships with numerous organizations within the profession. Those include many American Psychological Association (*APA*) board and committees including the Committee for the Advancement of Professional Practice (*CAPP*), Board of Professional Affairs (*BPA*), Board of Educational Affairs (*BEA*), Commission for the Recognition Board of Professional Affairs (*BPA*), Board of Educational Affairs (*BEA*), Commission for the Recognition of Specialties and Proficiencies in Professional Psychology (*CRSPPP*), the Council of Specialties in Professional Psychology (*CoS*). In addition to these, ABPP values its ongoing liaison relationships with the Association of Psychology Postdoctoral and Internship Centers (*APPIC*) and the Association of State & Provincial Psychology Boards (*ASPPB*).

Due to the pandemic, most meetings scheduled for this spring and early summer were modified to be held as video-based meetings, postponed or cancelled altogether. So far, in-person meetings that I had been scheduled to attend have been cancelled through July.

ABPP views our liaison activities as critical components of maintaining communication across the various organizations that are so important to the profession. The ability to work together on important issues has facilitated positive movement in the field in recent years, and we know that collaborative efforts will be key to the profession's continued growth and success.

supports our Board of Trustees, Specialty Boards, as well as the thousands of ABPP Specialists.

David R. Cox, PhD, ABPP
Executive Officer, ABPP Board of Trustees
Dear Specialist,

January 21st 2020. Not a particular day for most of us. January 21st - seems to be such a long, long time ago.

It was on that day, I began to compile submissions, in an attempt to create the first volume of our newsletter for this year. I had many ideas, plans and tons of items to follow up with. I was thankful that once again, many of you had responded to ABPP’s call and sent wonderful pieces, anecdotal stories and news. A few days later, in the midst of writing emails and editing, I began to listen to stories from Hunan, China describing a new virus. It was maybe similar to SARS I remember thinking; definitely no more lethal nor disruptive than the flu. But it was happening thousands of miles away from my hometown of New York. “I guess we are not attending the Chinese parade celebrating the Lunar Year with the kids, I thought. Not safe. What if one of the attendees among the crowds have recently travelled to Hunan? By February 22nd things were beginning to sound more ominous. The Venice Carnival is cancelled! All of the sudden, this invisible enemy is no longer contained in a far, far away land. This is my neighbor’s backyard, I said, and this thing is traveling across the globe. Less than two weeks later, my hometown became the epicenter of what the World Health Organization called a “pandemic.” The perception of time was altered. It was not that time stopped; it was as if it had been suspended. Things were busy, but concepts such as productivity and efficiency went out the window. As a frontline worker, my responsibilities did not diminish. However, my family- like so many others- were also trying to stay healthy and safe, maintain some normalcy- and not get on each other’s nerves during a county-wide lockdown. Many other families surrounding us, were not so fortunate.

Alas, the numbers are finally beginning to recede. With sincerest apologies, you are now reading the much delayed spring / summer volume of the Specialist.

In this edition, we are fortunate to have compiled a number of important articles. Stories, which speak to interventions, assessment and professional issues within our field of practice. Please join me in congratulating once more the caliber and versatility of your colleagues.

In the coming months, the ABPP Communications Committee has many projects in the works. We are preparing a special edition on the most relevant and important topic of diversity. Additionally, we are looking forward to your sharing of data driven interventions, anecdotal information as well as personal reflections on the COVID-19 pandemic for our next issue. A pandemic that shook and will continue to shake the pillars of our society for years to come. An announcement with additional guidelines is to follow.

I would like to take this opportunity to personally thank the members of our Communications Committee starting with my Associate Editor, Dr. Stacy Ogbeide, Jay Earles (Clinical Health), Jarrod Leffler (Clinical Child & Adolescent), John Watkins (Psychoanalysis) and Ellen Snoxell (Rehabilitation), for their invaluable guidance. Furthermore, I would like to express a sincere appreciation to Ms. Nancy McDonald (Associate Executive
Officer) for her extraordinary attention to detail and organization, Ms. Lanette Melville (Information Systems & Marketing) for sharing with me her resources, and lastly to Drs. Cox & Pietz for their support and mentorship. My dear colleagues, keep practicing physical distancing, but reach out to each other on an emotional, mental and spiritual level.

Warmest regards,

Kristine T. Kingsley, PsyD, ABPP
Editor, the Specialist
ABPP Communications Chair
Since the American Academy of Clinical Psychology’s disaffiliation from ABPP in 2017, the American Board of Clinical Psychology (ABCP) has developed the merged Academy of the American Board of Clinical Psychology. A new governance structure was approved by the ABPP Board of Trustees and the bylaws were edited to include the new board structure and duties. Three new board members joined ABCP to serve as the Academy Education Director (Edmund Neuhaus, PhD, ABPP), Academy Marketing Director (Kim (Jennifer) Penberthy, PhD, ABPP), and Academy Membership Director (Leonardo Caraballo, PsyD, ABPP). The merged Academy endeavors to promote the value of board certification in clinical psychology to the public and future specialists. The Academy of ABCP develops educational materials to ensure that the public understands the difference board certification brings to the care they receive. We also organize national, state, and local trainings regarding the value of board certification to disseminate the importance of seeking this respected credential.

To date, the Academy of ABCP has developed public education materials regarding board certification in clinical psychology, an educational brochure for early career psychologists and students considering board certification, national and regional CE offerings on becoming board certified, and a network of Academy Ambassadors that help disseminate information regarding board certification in clinical psychology in their state. We are also in the process of developing continuing education opportunities for clinical psychology specialists throughout the country. These virtual trainings will help ensure ongoing professional development and preparation for Maintenance of Certification (MOC). Additionally, we will continue to foster collaborative relationships with universities, hospital systems, and training programs to promote board certification in Clinical Psychology.

The Academy of the American Board of Clinical Psychology considers all Board Certified Clinical Psychologist to be members. Furthermore, instead of yearly dues, the Academy of ABCP utilizes donations to fund projects and initiatives.

Donations help fund:
- ✔ Local, Regional, and National CE Programing
- ✔ Early Career Psychologist Outreach
- ✔ Student Initiatives
- ✔ Public Education

Thank you to the many specialists that have donated!

We look forward to continued service to ABCP, ABPP, and the profession of psychology.

Leonardo Caraballo
Leonardo J. Caraballo, PsyD, ABPP
Early Career Psychologist
Just like a candidate preparing materials to submit for board certification, a specialty board preparing materials to submit for the Periodic Comprehensive Review (PCR) undergoes a process of review and reflection. ABCCAP spent much of 2019 completing such a review and reflection in anticipation of our PCR in 2020. We have learned a lot through the process so far. Here are three important points of what was learned.

ABCCAP is a relatively young board; it has been in existence for just 17 years, as it was founded in 2003. By the winter of 2004, there were 43 specialists boarded in Clinical Child and Adolescent Psychology. At the time of our first PCR in 2012 that number had grown to 134 specialists, and by the end of 2019 that number had doubled to 268 specialists. Seeing this significant growth, we came to realize that there was indeed a strong in board certification amongst clinical child/adolescent and pediatric psychologists.

As the specialty began to flourish, we recognized the need to expand our capacity to examine candidates. Therefore, a few years ago we began to develop geographic pods of examiners (e.g., New England, Minnesota, Florida, Texas), which in turn resulted in the reduction of travel burden for our volunteer examiners. Routine scheduling of examinations at national conferences furthermore, helped both examiners and candidates take advantage of already existing travel plans. Through these practical efforts & adaptations, we learned that it was possible to increase the number of active examiners within our specialty.

Moreover, we recognized and acknowledged the need to ensure that our growing number of examiners were well trained. In addition to the apprenticeship model currently used, we developed a training workshop which covers stages 2 and 3 reviews, while we also introduced scoring rubrics to aid in the decision-making process. The training was piloted in 2019 with members of the New England exam pod and was scheduled to be presented to our board members during the annual board meeting in March of 2020.

Lastly, we have learned that in order to make materials accessible to all current and future examiners, we will need to translate the in vivo training into digital web-based modules - so we’ve added that task to our current “to do” list.
The Power of Connection

Before you were board-certified as an ABPP specialist, how big was your professional world? On whom would you rely when you needed a colleague to help you think through a thorny case, or ponder an ethical dilemma, or incorporate new findings from the literature into your practice? Prior to becoming ABPP specialists, many psychologists may have had a few professional colleagues, a former classmate from graduate school, and, if lucky, a mentor or two. But the pool was often limited. Many specialists agree that the single greatest advantage of board-certification is their envelopment in a community of professionals who serve to broaden their access to their professional world.

A listserv is a closed, electronic mailing list, which allows a member of the listserv to send a single email which can be seen by all subscribers to the list. For many specialists, the listserv has become an indispensable tool. The listserv that is managed by the American Academy of Forensic Psychology provides access to a gold mine of knowledge and informed opinion.

Some postings to the listserv are very straightforward: “I am traveling without my test manual, and I need to know the percentile rank that corresponds to this raw score.” Such requests are often answered within minutes. Or: “I am working on a case that presents a novel issue. Can people provide some helpful references in the professional literature to help me think about this more carefully?” The responses come flooding in. Or: “I’ve not seen this group of letters after a psychologist’s name before. Has anybody heard of this ‘credential’?” Within hours, the list was blossoming with evidence of another diploma mill.

But, the listserv does more than provide answers to concrete questions. At its best, it stimulates its readers to think more deeply about some of the vexing issues in the specialty. Looking back at the AAFP listserv over just a few months, reveals discussions of provocative and stimulating topics. Here is a sampling:

✔ Do psychological tests become obsolete? If so, when? And who says so?

✔ What are the key issues in Kahler v. Kansas (a case heard by the U.S. Supreme Court in October 2019 that could have far-reaching implications regarding the insanity defense)? What did you think of how the case was argued?
✔ Given that there is no biological or genetic basis for “race,” how should the social construct of race be treated in reports for courts? Should reports ever include racial or ethnic identifiers? If so, when?

✔ Should sanity assessments be conducted with incompetent defendants? When, and under what conditions? Is a person “practicing psychology” when providing testimony? How do different state laws and state regulations perceive this issue?

✔ Somebody in my area did (insert ethically questionable behavior here). Is this a violation of the Ethical Principles of Psychology and Code of Conduct? What is my responsibility? How should I weigh the fact that the behavior occurred during litigation that is not yet complete?

These and other topics have led to riveting discussions. Sometimes, there is agreement about an answer, but often, there is variance of opinion. The true value of the listserv may not be that it provides solutions, but that it provides guidance about how to consider those questions with no easy answer.

We are fortunate that the listserv is not a computer. It is a group of people sitting behind their computers, sharing their knowledge and insights, their questions and concerns, their bedrock principles and their uncertainties alike. The listserv is a group of people who are generous with their time and expertise. It is a group of people who seek to improve the quality of practice within the field by supporting, challenging, and elevating the thinking of their peers.

Wouldn’t you like to hang out with these people?

This fall, the American Academy of Forensic Psychology is hosting its first annual meeting. **AAFP** will meet in Chicago at the recently-renovated *Hilton Doubletree Hotel Magnificent Mile*, just two blocks off Michigan Avenue. The meeting runs from **Wednesday, September 23 through Friday, September 25**. Registration is $300 for AAFP members and $400 for non-members of AAFP. Twenty half-day programs on advanced/focused topics will be offered during the three-day meeting, and attendees can earn approximately 18 CE hours. Program highlights include an episode of *Forensic Jeopardy*, a mock direct and cross-examination featuring Chicago area attorneys, and a plenary session on false confessions delivered by two Northwestern University law professors whose work has been featured on *20/20, 60 Minutes, Dateline*, and the Netflix series, *Making a Murderer*. Continental breakfast will be served each day, there will be two social hours, and AAFP will organize dinner rounds. More program details are available at [https://aafpforensic.org/upcoming-workshops/](https://aafpforensic.org/upcoming-workshops/).

It is hoped that psychologists and trainees of all specialties will attend, as the diversity of viewpoints can only serve to enhance the overall educational experience. Please join us!
The American Board of Geropsychology (ABGERO) has had an active year under the leadership of ABGERO President Shane Bush, PhD, ABPP. In particular, strides continue to be made in the areas of mentoring, diversity and inclusion, outreach, and collaboration with other specialty boards, among others.

Michelle Mlinac, PhD, ABPP has been instrumental in leading a highly successful mentoring program to assist applicants in navigating the board certification process. Undoubtedly these efforts were invaluable in supporting the 6 newest ABGERO specialists who successfully passed the oral examination this past November. Congratulations to Drs. Patty Bamonti, Paula Harrington, Lindsey Jacobs, Bernadette Pasquale, Jessica Strong, and Lauren Weber, and thank you to exam director and ABGERO President Elect, Andrew Heck, for his coordination. A total of 76 psychologists now occupy the ranks of board certified specialists in Geropsychology. A proposal to disseminate additional information about the ABGERO mentoring program at the Gerontological Society of America 2020 Annual Scientific Meeting is currently being drafted.

Other initiatives to identify and meet the needs of potential applicants, candidates, and board certified specialists from diverse backgrounds continue to gain traction as well. Chief among these include the ABGERO outreach committee’s plans to conduct a needs assessment of board certified specialists in Geropsychology to determine preferred means of encouraging sophisticated collaboration and discussion among them regarding complex clinical cases, training issues, and research questions. In addition, planned updates to the ABGERO website include expanded information about the benefits of pursuing specialty board certification in the field for potential applicants and a broader range of practice samples for candidates. The outreach committee also is working to ensure that ABGERO resources such as the mentoring program are readily reflected on the ABGERO website and to establish an interface with the webpages of Geropsychology professional organizations, such as the Society of Clinical Geropsychology (the American Psychological Association’s Division 12, Section II) and the Council of Professional Geropsychology Training Programs, to promote access to information about the board certification process more broadly.
Finally, ABGERO board members continue to seek ways to interface and collaborate with other organizations and specialty boards, including via production of a webinar on board certification in Geropsychology for VA psychologists intended to air this spring and planned participation in the newly forming ABPP Integrated Primary Care Special Interest Group along with 8 other specialty boards.

Gerontological Society of America’s Annual Scientific Meeting
November 2019

Chairs of the Council of Professional Geropsychology Training Programs, most of whom are board certified specialists in Geropsychology
Small, But Mighty: Secrets to the Group Specialty’s Steady Increase in Membership

By Andrew M Eig, PhD, ABPP

President

The small specialty faces specific challenges when it comes to membership recruitment. The American Board of Group Psychology (ABGP) has had to encounter many of these obstacles. Small specialties often provide little financial or career incentives for members. Many group psychologists also practice individual forms of psychotherapy and do not see themselves primarily as group clinicians, so they may gravitate towards other specialties within ABPP instead of group. Also, an ABPP is not essential for a psychologist to run groups. Despite our challenges, membership to the Group Specialty is up over two hundred percent within the past five years. This outstanding result has surprised the ABGP Board of Directors. Although no one can ascertain definitively the reasons for our success, I attribute it to four main factors: mentorship, diversity of recruitment, networking and personal connections, and group process (of course).

Mentorship: Within the past 6 years or so, our mentors have become more dynamic and influential. Each potential applicant is assigned a mentor. Throughout the process, the candidate is encouraged with consistent emails, phone calls, and in-person meetings. Many of these relationships develop into close collegial relationships extending even after the exam has been completed.

Diversity of Recruitment: ABGP, for many years, recruited mainly private practice practitioners from the national group psychotherapy organization called the American Group Psychotherapy Association (AGPA). This is no longer the norm for us. Although our relationship with AGPA is invaluable, we have branched out to other group organizations like Division 49 of APA. We have also begun recruiting psychologists who work in academia, the Federal Bureau of Prisons, and the Veterans Administration (VA) system. Group psychologists practice in many parts of the world in a variety of settings. We populate our board with clinicians that are diverse in terms of personal (age, gender, race, religion, sexual orientation) and geographical demographics as well their scope of practice, so that we can reach as many group psychologists as possible. Currently, our board of ten members consists of a full-time academic (who does research on group treatments people in African countries where there is armed conflict), a correctional psychologist in a maximum security prison, an internship training director, several influential thinkers in the field of group psychotherapy, and a corporate consulting psychologist. The majority of our board holds academic affiliations. They live and work in rural, urban, and suburban settings throughout the country.
Networking and Personal Connection: I believe that this factor is the strongest reason for our recent marked improvement. ABGP has set up various networking events in member’s homes and at major conferences. They are usually free and at times offer a didactic component showcasing the expertise of our membership and the power of group treatment. We also take the time during these events to discuss feelings around applying to be a specialist. Personal accounts of the trials, tribulations, and joys of exam process seem particularly effective in reducing the potential applicant’s hesitations.

Group Process: Our board works closely together and enjoys the relationships that have been established through this connection. Group psychologists view interpersonal challenges as relating to the group system as a whole, not merely a problem within one person or a subset of people. When faced with the inevitable difficulties of volunteer board work, we use our knowledge of group dynamics and group process work through whatever problems may arise. At times, we may even bring in an outside group consultant. This practice has allowed us to grow even closer and to function with enthusiasm. I believe that this energy shines through to our candidates. Clearly, the underlying thread for our success is personal connection, as with most psychological praxis. I hope that this brief report spurs ideas and interest for other specialists and specialties. If you have any thoughts or questions, please feel free to contact me at eigandrew6@gmail.com
In the fall of 2017, the ABPP Veterans Affairs (VA) Initiative was established by the presidents of the clinical specialties in order to: determine a mutually beneficial way to promote board certification of VA psychologists; provide an opportunity for discussions regarding the pros and cons of becoming board certified; and create a forum for continuing advanced training for interns, fellows, and early career psychologists. Since 2017 the Initiative has made significant progress and in December 2019 the ABPP Board of Trustees incorporated it as a VA Task Force (TF) reporting to the President. With ABPP’s resources and endorsement, we are in a stronger position to engage VA psychologists and encourage their participation in board certification. We are focusing on five key initiatives and the following is an update of each.

**A Clear Message** has resulted in webinars that Leo Caraballo, PsyD, ABPP and I have organized within the VA. Each specialty board webinar, led by specialists, has been well received, in that they provide useful information about their specialty and/or ABPP, and clarify how to pursue application to ABPP. Some of the webinars from 2019 have been recorded and posted on the VA Pulse Page [www.vapulse.va.gov/login.jspa?referer=%252Findex.jspa](http://www.vapulse.va.gov/login.jspa?referer=%252Findex.jspa). Subsequent webinars will also be posted.

The Webinars past and future are as follows:

**Past Webinars**
1. Introduction to ABPP   June 27, 2019
2. Clinical Psychology   September 5, 2019
3. Clinical Neuropsychology   October 17, 2019
4. Clinical Health   October 30, 2019
5. Rehabilitation   December 19, 2019
6. Group   January 30, 2020
7. Introduction to ABPP   February 20, 2020
8. Organizational/Business   Mar 25, 2020
9. Police and Public Safety   March 26, 2020
10. Counseling   April 23, 2020

**Going Forward**
12. Geropsychology   June 25, 2020
13. Couple and Family   July 23, 2020
In the fall of 2020, live webinars will be rescheduled for each specialty.

Early Career Psychologists are a major focus for the TF as well as ABPP. We are working closely with Dr. Caraballo, Chair of the ECP Committee, and James W. Lichtenberg, PhD, ABPP, chair of the ABPP Foundation Scholarship Program. The Foundation is offering $850 scholarships for ECPs who successfully complete the oral exam. This is critical support that often makes pursuit of board certification possible. For additional scholarship information contact

https://abpp.org/Foundation2.aspx
https://abpp.org/Foundation2/ABPP-Foundation-Funds.aspx
https://abpp.org/Foundation2/ABPP-Foundation-Funds/Early-Career-Psychologist-(ECP)-Scholarship.aspx

Organizing ABPP Psychologists in the VA is work in progress. We have identified VA psychologists who have obtained ABPP certification, thanks to Erin Patel, PsyD, ABPP, and are determining the best way to include those who would like to join us by promoting ABPP within the VA. They represent specialties across the VA and we would like to incorporate each as ABPP points of contact. If you are an ABPP VA psychologist and would like to join this group, please contact Dr. Patel, Erin.Patel@va.gov Training, Co-Training, and Clinical Directors is led by Dr. Patel. We currently have 30 Training and Clinical Directors in a network who are working with us to encourage their interns, fellows, and VA staff to consider pursuing ABPP. Our task is to provide them with ongoing information, e.g., webinars, Fact Sheets, etc. so that they can effectively inform their students and colleagues. Further, the ABPP Foundation offers a $1000 scholarship to defray costs for training or co-training directors as well as clinical directors. For additional scholarship information see contact
https://abpp.org/Foundation2/ABPP-Foundation-Funds/Training-Director-Awards-(1).aspx

Standardizing the Process for Applying to ABPP Across the VA is led by Lisa Kearney, Ph.D., ABPP and to date she is working through the chain of command to ensure this can be implemented. More to come . . .

The VA Pulse, mentioned above, is led by Lianna Evans, PsyD, and it provides useful information, e.g., webinars, Fact Sheets, etc., so that VA psychologists have an easily accessible source of information. VA psychologists can access the Pulse via www.vapulse.va.gov/login.jspa?referer=%252Findex.jspa. To achieve our objectives, we need many VA psychologists that believe in ABPP’s mission, to serve the public by promoting the provision of quality psychological services through the examination and certification of professional psychologists engaged in specialty practice is important for psychologists and our patients/clients. If you would like to join us or receive additional information, please contact Samuel James, sjames@srjames.com

Samuel R James, EdD, ABPP
Erin Patel, PsyD, ABPP
Leo Caraballo, PsyD, ABPP
Lianna Evans, PsyD
Jerrod Leffler, PhD, ABPP
Jay Earles, PsyD, ABPP
Avoiding Common Ethical Difficulties: how to enhance ethical awareness with some practical suggestions: Part II

Submitted by: Barney Greenspan, PhD, ABPP
ABPP- Clinical Psychology
- Clinical Child & Adolescent Psychology
- Psychoanalysis
- Former Chair, ABPP Ethics Committee
- Member, APA Ethics Committee
- Member, Idaho Psychological Association Ethics Committee

1. RESPECT AUTONOMY

Psychologists need to provide clients with information needed to give informed consent at the beginning of treatment. When details are not given, difficult situations may arise. For example, when psychologists fail to explain their duty to report abuse and neglect to an adolescent client before psychotherapy begins, they may be unsure what to do if abuse is later revealed that the client does not want reported.

Points to discuss with the client include:

- Limits of confidentiality, such as mandatory reporting.
- Nature and extent of the clinician's record-keeping.
- The clinician's expertise, experience, education and training as well as areas where the psychotherapist lacks training.
- Estimated length of psychotherapy.
- Alternative treatment or service approaches.
- Fees and billing practices.
- Whom to contact in case of emergency.
- Client's right to terminate sessions and any financial obligations, if that occurs.
- Services the psychologist will provide, and those not offered.

If individuals are not competent to make decisions for themselves, then the person who is giving permission must have access to that same information. Moreover, a signed consent form does not substitute for the informing process, which should occur first, and that includes situations where informed consent is implied, such as in an employee evaluation.

2. KNOW THE DIFFERENCE BETWEEN ABANDONMENT AND TERMINATION

Psychologists may discontinue treatment when clients:

- Are not benefiting from psychotherapy.
- May be harmed by the treatment.
- No longer need psychotherapy.
- Threaten the psychotherapist, themselves or others.
Psychologists should provide **pre-termination treatment** and suggest alternative providers. This may not be possible in all cases, such as if a client abruptly stops attending sessions. Such pre-termination discussion may include explaining the benefits of the new service and why the current treatment is no longer helpful, addressing feelings of separation by emphasizing the transfer is not a personal rejection and identifying practical issues in transferring the client, such as making financial arrangements with a new provider before ending treatment.

**Involve the client in the plan. Empower them to feel confident and competent.** Help the client understand that the transition is a constructive step toward achieving their goals. By contrast, abandonment occurs when a psychologist inappropriately ends treatment, such as halting needed psychotherapy with no notice.

### 3. STAY WITH THE EVIDENCE
When you give an expert opinion, or conduct an assessment, base your evaluation only on the data available. For example, psychologists in child custody cases should be certain they are not biased in favor of the parent who is more financially secure. The best approach is to stay mindful about what one knows, what one does not know and what have been the sources of information.

Some suggestions include:

+ Know the referral question(s) and choose assessment tools to validly answer question(s). This means psychologists need to read and understand test manuals. For example, personality tests appropriate for clinical use are not necessarily appropriate for employment selection.

+ Do not rely on third-party reports to formulate assessments and avoid giving an opinion of any person not directly evaluated.

+ Make certain the assessment is thorough. Do not give an expert opinion without consulting all sources available. For example, a psychologist conducting a custody evaluation fails to check with child protection services and therefore does not learn that one parent is being investigated for child neglect, a fact that may have changed the opinion of the psychologist.

+ Discuss the limitations of one’s work and make statements about the certainty of the findings. It is equally important to offer any plausible alternative hypothesis that would account for the data. In court cases, where the facts may be disputed, one may describe the contradictions between the two parties and then make a set of recommendations based on each party’s side of the story, leaving it to the court to decide the truth.

+ Ensure that tests were developed for the target population and that they are culturally appropriate. If not, make the proper adjustments and note the limitations of those adaptations in the findings.

### 1. SUPERVISORY RESPONSIBILITIES
Supervising psychologists should continually assess the competence of those they supervise and make certain they are doing what is appropriate. If a document is sent under the supervisor’s name, the supervisor is responsible. A client is not going to sue the receptionist/secretary, or the supervisee, but will sue the supervisor.
Supervisors should also:

- Establish timely and specific processes for providing feedback, and provide information about these processes at the beginning of supervision.

- Outline the nature and structure of the supervisory relationship, in writing, before supervision begins. Include the responsibilities of both parties, the nature and frequency of the supervision and other key aspects of the supervisory relationship.

- Document their experience with the supervisee, including supervision dates, discussions and other relevant facts. Such information will help if ethical dilemmas arise later.

- Explain to clients that the psychotherapist is in training and give clients the name of the supervisor. Note that billing may be under a supervisor’s name, not the supervisee, so that clients do not accidentally report billing problems when there are none.

- Avoid delegating work to people who have multiple relationships with the client that would likely lead to harm or the supervisee’s loss of objectivity. For example, avoid using a non-English speaking person’s spouse as a translator.
Scholarship News from the ABPP Foundation: Announcing the Walter Katkovsky Scholarship

James W. Lichtenberg, PhD, ABPP Chair, ABPP Foundation

The ABPP Foundation is pleased, and extremely fortunate, to be able to announce a new scholarship program. The Walter Katkovsky Scholarship was created at the end of 2019 through a generous donation by Walter Katkovsky, PhD, ABPP to encourage and support health service psychologists, at any point in their professional career, and to demonstrate and certify their competencies in their specialty area of practice by supporting them in their pursuit of specialty board certification through the American Board of Professional Psychology (ABPP). The Walter Katkovsky Scholarship funds have been dedicated to help defray the costs incurred by psychologists over the course of the certification process for the following specialty areas: Behavioral and Cognitive Psychology, Clinical Psychology, Clinical Health Psychology, Clinical Neuropsychology, Clinical Child and Adolescent Psychology, Counseling Psychology, Couple and Family Psychology, Geropsychology, Group Psychology, Rehabilitation Psychology, and School Psychology. Through the generous support of Dr. Katkovsky, the Foundation is able to award up to 15 scholarships each year beginning in 2020. Information about the scholarship program, including how prospective specialists may apply for the funds, can be found on the ABPP Foundation website: https://www.abpp.org/Foundation2/ABPP-Foundation-Funds/Walter-Katkovsky-Scholarship.aspx

I asked Dr. Katkovsky if he would be willing to share for the Specialist about his background and about what led him to establish and fund this scholarship program. He was happy to do so, and this is what he shared:

“When asked the reason for establishing an ABPP scholarship fund, my reply is to further promote excellence, i.e., high standards involving knowledge and research from theoretical and-evidence-based practices as well as ethical issues by psychology practitioners in their specialty areas. My introduction to ABPP occurred while I was in graduate training in the early 1950's. At that time the ABPPP concept, newly introduced, was controversial and opposition was expressed by my mentor on the grounds that the practice of clinical psychology was not sufficiently empirically based to justify establishing standards of excellence. The fallacy of that logic and opposition crystallized in my thinking during my early post-PhD experiences and remains my present belief. Even though psychological practice continues to be a young and developing profession, part knowledge and part art, that is not justification to oppose programs that endeavor to promote striving for excellence, which I understand is the implicit aim of ABPP. After about 10 years of post-PhD experience (two years teaching and co-directing the clinical training clinic at Pennsylvania State University, three years at the Fels Research Institute collaborating in...
child-development research, followed by joining the clinical training program at Fordham University), I felt sufficiently confident to pursue the ABPP evaluation. At that time the Psychology Department and the clinical training program at Fordham University was expanding and ABPP certification of a member of the clinical faculty constituted an essential criterion for APA approval of the program. My ABPP certification also was a significant factor in my subsequent career move. In the late 1960’s Northern Illinois University (NIU), formerly a teachers college was in the process of developing a Graduate School that included a Ph.D. program in clinical psychology. Again, an APA advisory evaluation mandated the hiring of an ABPP certified clinical psychologist to further develop and implement the program to qualify for APA certification. I subsequently spent the next 24 years of my career at NIU as Director of the Psychology Clinic interspersed with periods as Director of Clinical Training as well. Thus my ABPP certification has played a significant role in my career and I believe it is likely to do so for others. The scholarship fund constitutes both payback on my part and implements my continued desire to support the goal of excellence by practicing psychologists. Following my ABPP certification, I participated as examiner in a number of examinations in the specialty area of clinical psychology. My personal examination as well as my experiences as examiner raised questions in my mind that pointed to the need for continued study of the examination process with respect to identifying passing criteria. An often repeated phrase in evaluating professionals is “Effective practice requires knowledge, skill and art”. The difficulty identifying the variables under the heading of “art” opens the door to subjective judgments that may be inappropriate biases by examiners. Clear definitions of specialty areas are one step in maximizing knowledge over subjectivity along with having examiners who also represent the specialty area of the candidate. Additionally, the examination committee needs to consider idiographic factors about candidates including the nature of the populations served and specific personal factors about the candidates themselves. In summation, my hope is that the scholarships will not only increase the number of ABPP applicants in their efforts to pursue excellence but also will promote continued study of the ABPP examination process itself in its goal of pursuing excellence. “Thank you, Dr. Katkovsky.

As a reminder to all: The ABPP Foundation is pleased to be able to support ABPP and the profession by assisting those seeking specialty board certification through the provision of scholarships to help them with the costs associated with the board certification process. We invite and encourage members of the profession to consider donating to the Foundation—which can be designated for specific scholarship programs (including the Walter Katkovsky Scholarship), when they plan to make charitable gifts. Donations/checks may be mailed and made payable to The ABPP Foundation, Attn: Alessandra Shapiro, PsyD, ABPP 1298 NW 4th Street Boca Raton, FL, 33486 or donations may be made online at https://www.trailblz.info/abpp/Donations.aspx?ver=2
Call to Arms for Perioperative Cognitive Medicine Specialists

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Our healthcare system faces an extensive gap in evidence-based perioperative care for adults with Alzheimer’s Disease (AD) and related dementias and other progressive neurodegenerative disorders (e.g., Parkinson’s Disease). This is particularly concerning because at least 20% of older patients undergoing surgery have undiagnosed dementia (Amini et al., 2019a; Culley et al., 2016), and individuals with neurodegenerative disease will arrive at preoperative anesthesia centers in exponentially larger numbers over the next 25 to 50 years. By 2050, people aged 65 and older will reach 1.6 billion worldwide (He, Goodkind, & Kowal, 2016). Our healthcare system will face larger numbers of individuals with early to late stage AD (Hebert, Scherr, Bienias, Bennett, & Evans, 2003) and other neurodegenerative disorders needing procedures with anesthesia due to serious health related conditions (e.g., cardiac) and desire for quality of life improvement surgeries (e.g., joint replacement) (Williams, Wolford, & Bercovitz, 2015). Despite this, healthcare professionals within the perioperative setting typically know very little about neurodegenerative type, severity (measured by pathology, neuroimaging, or cognition), or neurodegenerative pharmaceuticals interactions with anesthesia agents (Aminoff et al., 2011).

Currently, patients with AD and other neurodegenerative disorders receive comparable perioperative care to that of their cognitively-intact counterparts (Silbert, Evered, & Scott, 2011). Patient-centric needs are not often proactively considered. Population and healthcare trends dictate an urgent need for an integrated approach to perioperative research for AD and related dementias. There is a unique need for clinical psychologists and particularly board certified with neuropsychology specialists with expertise in neurodegenerative disorders, pre to postoperative cognitive change, and delirium to: 1) create perioperative cognitive clinics within pre-surgical anesthesia centers; 2) provide tailored recommendations to patients and medical provider; 3) develop evidenced-based research addressing brain-behavioral profiles, neurodegenerative diseases, and anesthesia and surgical interactions.

Some reasons why:

Reason 1: Despite studying cognitive change after general surgeries with anesthesia and also delirium for over 70 years (Bedford, 1955), there are no known surgical or anesthetic mechanisms for cognitive complications. General anesthesia remains an unconfirmed influence on cognitive decline per randomized studies (Rasmussen et al., 2005; Somprakit et al., 2002; Williams-Russo, Sharrock, Mattis, Sztrowski, & Charlson, 1995) and large database analyses (Kline et al., 2012; Perucho et al.; Sprung et al., 2016). This is surprising given the numerous animal studies suggesting that inhalational anesthetics enhance oligomerization and cytotoxicity of amyloid β
peptides (a protein change associated with Alzheimer's Disease, (Perucho et al.), tau phosphorylation (Le Freche et al.), and associated neuro-inflammatory response in humans (Tang et al., 2011). Surgery-related mechanisms of postoperative cognitive dysfunction also remain inconclusive. For example, in total knee arthroplasty, tourniquet time has been hypothesized to be associated with increased embolic events and complications, but results show trends at best. In cardiac surgeries, the role of postulated surgical mechanisms such as cerebral embolic load, alterations in cerebral blood flow, core-periphery temperature gradients, and other issues related to cardiopulmonary bypass on post-operative cognitive dysfunction also remains controversial (Lund et al., 2005; M. F. Newman et al., 1995; Selnes, McKhann, Borowicz, & Grega, 2006; Tuman, McCarthy, Najafi, & Ivankovich, 1992).

Reason 2: There is resounding evidence that pre-operative cognitive characteristics are significant predictors for post-operative cognitive complications including later cognitive change, delirium, and mortality after elective surgical procedures. Increased age is a risk for cognitive decline after non-cardiac (Moller et al., 1998; Monk et al., 2008) and cardiac surgeries, with at least 10-15% of prospective study participants >65 years old experiencing cognitive decline at three months after surgery. Aside from age, lower education is a repeatedly established risk for postoperative cognitive change (Moller et al., 1998; Monk et al., 2008) with higher education and better outcome attributed to better preoperative brain status (greater cognitive reserve), better test-taking abilities, and the interrelationships between educational advancement, social support, and better postoperative medical care. Other published risk factors include lower preoperative executive function (Greene et al., 2009; Price, Garvan, Hizel, Lopez, & Billings, 2017), higher rates of pre-surgical depression (Greene et al., 2009; Price, Pereira, et al., 2015; Smith, Attix, Weldon, Greene, & Monk, 2009), frailty (H. S. Lin, Watts, Peel, & Hubbard, 2016), and pre-surgical evidence of a non-symptomatic stroke (Giovannetti et al., 2019; Goto et al., 2001). Nuances of pre-operative human brain function and behaviors deserve greater attention by our professionals. To date, the majority of the research addressing the role of preoperative cognition on outcome has been conducted by anesthesiology or surgeons. Yet, the cognitive and psychosocial aspects of these strongly established risk factors remain beyond the traditional scope of research and practice amongst anesthesiologists, thereby necessitating enhanced collaborations with neuropsychology and health psychologists. It is time neuropsychologists assist our collaborators in the anesthesia and surgical fields.

Reason 3: Baseline preoperative cognition is reduced in substantial sets of pre-surgical patients. Up to a fourth of community dwelling individuals present to a preoperative setting with early signs of mild neurocognitive disorder (Luck et al., 2017). Cognitive impairment has been shown through prospective investigations with screening tests (Amini et al., 2019b; Culley & Crosby, 2016; Culley et al., 2016) and in large prospective studies of patients being followed for post-operative outcome e.g., (Giovannetti et al., 2019). However, it remains unclear how the distribution and characterization of such baseline cognitive impairment is associated with the distribution of other important perioperative patient characteristics such as comorbidity status, health literacy, and global functioning. We do know preoperative cognitive impairment is associated with failure to arrive at scheduled procedures (Arias et al., 2019), increased use of emergency and rehabilitation services (de Gelder et al., 2018), prolonged hospitalization and complications (Culley et al., 2017; Fick, Kolanowski, Waller, & Inouye, 2005). Failure to identify cognitive vulnerabilities increases costs and negatively impacts benefits associated with necessary procedures. Insight into cognitive status within preoperative anesthesia settings will identify need for prehabilitation, additional preparatory planning support, and increase perioperative monitoring (Calkins, 2018; Mohanty et al., 2016; Prizer & Zimmerman, 2018). Discussions on pre-existing cognitive vulnerabilities help patient-caregiver dyads make informed healthcare decisions (Arias, Bursian, Sappenfield, & Price, 2018).

Reason 4: Patients with AD and related dementias as well as other neurodegenerative disorders such as Parkinson's disease (PD) have greater risks in perioperative settings (Aminoff et al.), and neuropsychologists are uniquely poised to identify undiagnosed characteristics of these disorders in a preoperative environment. Cognitive and psychiatric deficiencies associated with dementia interfere with a patient's ability to comply with medical recommendations and navigate complex environments independently (Ala et al., 2018). Cholinergic
system response to anesthesia (Pratico et al., 2005) and inflammation responses (Whittington, Planel, & Terrando, 2017) are hypothesized to be atypical for individuals with AD (Baranov et al., 2009; Silbert, Evered, Scott, & Maruff, 2011) as well as PD (Bohnen & Albin, 2011). Retrospective studies and single case reports show that individuals with neurodegenerative disorders such as Parkinson’s disease have greater rates of postoperative delirium and cognitive decline (J. M. Newman et al., 2018). Nevertheless, patients with AD and other neurodegenerative disorders receive preoperative care which is comparable to their cognitively-intact counterparts, not taking into account their special needs (Silbert, Evered, Scott, et al., 2011). Retrospective studies and single case reports show that individuals with neurodegenerative disorders such as Parkinson’s disease have greater rates of postoperative delirium and cognitive decline (J. M. Newman et al., 2018). There are few prospective human longitudinal studies involving patients who meet criteria for AD or related dementias (Eckenhoff & Laudansky, 2013). One factor is the many challenges with prospective recruitment of surgical patients with AD or other disorders for research studies (Price, Levy, et al., 2015). Anesthesiologists and surgeons are not trained to recognize these special considerations surrounding perioperative cognitive care for patients with neurodegenerative diseases. For these reasons, the benefit/risk ratio for procedures are misrepresented to patients with compromised cognition; precluding informed decision-making and inadequate risk identification of the potential for surgical anesthesia to exacerbate neurodegeneration. (Arora, Gooch, & Garcia, 2014). Consequently, there has been a call to action for preoperative identification of patients with AD and related dementias, improved understanding of brain mechanisms of change, and intervention options (Crosby, Culley, & Hyman, 2011). Board-certified neuropsychologists understand neurodegenerative disorders, their associated neurochemical disruptions, potential medication interactions, frailty patterns, vascular risk profiles. Neuropsychologists are therefore the appropriate peers to work with anesthesiology, surgery, and hospital administration to address perioperative cognitive care planning. If our disciplines develop integrated anesthesiology-neuropsychology-geriatric teams such as those at some major universities, then largescale multicenter prospective clinical research addressing surgical-anesthesia risk for individuals will be feasible.

Reason 5: Post-operative cognitive, delirium, and brain profiles appear to vary based on preoperative brain profile. Individuals can exhibit isolated post-operative memory impairment (55%), isolated executive impairment (33%), and ‘combined’ impairment (12%) despite performance of ADLs at a level that may mask preliminary stages of functional impairment (Price, Garvan, & Monk, 2008). Results suggest that clinicians can expect at least 15% of their older adult non-cardiac surgery patients to experience at least mild postoperative memory disturbances (1 standard deviation decline from baseline), with approximately 11% of all patients experiencing executive problems alone or in combination with memory problems. These findings have been replicated (Price et al., 2014) and indicate individuals can have different neuroanatomical regions of vulnerability. This fits with our understanding of brain & behavioral vulnerabilities and the threshold effect (Satz, 1993). Preoperative cognitive and brain vulnerabilities also predict intraoperative responses and acute pre to post-operative functional and microstructural changes. Preoperative cognitive reserve and brain integrity (e.g., reduced entorhinal thickness, more white matter disease, large ventricular size) predict differences in intraoperative anesthesia brain EEG responses(Giattino et al., 2017; Hernaiz Alonso et al., 2019) and pre-post brain functional and structural changes (Browndyke et al., 2017; Hardcastle et al., 2019; Huang et al., 2018; Tanner et al., 2019).

Reason 6: Anesthesia providers have growing awareness regarding the value of cognitive assessment in the preoperative setting. Although in 2013 the United States Preventive Services Task Force (USPSTF) refrained from recommending routine screening for cognitive impairment (citing stress related to misdiagnosis and the absence of efficacious treatment to mitigate cognitive decline may reduce the potential benefits associated with early detection of dementia) (J. S. Lin, O’Connor, Rossum, Perdue, & Eckstrom, 2013); the new 2019 American College of Surgeons Geriatric Surgery Verification (ACS GSV) Program (Surgeons, 2019) strongly recommends preoperative and postoperative cognitive and functional status screening for older adults electing surgery. The ACS GSV Program also recommends that the cognitive screener completed preoperatively should also be administered post-operatively. Cognitive screening documents should then be attached to medical records.
for geriatric interdisciplinary care teams. Based on these recommendations and the plethora of growing data showing the value of cognitive screening in older adults, medical teams are now faced with the dilemma of which measure to choose and how to appropriately use them in the clinical setting. Colleagues in the American Society of Anesthesiology (ASA) and the International Anesthesia Research Society (IARS) are asking for collaboration with neuropsychologists to promoting brain health before, during, and after surgery. Anesthesiologists have pushed the concept of a ‘perioperative home’ for patient care and have a strong record of team science. There is a clear desire for collaboration from our medical colleagues. It is now our time – as neuropsychologists – to bridge the gap with anesthesiology and surgery to address brain-anesthesia interactions. The bottom line: The field of perioperative medicine needs clinical psychologists and particularly those with neuropsychological and health psychology expertise. These disciplines understand brain-behavioral, cognitive-behavioral nuances, neuroanatomy, neuroscience, and psychological disorders. More importantly we are invested in preserving brain-behavioral function. This potential capitalizes upon neuropsychology’s existing foundation with peri-surgical epilepsy, movement disorder (deep brain stimulation), and brain-tumor mapping programs. We are consequently uniquely poised to provide useful recommendations to providers for intraoperative and post-operative considerations, and develop evidence based perioperative interventional approaches particularly for patients with neurodegenerative disorders needing/electing surgical procedures with anesthesia. The neuropsychology specialty is perfectly positioned to work with geriatric medicine to co-lead clinical and research endeavors for patients and healthcare systems. New frontiers await with specialty development of perioperative cognitive medicine. With our perioperative medical colleagues we can tackle complex topics that will be increasingly problematic in the years to come.

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**Dr. Catherine Price** is board certified clinical psychologist with specialty in neuropsychology. Her academic goal has been to address the intersection of neuropsychology, neuroimaging, and cognitive change either due to neurodegenerative disorder acceleration or insults from medical interventions (such as elective surgeries with anesthesia). Her career developed in a series of stepping-stones. First, she states she garnered foundational expertise on brain-behavioral concepts. Next, she immersed myself in a number of endeavors: 1) research addressing cognitive profiles in common neurodegenerative disorders; 2) expertise development in cognitive-neuroimaging applications; 3) focused research on white-gray matter disease interactions for mild cognitive impairment, Alzheimer's Disease-vascular dementia spectrum profiles, and Parkinson's Disease; 4) focused prospective research on older adult brain-behavioral changes after surgical/anesthesia exposure; and 5) research into digital neuropsychological applications for early disease recognition. Now she is targeting clinical-research addressing larger public health related questions on older adult cognition and neurodegenerative disease prevalence in the preoperative setting, and neuroimaging/biomarker brain burden risk profiles for negative postoperative cognitive complications. She has had three NIH R01s and she is the recent recipient of a NIH five year academic leadership award to develop the Perioperative Cognitive Anesthesia Network research-clinical-training program for Alzheimer’s Disease and related dementias.
Dungeons, Dragons, and Detainees: Using Role Play to Cultivate Moral Reasoning in Incarcerated Women

Francesca McCarthy, MS, PsyM
LaTrelle D. Jackson, PhD, CCFC, ABPP

Dungeons and Dragons has a history of being perceived as evil. Embroiled in the satanic panic of the 1980’s, the early years of the game were marked by accusations of harmful psychological effects on players. At the same time, Dungeons and Dragons fascinated a generation. Recently, Dungeons and Dragons has experienced a resurgence in popularity and is once again fascinating children and adults alike. Despite its history and the negative misconceptions held by many, including mental health professionals (Ben-Ezra, Lis, Blachnio, Ring, Lavenda & Mahat-Shamir, 2018; Lis, Chiniara, Biskin, & Montoro, 2015), Dungeons and Dragons can be used as a vehicle for the development of an array of skills.

This case study outlines the use of Dungeons and Dragons as a group modality with five female inmates serving sentences for varying crimes. Their status as inmates indicates they violated the moral standards of our society. The question is, can their level of prosocial behavior when faced with an ethical dilemma be increased through the use of Dungeons and Dragons? The correctional institutions of the United States have a long history of emphasizing punishment, but as the pendulum has swung toward rehabilitation Dungeons and Dragons can be a fun and creative method for engaging inmates in the development of their moral reasoning skills.

Board Certified Clinical Psychologists have a commitment to stay abreast of innovative approaches to clinical care, seek culturally congruent interventions for the populations they serve, and support the professional development of the next generation of psychologists. The following narrative illustrates an innovative intervention for working with incarcerated women that yielded positive outcomes. Given the unprecedented rise in the number of women engaged in the correctional system, it is beneficial to consider unique options for treatment.

The Moral Reasoning Group

The Moral Reasoning Group was conducted with five female inmates incarcerated in the Ohio Reformatory for Women, a multi-security level state prison in the Midwest. Familiarity with fantasy role playing games was not required for group participation. Following the initial group session, two members left the group due to scheduling conflicts. These members were replaced at the start of the next session.
Dungeons and Dragons was the fantasy role play modality used for the group. Dungeons and Dragons, first released in 1974, is a fantasy tabletop role playing game. Players create characters to inhabit a world designed by the game facilitator, referred to as the Dungeon Master. Within the world created by the Dungeon Master, players complete a campaign, or a set of specific quests and adventures. The game integrates a base set of rules, player imagination, miniature figures, and battle maps to bring the Dungeon Master's world to life. As players interact with non-player characters, explore cities and dungeons, and slay monsters, they roll dice to determine whether they are successful at the activities which they are attempting to complete. Together the players form a party, which typically consists of characters with unique individual skills. They must collaboratively use their characters' skills and abilities in order to be successful during their adventures. Previous research illustrated that participation in group fantasy role playing games, such as Dungeons and Dragons, affords individuals opportunities to develop and practice social skills. This process increases social competency, engagement in decision-making and problem-solving, and perspective taking which may promote moral growth (Adams, 2013; Blackmon, 1994; Orr, 2017; Wright, Weissglass, & Casey, 2017; Zayas & Lewis, 1986). Specifically, a study by Wright, Weissglass & Casey (2017), highlighted the positive impact of utilizing a role-playing group such as Dungeons and Dragons to foster moral reasoning development in young adults. In their study, twelve college students participated in six 4-hour gaming sessions. Social and moral dilemmas were embedded throughout the game that required participants to work through as a group. Results of the group indicated that compared to two control groups, participants had significant growth in moral development as measured by the Defining Issues Test and the Self-Understanding Interview. Researchers concluded that imaginative role-playing games provide a structure that allows for an engaging and interactive arena to practice moral reasoning and can be used as a medium to promote moral development. Based on his research, the clinicians theorized that the unique elements of Dungeons and Dragons would provide participants a medium to practice moral decision making in a way that would allow for immediate feedback in addition to promoting other positive skill development.

**Goals**

The group was designed to promote the practice of moral reasoning skills through the fantasy role playing game Dungeons and Dragons. Players were required to create characters driven by altruism and the rights of others. Additionally, players were expected to discuss their character's ethical decision making process during the discussion portion of the group and attempt to apply the skills they practiced to their everyday life.

Participants’ post-group moral reasoning skills would be measured following completion of the group using the Moral Metacognition Scale (MMS). Their evaluation of the group itself would be achieved by providing group feedback forms at the conclusion of the group. The feedback form gave group members the option of providing qualitative group feedback along with the opportunity to use a Likert scale to provide their opinion on whether or not the group improved their moral reasoning skills, if the content of the group applied to their real life, and if they would recommend the group to others.

**Group Intervention**

The group consisted of five sessions lasting one hour and thirty minutes each. The first hour was dedicated to game play and was followed by thirty minutes of process about what took place during the session and each group member’s ethical decision making process. A part of the first session was dedicated to teaching the group members the rules of the game. Members were encouraged to ask questions anytime during the group. Further, it was emphasized that engaging in role play and discussion was more important than memorizing the rules. Each player then chose a character, all of whom were focused on altruism and the rights of others, and created a character backstory. The group facilitator emphasized that throughout the adventure group members would be making decisions based on their character’s prosocial ideals and values. At the beginning of each session, group members were given a set of dice and the group facilitator recapped the previous session. Each session incorporated an ethical dilemma into the characters’ adventure. Following gameplay, questions based on the dilemma were discussed with the group.
<table>
<thead>
<tr>
<th>DILEMMA</th>
<th>KEY DISCUSSION QUESTIONS</th>
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| Should the group stop their travel in order to help a woman being held captive by a group of goblins? | What made you stop and help?  
Why didn't you take the bribe?  
How did it feel to help the woman?  
Have you had a similar real life experience? |
| Should the group help the man being prepped for execution for stealing a healing potion to save his dying wife? | Should the man have been punished for stealing the potion?  
What factors go into deciding whether you should step into a situation to help another person? |
| Should the group help the queen save her city even though she has no gold to pay us? | Why did you decide to help knowing you would not receive a reward?  
What is a situation in your real life that you helped or did not help someone based on the reward or lack thereof? |
| Should we take the water from three individuals to save the many individuals dying of dehydration in a nearby town? | What were you thinking about when deciding how to resolve the conflict?  
How do you resolve conflicts in real life? |
| Should we share the treasure we discovered with the queen and her city or keep it for ourselves? | How did it feel to use the treasure to save the city rather than taking it for yourselves?  
How does it feel to help others in real life? Have you ever sacrificed something to help another person? |

**Group Application**

The use of the Dungeons and Dragons modality not only allowed the participants to practice higher level moral reasoning, but also other prosocial skills. Teamwork and collaboration, critical and creative thinking, and conflict resolution were all practiced and required to be successful in the game. Specific events that occurred during the group highlight the practice of post-conventional moral reasoning and the use of a variety of skills during the adventure.

Ethical dilemmas were faced throughout gameplay. An example of this was the in-game presentation of Kohlberg's classic Heinz Dilemma. A man was on trial in a small town for stealing a healing potion to save his dying wife. The town law stated that this offense was punishable by death. A large group of townsfolk were debating the man's punishment. The group members shared their opinions about how the dilemma should be handled and compromised to come to a conclusion which all group members agreed upon. The group agreed that the punishment of death was too harsh, so two of the group members stood in front of the crowd and gave a speech about empathy and perspective taking. The crowd was convinced, and the man was freed with the expectation that he would participate in volunteer work for the town. During the discussion portion of the session the group members discussed how saving the man's life was more important than the specific law and that they felt they should have stood up for the man even though it could have put them at risk.
Another moral dilemma encountered by the group resulted in both moral reasoning and conflict resolution. The adventurers encountered a group of individuals who had several barrels of water. They were unwilling to share their water with another individual who wanted to take the water back to his town where individuals were dying due to dehydration. This individual wanted to steal the water, because he believed the needs of the many in his town outweighed the needs of the three individuals who possessed the barrels. Adding to the dilemma, the individuals who had the barrels did not want their water to be shared with anyone in the town due to religious differences. The group members engaged in respectful discussion and developed a creative solution which satisfied both parties. The group members emptied all of their water in three of the group members’ canteens. They gave those canteens to the individual to be taken back to his town and convinced the group with the barrels to fill their other two canteens. This resolution ensured their water would not be used to help the town but would support the adventurers.

The group members also encountered situations that required them to embrace their unique set of skills and collaborate to find solutions in order to move forward in the game. The game included several puzzles that required the group members to work together and combine their diverse skill sets. One example is a puzzle that involved moving heavy statues. In order to know which statues to move, one adventurer had to use her character’s knowledge of history while another used her character’s strength to move the statues to the appropriate places.

**Group Results**

**MMS Results**

The Moral Metacognition Scale (MMS) developed by McMahon and Good (2016) was administered pre and post group. Following the initial group session, two members left the group due to scheduling conflicts. These members were replaced at the start of the next session. Due to this change, only three group members completed all five sessions. Thus, only their MMS results will be discussed.

The MMS gives a total score that explains how much an individual monitors and regulates their thinking when processing an ethical dilemma. Higher scores indicate an increased likelihood that the individual monitors and regulates their thinking when making a decision. Factor scores can also be examined and provide information about specific skills related to ethical decision making.

McMahon and Good (2016) reported an average score of 4.481 on the MMS for 175 female participants and a standard deviation of .752. All three of the Moral Reasoning Role Play group members started with scores in the average range. Two group members showed an increase of one standard deviation on their overall scores at the conclusion of the group. The other group member’s overall score decreased by less than one standard deviation.

When analyzing overall scores and examining factor scores, the group member with the highest score increase showed the greatest improvement on the Regulation of Cognition factor score. The Regulation of Cognition factor score measures how much she regulates her thinking, the amount she plans, and the amount she evaluates her thinking when engaged in ethical dilemmas.

The group member with the second highest score saw the greatest improvement on both the Regulation of Cognition factor and the Conditional Knowledge of Cognition factor. The Conditional Knowledge of Cognition factor reflects her understanding that her ethical decision making may be impacted by her context and personal characteristics.

One group member had an overall score decrease of less than one standard deviation. The clinicians hypothesize that this decrease can be attributed to an increased knowledge and/or awareness of her actual strengths and
weaknesses in the area of moral reasoning. When faced with several moral dilemmas, she may have realized she overestimated her abilities during the pre-test. This hypothesis is supported by her having the highest pre-test score of the group, which was higher than that of the average female participant in the McMahon and Good (2016) study.

Likert Scale Responses

The following scale was provided on the end of group feedback form:
1= Strongly Disagree  2= Disagree  3= Somewhat Agree  4= Agree  5= Strongly Agree

The form asked participants to read statements and rate how much they agree with each using the above scale. The statements are provided below along with participants’ average rating:

The group improved my moral reasoning skills. = 5

The content of the group applied to my real life. = 4.4

I would recommend this group to others. = 5

Anecdotal Responses

The following comments were written on the end of group feedback forms:

“It put me in predicaments that I had to weigh and think out every angle. It was an escape from my own reality. To let me see how courageous I could be since my character displayed bravery I know I have it in me. I loved it. I value the connections I have made and friendships I have gained.”

“It helped me weigh out all of the common factors before making an impulsive decision. It also helped me learn to ask for advice and opinions from others. I enjoyed how it was able to bring me out of my element and have fun, and also helped me strategize and make decisions as a single entity and as a unit.”

“I did practice my ability to think about my actions and words before taking action on them. Everyone could use practice in that area of life -especially in prison! Thinking of all possible outcomes to each situation we faced in the game. I really liked the way it took me away from the ‘world in prison’ and let me use my imagination. We don't ever get to do that here and finding something that can pass time in a constructive and fun way should be utilized!”

“It improved my ability to make decisions because it allowed me to see how others would or would not handle things, as well as allowed me to see the outcomes of my decisions with right or wrong. Giving me a chance at thinking why and making a better one next time. I liked how I felt whole again like I had choices and like I was out of prison if only for that small moment. I think in the six years I have been here I have never felt as good about waking up as I have on the days we had our group.”

“It made me think more about if my actions coincided with the alignment of my character instead of just acting without thought or irrationally. Wonderful experience to get our minds out of the prison environment! Allowing us to act in ways that we may not be able to on a daily basis (i.e. being assertive instead of passive). An excellent way to work on moral reasoning and cognitive decision making.”
Student and Supervisor Experience

“Facilitating the group was one of the most powerful experiences I have had working in the field. I watched the group members take on the roles of their characters and think about ethical dilemmas in ways they had never done before. I also witnessed laughter, joy, and personal growth in an environment in which they are not commonplace.” - Francesca McCarthy, Dungeon Master and Clinical Psychology Doctoral Student

“I was skeptical at first about the group helping inmates, but after seeing the positive impact it had on the women I am now a huge believer! One of them said it was the first time she was able to wake up happy at prison knowing she had the group that day. I saw smiling, excitement and engaged social interactions that I had not previously witnessed from these women. And the impact has lasted as the women are still discussing their characters and moral reasoning strategies discussed during the group. So in short, I am now a huge fan and am excited about the possibilities of this group adding to the curriculum here at the prison and the field of psychology!” - Dr. Christy Tinch, Psychologist at the Ohio Reformatory for Women and Clinical Supervisor

“Developing this group with my peers was such a cool experience as it allowed us to think creatively –taking us out of our traditional academic box. It was heartwarming to see that the women felt they had benefitted from the group. It’s encouraging to see positive results and the implications that they can have on future women inmates who participate.” -Gabrielle Armer, Clinical Psychology Doctoral Student

“Prior to participating in D&D myself, I held negative assumptions about the game and would have never envisioned utilizing elements of D&D for therapeutic means. Gaining a better understanding of how many practical skills can be learned and practiced in D&D and then seeing such positive feedback from the women who participated in the group was powerful. This experience really encouraged me to be more creative and open-minded in therapy and to consider how we can use innovation to better meet the needs of the population we are serving.” -Abbie Patzke, Clinical Psychology Doctoral Student

Conclusion

While the clinical benefits of role-playing games are only starting to be uncovered, the outcomes of the Moral Reasoning Group clearly depict the utility that games, such as Dungeons and Dragons, can have within a correctional setting. By establishing clear goals and group expectations, participants engaged on multiple levels. Although this study showcases a small number of quantitative data from the MMS, these results capture promising clinical benefits for role-playing games. Additionally, the qualitative feedback collected from this group indicate that by playing Dungeons and Dragons, the participants experienced an increase in their moral reasoning abilities. Additionally, the Moral Reasoning Group provided a safe space where the participants could practice communication skills, team building, critical thinking and decision-making. The adage, “meeting clients where they’re at” stands true, even in a correctional setting where inmates may feel that they are the ones living in a dungeon. In a stringent setting such as prison, role-playing games allow inmates to tap into their creative sides which may increase their participation in a clinically relevant and unique way. Considering that most inmates will return to the community, role-play games, such as Dungeons and Dragons, allow participants to build skills that may ultimately help them adapt to life outside of prison.

Acknowledgements

The authors would like to thank Drs. Christy Tinch and Jennifer Kennedy, for supporting this project from its conception and for their tireless efforts to provide Ohio Reformatory for Women inmates with the best possible care.
References


Help me be a better psychologist…
(An encounter during my time in York County Prison)

Bryce Lefever, PhD, ABPP

It was a form of incarceration, I suppose. I spent 18 months behind bars as Director of Mental Health at York County Prison. There, I encountered a range of humanity—and they were human, with human problems, human mistakes, and they were highly relatable. Their frustrations, anger, resentment, fear, desire for better lives, and delving into relief from pain—all of this I could understand. There was one I could not and I asked him for help.

Herald was in his early fifties, educated, good-looking, verbally skilled, and personable. He was charged with a sex crime of a child. This was not his first offense. He readily admitted his actions to me—and seemed unaffected by them. So, I asked for his help so that I could understand him and possibly help others.

Carl Jung said: “One understands nothing unless one has experienced it for oneself.” I hope this is not true—that I would have to undergo all the possible horrors and terrors possible across a range of human lives in order to understand and to be of help, guidance, support and to promote change. However, I suspect that there is an element of truth to Jung’s contention. So I said to this man: “I cannot relate to or understand this particular attraction, but I believe that you have it and that there was certainly a cause. Given this, help me to understand what green-lighted you to act on it.”

He was happy to address my request. First, he did, in fact attempt to explain his attraction by saying it was a case of unrequited love—or rejected love—at a particular age and that he had fixated on girls of that age. Again letting him know that I believed he was thusly attracted, I again asked him about allowing himself to act on it. He gave me a lengthy response and, frankly, I don’t recall what he said. I will readily acknowledge that I remember stories very well, but where there is a set of sentences that don’t hang together with a coherent theme I am lost and hopelessly amnesic.

So, I believed I was getting nowhere in furthering my development as a psychologist and the session was getting a little long, so I said, “OK, we need to wind this up.” At this point, he continued to speak (and possibly address) the reasons that permitted him to seek illegal contact with children. Again, I have no idea what he said. However, I know what I said—our time is up and our session is over.” Again, he began to speak in an amiable and animated way about something or other—and I let this go on for a few sentences as my sympathetic nervous system kicked in and my irritation grew. Then I said (rather forcefully): “We are done. Get out.” And he looked a little surprised and he did get out.

Here is what I learned that day. This child sexual abuser did not care about what I wanted. Herald may have picked up my clear and direct cues, but he did not accede to them. He did not take “no.” He persisted in what he wanted (a lively conversation or, I suppose, not being in his cell for a while, etc.) and did not pay attention to what I wanted. So I noted his disregard of my initial efforts to establish boundaries, and thought “if he is not backing off and taking ‘no’ from me, what chance does a 7 or 8 or 9 year-old have?”

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1 I have two remarks at this point. One, I understand the difficulty (and some would say futility) of treating pedophiles. Two, being a stubborn optimist and hoping that no one is beyond recovery and redemption, I endeavored to persevere.

2 This statement suggests that he may have had (a whole lot of) contact with mental health professionals.

3 Ironic choice of words here.
I suspect many of us have worked with a number of clients who experience anxiety in social settings. Reducing anxiety is likely a common treatment goal. Perhaps we suggest our client joins a book group or meetup or that s/he gets together more often with friends. Perhaps we even propose that our client goes to a coffee shop or bookstore. However, how often have you directed a client to talk to strangers, as part of their treatment plan? “Your homework is to talk to at least one stranger a day!” In a society where we are often taught “Don’t talk to strangers”, as children, it is no wonder that many individuals among us develop a life-long nervousness in interacting with new people.

With so much negativity and fear of war, terrorism, infection in the world and in the news, it is no wonder people feel alone and skeptical of others. But, what if it didn’t have to be that way? There is also beauty, kindness, and compassion depending on what lens you look through. Some peoples’ resistance and fear are so profound they avoid leaving their homes and decline invitations where they might feel discomfort. Many of us know the core of such avoidance often evolves around fear: fear of rejection, fear of failure, fear of uncertainty, fear of judgment, fear of obligation, etc. The list goes on. I have found that clients are amazed to learn that at the foundation of their fear, lies their avoidance of said fears. I regularly educate clients and students that overcoming fear involves engaging in habits that involve confronting the very circumstances they fear. We discuss the power behind reinforcing a message of safety and success over progressive episodes of exposure while resisting the avoidance response. I am consistently impressed to watch the immediate shift in body language as clients practice new approaches as they become willing to overcome long-held debilitating fears.

What if I suggested that encouraging clients to talk to strangers might actually be just the solution to their anxiety? Of course that would be appropriately executed in safe situations. One may consider it a direct application of exposure and response prevention. Talking to strangers, exposes clients to their fear of judgment / evaluation / clumsiness; over successive practice (and likely after much initial social clumsiness), chatting with strangers may result in remarkable improvements in confidence. There is an adventure, an innocence, a poetic essence, if you will, around talking to strangers that is unmatched anywhere else in life. Each connection could potentially change your client’s life...or not. What we know is they’ll never know if they don’t take a chance and try.

As clients step out of their comfort zone in safe and progressive ways, I coach them through practicing effective verbal and non-verbal communication micro-skills. In so doing, they begin to realize their influence, attract more laughter, friendship, or even flirting and romance into their world. They realize that as they survive the first awkward encounters, they feel less scared. They realize their fears of judgment or consequence didn’t kill them… and eventually the clumsiness becomes less evident. Clients begin to experience gifts of talking to strangers in personal, professional, romantic, or passing encounters. They realize the value in the mantra: “Do it scared, do it ugly, do it often.”

Some clients might initially respond, “But I’m fine in my bubble. I don’t need new friends.” To this argument, I propose talking to strangers isn’t always about making new friends but about attracting more joy, warmth,
and engagement into one’s world. It may be about feeling more seen and/or helping another person feel seen. I propose, “Always talk to strangers…positively engaging everyone, not because a person deserves it or an event demands it but because you choose to carry yourself as such.” Be the change you want to see in the World. Contribute to a warmer, kinder social environment, in effect, helping to create space for others to feel more emotionally safe and kind in return. While showing kindness with strangers does not guarantee compatibility or lasting connection, it does allow for more favorable and memorable first impressions and more enjoyable, fleeting moments in time. I task clients to track the result of doing so on their mood and sense of self-worth and confidence over time. The end result, when a client is consistent, is profound.

When working with the most obstinate of clients, I’m amazed at the response when clients are asked, “What if I told you that making subtle changes in your presentation (facial expression, posture, or tone of voice) could change how others respond to you and / or put others at greater ease around you...would it matter? Would it be worth adapting?” Even clients who feel content, respond that perhaps they are missing an opportunity. Honing impression-management isn’t just for those pursuing new relationships. It overall inspires more positive, fleeting memories and a greater sense of mastery in life. To think of the influence one has in the world is exhilarating! Imagine the impact on depression, anxiety, or low self-confidence of recognizing one’s power.

Strategies for interacting more favorably with strangers are so straightforward, easily taken for granted, yet powerful in creating lasting impressions. Clients are often educated about the power of non-verbal communication skills - even the choice of attire on first impressions or interpersonal connectedness. How often do clients though consistently practice those applications may be a different situation. That’s where habit training is critical. Knowledge alone isn’t power; application of knowledge is. Even subtle changes practiced consistently can dramatically affect new patterns of relating that foster warmer, more inviting connections. Each progressive moment leaves an imprint: the laugh with someone on the line for coffee, the joke one shares with someone at the hotel pool, the conversation at the airport about your travel plans … each of these moments cultivates confidence in one’s ability to engage others in lasting memories and joy. It’s often easiest and least threatening to practice these developing skills with strangers and in new or unfamiliar environments away from home where the consequence of awkwardness is less impactful on career or day-to-day life.

A critical factor in whether or not the “prescription” fosters memorable moments, also depends on the providers’ attitude about strangers. The impact of a provider’s own attitudes, judgments, and potential blind spots can have significant implications on a clients’ willingness to confront fears. Upholding a positive attitude about who one might meet, especially when aligned with warm facial expressions, can result in notably more positive connections. In fact, adopting an attitude of curiosity and enthusiasm for adventure around any new experience can be life-changing. Beyond fleeting moments and personal growth, talking to strangers can also impact the trajectory of one’s professional growth and identity. Developing comfort and skill around talking to strangers (and enjoying it!) over time can certainly enhance professional confidence, interviewing skills, networking skills, and leadership strengths.

Above all else, talking to strangers may have a positive impact in reducing how disconnected our modern world feels. After all research suggests that a lack of social connectedness is a key predictor of suicide risk. According to Dr. Thomas Joiner, expert in suicide prevention and author of the Interpersonal-Psychological Theory of Suicidal Behavior presents three key components to be highly predictive of suicide (Why People Die by Suicide, 2005). Specifically, he identified thwarted belongingness (along with perceived burdensomeness and capability to suicide) as factors that together lead to suicide attempts. What better way therefore, to enhance a sense of belongingness than by broadening our social networks and improving the very skills that help us to connect?

The goal of refining skills for interacting with strangers isn’t to win everyone over but to create more extraordinary and memorable moments in life and to show curiosity into the gift that each moment might hold. I’m a firm believer that the Universe makes no mistakes, and each interaction holds lessons of what we may learn
to do more or less of. If we were to encourage clients to look curiously for gifts, while treating others with more civility and kindness, the world might simply be a nicer place to live in, and we’d experience greater ease and fun along the way. Please join me in encouraging clients to consistently practice their influence in connecting meaningfully with strangers (who could be more!) anywhere they go,

Dr. Nademin’s book as a handbook for clients to follow. She’s also posted a worksheet for readers to download to track the memories they create along the way (www.4anewyou2.com/BookTeasers). You can find her book, “Don’t be a Stranger” in paperback or Kindle ebook forms on Amazon, iTunes, or ask for it at the local bookstore.

References


Dr. E Nademin, Board Certified in Behavioral and Cognitive Psychology, Home-Based Primary Care Psychologist working with elderly, progressively ill veterans, in private practice, and entrepreneur has published a self-help book on skills for connecting more successfully strangers. Everyone’s a stranger until they’re not, and often the greatest gifts in life arrive in relationships with strangers we’ve yet to meet, whether a neighbor, an interviewer, a new friend, business partner, or romantic partner. With so much perceived disconnectedness and social anxiety in our world and among our clientele, Dr. Nademin provides a casual, personal approach to practicing long-held yet often overlooked skills of engagement, civility, and warmth. Her overarching message is one of taking personal responsibility in cultivating an environment most likely to engage the best in others. Her intention is to help others create more memorable moments in life for the purpose of attracting greater joy, reducing patterns informed by anxiety, and igniting the foundation for more meaningful, lasting relationships. Many of the skills she’s laid out are inspired by cognitive-behavioral techniques and reinforce the impact we have on reinforcing them in our respective lives. Dr. Nademin encourages us to join her in making the world a kinder place, one memorable moment at a time.
Men and Violence
Ronald F. Levant, EdD, ABPP

The vast majority of sexual and gun violence crimes are committed by boys and men, yet most boys and men are not violent. An unpacking of this seeming paradox requires an analysis of the role of masculinity. This is the first book to examine that question head-on, synthesizing over 4 decades of research in the psychology of men and masculinities as well as popular accounts of recent events. Written for the professional as well as the educated lay reader, this book connects the dots between masculinity and the present moment in U.S. Culture, defined by such high profile movements as #MeToo, #MarchForOurLives and #BlackLivesMatter.

Men are expected to be masculine, which usually means being self-sufficient, stoic, strong, dependable, brave, tough, a leader, hard-working and avoiding conduct that is stereotypically feminine, such as emotional expressivity, empathy, and nurturance. However, few realize that these qualities (when taken to the extreme) can imprison some men, resulting in the constriction of their emotions, aggression and violence. Further, even though most men are not violent, decades of research have shown that masculinity is related to sexual and gun violence, and exacerbates working class men's economic stagnation. To make matters worse, too many men are harmed by masculinity, suffering as a result of their adherence to masculine norms from poor physical health, shorter lives, depression, alexithymia, substance abuse, difficulty in recovering and growing from trauma, and, most tragically, suicide. Masculinity varies with other aspects of a person's identity such as race/ethnicity, sexual orientation, gender identity, and age cohort, so that is more appropriate these days to speak of masculinities. Girls and women benefitted from many decades of conversations on to navigate their gender in a changing world, and similar discussions are urgently needed for boys and men. New efforts to help boys and men find new ways to be in the world are presented, to both address urgent social problems and to help the men themselves and their families.

I want to announce my most recent co-authored book (with Shana Pryor and published by Oxford University Press): The Tough Standard: The Hard Truths about Masculinity and Violence.

You can get more information at https://thetoughstandard.com
Specialist in the News

Dr. John C. Norcross, Elected to National Register of Health Service Psychologists Board of Directors

The National Register Board of Directors elected John C. Norcross, PhD, ABPP, of Pennsylvania, to a four-year term that began January 1, 2020. An internationally recognized authority on psychotherapy, John C. Norcross, PhD, is Distinguished Professor of Psychology at the University of Scranton and Clinical Professor of Psychiatry at SUNY Upstate Medical University. He has published more than 400 publications and scores of books, including among many others the APA Handbook of Clinical Psychology, the Handbook of Psychotherapy Integration, and Systems of Psychotherapy: A Transtheoretical Analysis, now in its 9th edition. He recently published (with Gary VandenBos) the second edition of Leaving It at the Office: A Guide to Psychotherapist Self-Care. Dr. Norcross has been credentialed by the National Register since 1989.


New Board Certified Specialists/Subspecialists
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Adam R. Fisher, PhD

Group Psychology
Michele D. Ribeiro, EdD
Larry A. Gaupp, PhD, ABPP – Clinical Psychology

Larry A Gaupp, PhD of Burlington, CT died unexpectedly March 17, 2020 at the age of 75. Larry was born in Egg Harbor City, NJ on November 6, 1944. He was raised in a German farming community and from an early age worked on his grandparents' commercial flower farm. The efforts and success of his extended family on the farm influenced his personality a great deal. He was an industrious and devoted man, fully committing himself to his family, profession, and beliefs, initially to the Moravian church as a child and Buddhism in his adulthood. Larry attended Indiana University where he chose a career in psychology. He earned his PhD at Penn State during the Vietnam War and completed his internship at Walter Reed Army Medical Center. He was then commissioned into the US Army, serving his tour of duty in South Korea. He returned to the US in 1974, joining the psychology staff at Audie Murphy Veterans Hospital in San Antonio. In 1985 Larry became Chief of Psychology at the Newington Veterans Administration hospital in Connecticut, where he served until his retirement in 2013. Upon retirement, Larry committed more than 42 years to the veterans of our country. He enjoyed his career, particularly when training his beloved interns who he mentored in his unique way.

James S. Walker, PhD, ABPP - Clinical Neuropsychology & Forensic Psychology

James S. Walker, PhD, a neuropsychologist and forensic psychologist, died unexpectedly at his home in Delray Beach, Florida, on November 22, 2019. He was born on January 6, 1964, in Wheaton, Illinois. Jim lived and worked in Nashville from 1998 to 2019; he moved to Florida in May 2019. Jim graduated magna cum laude from Asbury University, Wilmore, Kentucky. He earned his master's degree and PhD in clinical psychology at the University of Louisville, Kentucky. Jim was an assistant professor in the Department of Psychiatry, Vanderbilt University School of Medicine, where his practice consisted of psychological, neuropsychological, and forensic evaluations. He also served as chairman of the Treatment Review Committee for the Tennessee Department of Corrections. He developed a program called Clarity Professional Evaluation Center, which conducted fitness for duty evaluations of impaired professionals. Most recently, Jim was employed by the Romano Law Group, West Palm Beach, Florida.